A Survey of Treatment Procedures in improvisational Music Therapy

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Abstract

Major models of improvisational music therapy are described in terms of clinical applications, goals, session formats, media selection, and methodological procedures. Details are given on procedural steps or cycles that occur within a typical session in each model. Two prototypes for improvisatory sessions are identified, and procedural objectives found in most models of improvisational music therapy are summarized.

Musical improvisation has been used as the cornerstone of several models of music therapy, and with a broad spectrum of client populations. Given this diversity of application, procedures for incorporating improvisation into clinical treatment vary considerably.

The purpose of this paper is to summarize major models of improvisational music therapy with regard to treatment procedures. As such, the paper condenses and paraphrases previous (more comprehensive) descriptions of these models by the author (Bruscia, 1987). Given the number of clinical models to cover, and the limited scope of this paper, the specific focus will be procedural steps or cycles that occur within a typical therapy session. The reader is referred to the original sources for musical examples and case material, both of which could not be included herewith.

Creative Music Therapy

During their 17 years of collaboration, Paul Nordoff and Clive Robbins developed an improvisational model of therapy which they called "Creative Music Therapy" (1965, 1971, 1977, 1983). Though originally designed for handicapped children, the model can also be used with adults. its main goals are to develop self-expression,

communication, and human relationships, to build stronger richer personalities, to enhance personal and interpersonal freedom and creativity, and to dispel pathological behavior patterns.

Creative music therapy can be implemented in individual and/or group settings. ideally, two therapists work as a team, with one improvising at the piano to engage the client(s) in a therapeutic music experience, and the other helping the client(s) to respond to the improvisation and to the clinical intentions of the therapist at the piano. in individual therapy, the client uses two media predominantly: vocalizing/singing, and playing a drum and cymbal, with other media and instruments added as necessary. In group therapy, clients sing, play a wide variety of percussion, wind, and string instruments, and participate in specially composed musical dramas.

The individual session can be broken down into three procedural phases: meeting the child musically; evoking musical responses; and developing musical skills, expressive freedom and interresponsiveness. These phases occur spontaneously, as the client's responses dictate. Thus with some clients, an entire session might be devoted to one phase, with others a session might include all three phases or the entire cycle repeated several times.

Meeting the child musically, which is the condition for implementing every procedure and technique, involves improvising music that matches the child's emotional state, while also accepting and enhancing its expression. The objectives of this phase are to establish musical contact and rapport, to explore and gratify the client's musical tendencies, and to develop a trusting, accepting relationship. Musical reflection is the most frequently used technique.

Evoking musical responses involves a variety of techniques aimed at engaging the client in musical improvisations with the therapist. The main techniques

are: presenting and/or demonstrating instruments, improvising music that stimulates or calls for a vocal or instrumental response, establishing musical turn-taking, helping the client phrase or shape his/her musical ideas or impulses, providing musical structures that support the client's improvising and make it more meaningful, and giving the improvisation musical form. The main objectives are to help the client develop a musical vocabulary that will facilitate self-expression, and to create a musical context wherein client and therapist can build a working relationship .

Developing musical skills, expressive freedom and interresponsiveness are objectives of the third procedural phase. Developing musical skills may include establishing a basic beat, forming rhythm patterns or melodic motifs, or creating an instrumentation for a phrase. Expressive freedom is developed by exploring the musical options and choices inherent in each musical skill. For example, upon establishing a basic beat, the client discovers that it can be fast or slow, loud or soft, and accented or unaccented; upon developing a melodic motif, the client discovers that it can be high or low, and with or without words. In the process of discovering these expressive freedoms, the client also realizes that there are many options for relating his/her music to that of the therapist—that the beat can be faster or slower than the therapist's, that the melody can be higher or lower—that music can be an "interresponsive" give-and-take with another person. Pathological restrictions in the client are frequently encountered in this phase, and efforts are made to modify or dispel them through the musical objectives.

Free Improvisation Therapy

Juliette Alvin (1975, 1976, 1978) used "free improvisation" as part of a comprehensive approach to music therapy which employed various other musical activities as well. The improvisations were considered "free" because the

therapist does not impose any rules, structures. or themes on them, but rather allows the client to "let go" on a musical instrument while also finding his/her own way of ordering and sequencing the sounds.

Though Alvin is best known for her work with autistic children, she did work with many other populations, including adults. As described here, free improvisation therapy can be used with children with various handicaps. its main goals are self-liberation, the establishment of various kinds of relationships with the world, and developmental growth in the physical, intellectual, and social-emotional domains.

The model can be used in individual, family, and group therapy settings, depending upon the specific kinds of relationships that the client needs to explore at his/her developmental stage. The therapist selects his/her own instrument according to the client's needs and preferences, and allows the client to use instrument(s) of choice.

In her work with autistic children, Alvin (1978) planned therapy according to three developmental stages: relating self to objects, relating to self and therapist, and relating self to others. Each stage is characterized by certain techniques, which can be either active (when the client makes music) or receptive (when the client listens to music). The therapist chooses the most appropriate technique according to the client's immediate needs and reactions, and any situational factors that may be relevant.

In the first stage, "active" techniques are used to help the client to relate to instruments and to music, and to develop sensorimotor awareness, perception, and integration. "Receptive" techniques are used to introduce the client to-the therapist's instrument and music. During this stage, the therapist is nondirective and respects the client's territoriality. Emphasis is given to deriving musical pleasure through the free use of instruments.

In the second stage, "active" techniques serve to project the client's feelings onto the instrument and to develop some level of trust in the therapist. Examples include: improvising dialogues and duets, sharing instruments and territories, and exploring the therapeutic components of each instrument. "Receptive" techniques aim at bringing the client an awareness of his/her own musical and personal problems and feelings. This can be done through various listening activities. Having the client listen to tapes of his/her own playing is particularly effective.

In the third stage (which may not be necessary or appropriate for everyone), the client is transferred from individual therapy to a family or group setting. The musical activities and experiences developed with the therapist in previous stages now provide models for developing or improving relationships with significant others or peers. Group techniques include free improvisation, titled improvisation, listening, singing, discussion, and movement activities.

Analytical Music Therapy

Analytical music therapy was originally conceived and developed in the early 1970's by Mary Priestley, Peter Wright, and Marjorie Wardle, however because Priestley (1975, 1980) has been primarily responsible for clinically testing and refining the model, she is generally considered to be its founder and chief proponent. More recently, it has been also called "exploratory music therapy."

Analytical music therapy is defined as the use of words and symbolic music improvisations as a means of exploring the client's inner life and facilitating growth. A characteristic feature is that the client's improvising is often stimulated and guided by verbal titles which describe emotional issues that the client needs to examine. The titles or issues may be specific feelings, ideas, images, fantasies, memories, events, or situations.

The model was originally developed for adults with emotional or interpersonal problems. it has also been used with couples experiencing relationship problems, and as a method of training therapists called "Intertherapy." its chief goal is to remove obstacles which prevent the client from realizing his/her full potential and from achieving personal goals. This may require "central" work (i.e., confronting problems within the client's self or inner life) and/or "peripheral" work (i.e., confronting problems of everyday life and "outer" life relationships).

Individual sessions are most common, however analytical music therapy can also be implemented in client dyads and groups. in individual sessions, the client uses a wide array of instruments and may sing if so inclined. The therapist Usually plays the piano but may also select an instrument according to the client's needs, or the specific role to be played in the improvisation.

An analytic session can be understood in terms of a four-phase cycle: identifying and entitling an issue for investigation; defining improvisatory roles of the client and therapist; improvising the title; and discussing the improvisation experience afterwards.

To identify an issue that needs investigation, the therapist may engage the client in a verbal discussion or an untitled musical improvisation, or simply observe the client's body language. The key is to discover where the client's psychic energy is blocked and to determine whether it is blocked at the conscious or unconscious levels. Priestley has also developed specific techniques for accessing unconscious material, for exploring conscious issues, and for strengthening the ego. She describes these techniques as "a particular focus for emotional investigation through music" (1975, p.120).

Defining what roles the client and therapist are to take in the improvisation depends upon several factors. These

include: the therapeutic issue being explored, the role possibilities inherent in the title, the technique employed by the therapist, the client's need for direction or support, and the client's readiness for playing specific roles.

Improvising the title is aimed at putting the client in musical contact with his/her own feelings and letting the 'inner music" flow. inner music is defined as "the prevailing emotional climate behind the structure of someone's thought" (Priestley, 1975, p. 199), or the way one's inner life sounds. Depending on the purpose of the improvisation and the client's needs, the therapist may sit back and listen, or improvise along with the client. In either case, as the client improvises, the therapist must maintain musical contact with the client's feelings as well as his/her own reactions to them, so that the client's inner music can be comprehended and distinguished from the therapist's. The improvisation is usually tape-recorded for later use.

The final phase in the cycle is discussing the improvisation. The therapist usually begins by asking the client to verbalize his/her immediate reactions to the improvisatory experience. The therapist may focus on what the client's musical intentions were, what feelings were aroused by the process of improvising and by the sounds that came forth, and how the client attempted to respond to these feelings within the improvisation itself. Depending on the circumstances, the therapist may listen silently, make a few comments, or engage the client in an indepth discussion. After processing immediate reactions and impressions, the therapist may have the client listen to a tape of the improvisation for further analysis, however this is done only if the client can tolerate such direct feedback, and only if s/he is ready to delve deeper into the emotional significance of the improvisation. On the other hand, if the client's reactions reveal new or more relevant issues to be investigated, the therapist may begin the entire cycle again by formulating another title to improvise. Or, if the client was unable to explore

the original issue adequately through music, the therapist may ask the client to draw, paint, or dance instead. A key consideration for the therapist then is to recognize when the client is resisting through words and when the client is resisting through the music.

Experimental improvisation Therapy

Experimental improvisation therapy is a model of group therapy and training which employs both music and dance. It was originally developed by Anne Riordan as a method of teaching dance improvisation to handicapped persons, and was later adapted by the present author for music therapy (Bruscia, 1987). After several years of collaboration, a combined music-dance model was developed. As presently described, experimental improvisation therapy can be used with adults and children, handicapped or nonhandicapped, for therapeutic or educational purposes. Its primary goals are: to enhance potentials for self-expression and creativity; to develop individual freedom within group situations; to develop group skills; and to build physical, social, emotional, cognitive, spiritual and creative skills inherent in music and dance.

Each session is organized according to procedural cycles that are repeated until a complete improvisation is fully developed, rehearsed, and ready for performance. In the first cycle, the therapist gives the group a focal point for developing the first theme of an improvisation. The focal point may be a "vocabulary given" (anything that limits the kinds of movements or sounds that can be used), a "procedural given" (anything that stipulates the temporal ordering of events), and/or an "interpersonal given" (anything that stipulates what kinds of interactions or relationships will take place among the improvisers). The group then experiments within the given to discover what possibilities there are thematically.

To give a musical example, the therapist may ask the group to explore various ways of making "slow-moving or

sustained sounds," with each person having free choice of instrument(s). As the improvisation begins, groups usually discover that with this particular given, the volume or dynamics of the music are very important. Silently, while continuing to play, individuals begin to grapple with several questions: Who is playing loud and soft? Which sounds better? Why did the therapist omit directions about how loudly to play? How can we coordinate what everyone is doing? Who is controlling the volume of the group? Meanwhile, the ongoing task is to create sounds that contribute to the group effort.

Upon completing the first experiment, the group discusses what was discovered or experienced while improvising, and the implications that the improvisatory or group "process', had on the "product(s)." in the above example, the group might discuss similarities and differences in how each member approached the music, and what effects each person had on the group or the music. The therapist might ask them to describe how the question of dynamics was resolved, and who played the most important roles. The therapist might also ask the group members to decide whether they prefer loud or soft sounds, and which they feel is more appropriate for a "slow and sustained" theme.

The discussions and reactions are then used to develop guidelines for a second experiment with the same given (i.e., slow and sustained). The purpose of the second experiment is to formulate a "theme" out of ideas that emerged in the previous improvisation. In the example, the theme might be an established sequence of instrument combinations or players, an overall musical shape through directional changes in dynamics, etc.

After a clear theme has been formulated and rehearsed, the therapist provides another "given" for the group to develop a second theme, and the entire cycle is repeated. With the present example, a second given might be to

make sounds that are "fast-moving and fleeting," however this time using only melodic instruments.

After two or more themes have been established, they are connected and rehearsed through the same procedural cycle and a final performance of the entire improvisation is prepared.

During each cycle, many musical and interpersonal issues arise. The therapist helps the group to resolve them through sensitive selection of the most appropriate ' givens," through guidance of group discussions after each experiment, and through consultation during rehearsals for the final performance.

Orff Improvisation Models

Originally conceived by the twentieth century composer, Carl Orff, the "Orff-Schulwerk" is a philosophy of music education that has been incorporated into music therapy by three leading proponents: Gertrude Orff (1980), Carol Bitcon (1976), and Irmgard Lehrer-Carle (1971). A core concept in Orff's philosophy is "elemental music," which is defined as the universal tendency to create music out of the natural rhythms inherent in movement and speech. Elemental music develops in individuals in stages that correspond to the evolution of music in the species.

Orff models of therapy and special education have been used with children, teenagers, adults, and senior citizens having a wide range of handicaps. Because of the diverse activities employed and the many skills in them, the goals possibilities in Orff therapy are myriad. Specific goals are determined according to the characteristics and needs of the clients. The overall goals are to help each participant fully experience his/her own self within the social and physical worlds, and to develop qualities of creativity, playfulness, and spontaneity.

Group work is the most common format, however individual sessions are used with clients who are severely aggressive or unable to benefit from a group setting. A wide variety of modalities and media may be employed, including vocal, instrumental, motor, verbal, art, and emotional activities.

The Orff session typically begins with a "warm-up" or opening activity that prepares the client for the main activity while also fostering group interaction. Names and greetings are frequently incorporated into the activity. Once the group is prepared emotionally, cognitively, and socially, the therapist is ready to "stimulate" the main activity. This is accomplished by presenting a "germinal idea" for individual and group improvisation. Ideally, the germinal idea sets the stage for a creative play situation to emerge. As such, it can be a sound, rhythm, melody, rhyme, movement, instrument, prop, etc. that invites each member of the group to spontaneously create a unique response.

Before the group begins to explore the idea, the therapist also "coordinates" how and when the participants will respond. Usually this involves organizing the musical parts of the soloist and group so that simultaneous components of the activity fit together, and so that sequential events have the desired flow. Ultimately, this helps the group to form musical and interpersonal relationships within the activity and media. As the group begins to explore the germinal idea and play with its possibilities, the therapist fosters a group attitude that expects the best effort from each individual while also valuing everyone's contribution. The therapist must also be concerned with the dynamic flow of the activity and its impact upon the group.

After everyone has had sufficient opportunity to play with the germinal idea, it is time for the group to "formalize" the improvisatory routine, or to concretize what was discovered and accomplished during the activity. This can be accomplished through verbal discussion of the

improvisation, or through activities that re-create or improve it in some way.

This cycle of stimulating, coordinating, exploring, and formalizing may take an entire or session or it may be repeated. At the end of the session, the therapist presents a closing or good-bye activity.

Paraverbal Therapy

Paraverbal therapy is a method of psychotherapy developed by Evelyn Heimlich (1965, 1972, 1980, 1983, 1985). As implied by its prefix, ,,paraverbal" therapy utilizes both nonverbal and verbal channels of communication, and employs various expressive media (viz., speech, language, music, mime, movement, psychodrama, painting, drawing) in unorthodox and nontraditional ways. its main purpose is to gratify the expressive, communicative, and therapeutic needs of the client as they are manifested from moment to moment.

Paraverbal therapy has been used primarily with children who have emotional or communication problems that are not responsive to verbal methods of therapy. This includes children with various diagnoses including psychoses, emotional disturbance, mental retardation, learning disability, medical illness, etc. The method is also used with mother-child dyads and with developmentally disabled individuals of various ages.

I he basic goals are to fulfill the client's basic emotional needs, to develop a sense of self, to foster self-expression and communication, to provide relief from painful emotions, and to eliminate symptoms.

The paraverbal session contains four main procedures: observation, maneuver, shift, and encounter. Observation is an ongoing, continuous process in Paraverbal therapy. The therapist proceeds "moment to moment, according to the observed cues, gleaned from the child's own responses to the stimuli presented"

(Heimlich, 1983, p. 58). Thus, the therapist observes the client before, during, and after each intervention. The focus of these observations are the child's communicative tendencies and needs, his/her emotional needs, and his/her readiness for various maneuvers and encounters with the therapist.

Based on close and sensitive observation, the therapist seeks to engage the child in some form of paraverbal expression or communication that will both bring pleasure and meet his/her communicative and emotional needs in the moment. Heimlich has developed several "maneuvers" that can help to engage the child in this way. Some of these maneuvers involve improvisatory rhythmic dialogues, story improvisations, song improvisations, exploring instruments, playing instruments jointly, using instruments metaphorically, the metaphoric use of songs, reciprocal rhythmic movements, drawing or painting to music, miming, playing games, and dramatic activities.

As the child engages in these paraverbal forms of self-expression and play, the therapist observes his/her reactions, choices, tendencies and therapeutic needs. Often. these observations reveal a need for the child to 'shift" or change from one communication channel, medium, role or material to another. Shifts between verbal and nonverbal channels can bring a maneuver closer to the child's feelings or make it more distant. Shifts in media (e.g., reciprocal movements to improvisatory rhythmic dialogues) can help to engage the client more fully or provide greater satisfaction. Shifts in roles can bring closeness or distance between the client and therapist. Shifts in materials can be useful in accommodating the child's capabilities and motivational needs.

The maneuvers provide rich opportunities to observe and understand the child's emotional world. Often, the child's concerns, conflicts, and symptoms arise within the maneuver. When this happens, the therapist must decide

whether the child is ready for an "encounter." An encounter is any attempt the therapist makes to help the child confront, work through, abandon, or resolve his/her problem.

Since the paraverbal session is organized around the child's responses, these procedures are used spontaneously as the child's needs emerge from moment to moment.

Improvisation Assessment Profiles

The improvisation Assessment Profiles (IAP) were developed by the author (Bruscia, 1987) to provide a comprehensive model of client assessment and evaluation. They can be used with children or adults, at various developmental levels and with varying handicaps and diagnoses.

Using the IAPs involves three procedural steps. The first is to observe the client improvising under various conditions (e.g., alone, with the therapist or significant other, with and without imagery, and with and without various musical directions). The second step is to musically analyze the improvisations according to the profiles and subscales provided, and the third is to interpret the findings according to a psychological theory that is relevant to the client's problem (e.g., developmental, psychoanalytic, existential).

The IAPs consist of six profiles that have subscales for each musical element. Each profile focuses on a particular musical process (e.g., integration), and provides a continuum of five gradients ranging from one extreme to its opposite (e.g., undifferentiated, fused, integrated, differentiated, overdifferentiated). Each subscale focuses on how that process is manifested in a specific musical element (e.g., rhythmic integration, harmonic integration).

The six profiles are: integration (how simultaneous aspects of each element are organized); variability (how sequential aspects of each element are organized); tension (how each element accumulates, sustains, modulates or releases tension); congruence (whether simultaneous feeling states and role relationships are consistent among each element); salience (how much prominence and control each element is given); and autonomy (the kinds of relationships formed between the improvisers through each element).

Metaphoric Improvisation Therapy

Shelly Katsh and Carol Merle-Fishman (1984) developed a model called "Metaphoric improvisation Therapy" for use with adults in the community. The model combines music therapy and psychotherapy, and was originally conceived as a form of individual therapy within a group setting, employing two therapists. Its goals are to increase awareness, contact, spontaneity, and intimacy in relating to self and others.

The typical session is divided into five sections. Every session begins with a warm-up and ends with a closure, while the middle of the session consists of a three-phase cycle which is repeated as each client takes a turn working with the therapists.

In the "warm-up", the clients and therapist develop (or renew) working relationships as a group, while also discussing individual goals for therapy or specific objectives for the session.

Upon completion of the warm-up, a client volunteers to work with the therapists, and the repeated phase cycle begins. The purpose of the first phase is to help the client to "identify an issue". An issue can be a habit, blindspot, fear, inadequacy, or anything that keeps the person "stuck" in old patterns and unable to meet desired goals. It can be manifest or latent. Methods for uncovering the

issue include guided fantasies, relaxed listening, and free improvisation.

Once the client has an issue, the therapists and client explore the issue through musical "experiments." In these experiments, the client enacts or depicts the issue (or its resolution) by improvising musical metaphors of it.

After the experiment, the client and therapists discuss what the client experienced while working through the issue and what might be gained from the experience. The purpose of this discussion phase is to "consolidate" the client's understanding of the issue as gained in the experiment. Often the consolidation of one client's experience strikes a resonance with other clients, so that an identification process begins within the group. Through this identification process, a natural flow develops between each individual client, and one repeated phase cycle leads quite smoothly into the next. Themes often emerge for the entire group to consider.

After every client has worked on an issue, the therapists try to gain "closure" to the session through verbal summaries, group discussions, group improvisations, and/or performances by the therapists aimed at nurturing the group through music.

Integrative improvisation Therapy

Integrative improvisation therapy was developed by Peter Simpkins (1983), as a result of his work with atypical children having various diagnoses. He later adapted it to psychiatric adults. Its main goal is to integrate various aspects of the client's world, including: the various senses, the body with the psyche, the ego with the id and superego, the unconscious with the conscious and the here-and-now, the nonverbal experience with the verbal, and the self with other.

The model can be used in individual or group sessions. however clients who are severely withdrawn or aggressive are usually seen individually. The therapist integrates verbal and musical means of interaction, using piano and voice as primary musical instruments. The client is given a choice of instruments and is also encouraged to vocalize, sing, or verbalize.

Each session is organized around four phases or objectives: attend, engage, work through, and integrate. A basic feature of integrative improvisation therapy is that the therapist allows the client to disclose him / herself spontaneously, without imposing any structures on the content or nature of such self-disclosure. Essentially this involves waiting for the client to express him/herself through the various media and materials that are; made available, and waiting for the client to accept the therapist's presence. The waiting is a very active process of "attending" and reflecting whatever the client offers. Of particular note are the quality and shape of the client's efforts, whether observed in his/her movement or music. This "attending" is ongoing throughout the session and provides the basis for each intervention.

If the client does not respond musically or verbally, the therapist works to evoke a response, and thereby "engage" the client in some kind of interaction. If the client responds musically, the therapist engages him/her through improvised dialogues. If the client responds verbally, the therapist responds verbally and then attempts to cast the verbal materials into a musical improvisation. Ultimately, by engaging the client musically, unconscious drives and conflicts are given form and previously blocked energy is safely released.

As the client's conflicts are externalized, deep emotional and/or interpersonal struggles come to the surface, and the therapist attempts to help the client "work through" the struggles, both musically and verbally when possible. In working through emotional struggles, the therapist might

help the client to contain or release the feelings musically, or to verbally label the wishes and feelings and discuss their origins and effects. In working through interpersonal struggles, the therapist elicits positive and negative transferences by introducing compatible and incompatible elements (musically and/or verbally) and then helps the client to integrate them.

As insight is gained or some resolution is reached, the therapeutic experience has to be integrated into the client's world—the here-and-now, real world outside of therapy. This is accomplished by "consolidating" the experience in the client's awareness or memory and relating it to other situations.

Developmental Therapeutic Process

Developmental therapeutic process was developed by Barbara Grinnell (1980) for children who are severely emotionally disturbed or psychotic. The approach combines music therapy, play therapy, and verbal psychotherapy according to developmental stages. Its main goals are to develop interpersonal relatedness through nonverbal and verbal modalities, and to; work through emotional conflicts, symptoms and developmental obstacles.

Used primarily in individual settings, the therapist works at the piano while the child either listens, or plays a drum, cymbal or other percussion instrument. Procedural aspects are determined according to three developmental stages.

During the first stage, the therapist establishes a relationship with the child through musical improvisation. Typically, therapy begins with piano improvisations that nonverbally reflect the child's mood. As rapport is gained, the therapist uses song improvisations to communicate with the child and to elicit musical responses from the child. The eventual goal is to engage the child in musical

games and improvisatory dialogues. The music during this stage is always reflective of the child, or under the child's control. An effort is made, however, to introduce the child to musical and emotional contrasts. The same music is used from one session to the next, and gradually a repertoire of improvised and precomposed pieces are built, each associated with a particular activity.

During the second stage, the therapist helps the child to find a means of symbolically expressing his/her feelings. This is done through the combined use of song improvisations, projective musical stories, doll play, and puppetry. When the child is threatened by such activities, the therapist reintroduces nonverbal, musical forms of expression from the previous stage.

During the third stage, the therapist works to build a relationship that will permit the child to verbally process those conflicts and issues that have arisen during the previous stages. This is accomplished through activities such as drawing, doll and puppetry dramas, personalized games, and verbal discussion. When the child feels threatened by this level of processing, the therapist allows the child to return to forms of expression from the previous stages.

Miscellaneous approaches

Gillian Stephens (1983) developed an approach to music psychotherapy geared primarily to psychiatric adults. Her approach incorporates all kinds of improvisation (viz., titled and untitled, vocal and instrumental, solo and ensemble) while also integrating both verbal and musical techniques.

Musical psychodrama is an approach developed by Joseph J. Moreno (1980, 1984), which uses musical improvisation as a means of facilitating the group warm-up and enhancing the enactment of the psychodrama itself. During the warm-up, the group improvises (with or without a title), listens to taped play backs, and discusses

the improvisation. Or the therapist or a trained ensemble improvises music while the group listens in a relaxed state. These experiences are intended to sensitize the group to the emotional implications of musical improvisation, and to help them select a protagonist for the psychodrama. During the enactment of the psychodrama, the protagonist, auxiliaries, or group improvise music to help the protagonist recognize, work through, and release emotions and conflicts that are surfacing during the enactment. Musical "doubling" is a commonly used technique wherein the director or group express or intensify feelings of the protagonist, either musically or verbally.

Lisa Sokolov (1984) developed a model which uses breathing, toning, vocal improvisation, singing, body alignment, touch, verbal imagery, and psychotherapeutic techniques. It can be used with neurotic adults, pain sufferers, stroke patients, psychiatric patients, and in childbirth.

Rolando Benenzon (1982) developed an approach which employs the isoprinciple in designing improvisations and other musical activities for the patient. In his conception, "isos" are sounds or sound complexes that characterize a person, group, environment, etc. His clinical work is divided into three stages. In the "regressive" stage, the client listens to sounds and music which are consistent with his/her iso, sometimes playing with water. In the "communicative" stage, the therapist engages the client in improvised musical dialogues based on information gleaned from the client's responses during the regressive stage. In the "integrative" stage, the child interacts with the environment and family group, using channels of communication that have developed in the communicative stage.

Edith Boxill (1985) uses a "continuum of awareness" in her work with developmentally disabled clients. Her model employs three main strategies: reflection (instantaneous musical playback); identification

(instantaneous musical feedback); and contact song (reciprocal musical expression).

Dorothy Crocker (1957) developed a method for using improvisation projectively with emotionally disturbed children. The method consists of four steps: having the child free-associate to chords; eliciting a story from the child as the therapist improvises around the most emotionally significant chords; eliciting a story as the therapist improvises around a emotionally significant title; and composing a song about significant family members.

Synthesis of treatment procedures

In comparing the various models, two basic kinds of improvisatory sessions can be discerned: structured and free-flowing (Bruscia, 1987). in the "structured" session, the therapist organizes the session so that it has a beginning, middle, and end. Procedural phases are sequenced so that they move towards or away from a focal event or activity. Examples of this type include experimental improvisation therapy, Orff models, metaphoric improvisation therapy, and musical psychodrama, all of which are group models.

In the "free-flowing" session, the therapist lets the client determine the direction of the session from moment to moment, and uses procedural cycles that are repeated or layered according to recurring musical or emotional themes in the client's responses. Examples of this type include creative music therapy, analytical music therapy, Paraverbal therapy, integrative improvisation therapy, and developmental therapeutic process, all of which are individual models.

In comparing the procedural phases and cycles used in the various models, many commonalities can be found with respect to what the therapist is trying to accomplish at different points within a session (Bruscia' 1987). Most models have procedures for accomplishing the following

clinical objectives: to prepare the client to participate or interact, to evoke some kind of expression or communication, to adapt the modality or media of expression to the client's needs, to focus the client on a particular aspect of his/her experience, to help the client fate or confront his/her problem, to explore solutions or options that are available to the client, to evoke new responses to the problem, to concretize and generalize whatever has been discovered or learned within the therapy session, and to bring some kind of closure to the session (Bruscia, 1987).

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