The Playwheel

A Model for Therapeutic Improvisation

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Abstract: This article presents a Model of clinical techniques of improvisation in Music Therapy. The basic elements of therapeutic process are outlined and organized into a Model of improvisation that provides a synthesis of clinical musical techniques. This learning tool is meant to function as an explanatory guide and a mnemonic device for student and intern, as well as the professional music therapy practitioner. The work of innovative contributors to this topic is considered in light of this Model (Alvin, 1975; Priestley, 1975; Nordoff and Robbins, 1977; Bruscia, 1987; Kenny, 1989; Pavlicevic, 1997; Ruud, 1998; Lee, 2003; Wigram, 2004; Smeijsters, 2005).

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The Importance of Improvisation

For the music therapy clinician, therapeutic improvisation is an essential and effective working method. In the last thirty years there have been several advances in approaches taken to improvisation in the profession of music therapy, as reported by a variety of innovators (Alvin, 1975; Priestley, 1975; Nordoff and Robbins, 1977; Bruscia, 1987; Kenny, 1989; Pavlicevic, 1997; Ruud, 1998; Lee, 2003; Wigram, 2004; Smeijsters, 2005).

The Latin *improvisus* means *unforeseen*. Mercedes Pavlicevic reminds us that, "Music improvisation has always been. Before music was notated, oral tradition ensured that songs and pieces were kept alive through performance, and each performer added something distinctive to the music, which transformed it, albeit subtly' (1997, p. 73).

One could argue that all music therapy work involves a degree of improvisation. Three primary reasons for this are uniqueness, exploration, and natural process.

1. *Uniqueness*: Each individual (or group) has a unique set of presenting conditions and requires a treatment program suited to that uniqueness. Each music therapist has a unique world view and skill set developed through the opportunities and challenges of their own experience. It follows,

therefore, that when the music therapist comes together with the individual (or the individual in the group) to help bring about a positive change, it is essential that the therapist adjust their approach to the uniqueness of that person. Improvisation provides an open and effective forum for this dialogue. This allows for an ongoing assessment within the treatment plan.

2. *Exploration*: Improvisation permits a range of exploration within the dynamic process of music therapy. This opens the door to personal expression as well as new possibilities for dyadic communication. Exploration opens the door to possibility.

3. *Natural Process*: In the same way that we improvise through verbal language; we think as we speak in the ongoing dialogue of conversation; so music therapy process allows for the give and take of the ongoing musical dialogue. We can apply the improvisational skills of language to the skills of music, and vice versa. For the musically untrained client, the process might feel anything but natural at first, presenting a challenge similar to that of learning a new verbal language.

These attributes of improvisation—uniqueness, exploration, and natural process—highlight the importance of improvisation within music therapy.

Note: The reader will note that in this essay we are using the word *individual* (rather than client, patient, etc.) to represent the person with whom the music therapist is working. Also, we are using the feminine pronoun *she* (rather than "he or she", etc.) when referring to the music therapist.

It is important to recognize that "therapeutic improvisation" is different from "performance improvisation" in music, as in Jazz or in various World musical cultures (Indian, African, etc.) in two ways: 1) Therapeutic improvisation always involves the *dyadic relationship* of therapist and individual. 2) This dyad is guided, not necessarily by the rules of rhythm, melody and harmony--but rather by an unfolding process based on the *therapeutic intent* of the work.

Given the central role that improvisation plays in the clinical practice of music therapy, it is important that the music therapy student be initiated in the ways of therapeutic improvisation. The present model emerged as an attempt to teach classically trained music students to improvise--not only in a solo style, with their instrument, and not only in a musical group context, with each other, but in the context of a *musical dialogue in a therapeutic dyad.*

In Kenneth Bruscia's seminal study he "provides a taxonomy of clinical techniques commonly used in improvisational music therapy" (1987, p. 533). In his synthesis, these total 64. This begs the question: How does one access this large number of improvisational techniques in an intuitive and masterful way as "action knowledge" during a music therapy session? For the educator: How do we train the music therapy student in these techniques?

In this article I will present a "Model for Therapeutic Improvisation." The goal is to build a model that will be useful in both the classroom and the clinic. It will contain all of the major elements necessary for therapeutic improvisation. It will serve as a synthesizing summary of basic techniques, an explanatory guide, and a mnemonic device for student, intern, and professional music therapy practitioner.

It is my hope that this Model can be of service to instructors of therapeutic improvisation at both the undergraduate and graduate levels. As well, it is my intention to contribute to the ongoing dialogue concerning improvisation in the field of music therapy.

Elements of the Model

In designing a Model for Therapeutic Improvisation, one must consider the basic elements involved. These basic elements are:

1. The persons involved (WHO): The practice of therapy is at the least a dyadic process, in that there is always the *therapist* and the *individual* with whom he or she is working. In Music Therapy, this dyad is communicating through the *music*. (Some speak of music as being a "co-therapist", but this is an added level of complexity to explore in another article.)

2. The actions taken (WHAT): This would include all of the actions of the therapist and the individual. Are they performing the *same action* as the other, or a *different action*? For example, are they using the same instruments while playing the same music?

3. The time frame (WHEN): In speaking of the time frame of the actions, are they happening at the *same time* or at a *different time*? If they are at a different time--are the actions of the therapist happening *before* or *after* the individual?

4. The therapeutic intent (WHY): This would speak to the two major approaches with which one engages at the core of therapy 1) Is the therapist now using a technique of *support* (is she *following* the individual's lead), or is she using a technique of *redirection* (is she *leading* the individual)? One dimension of *support* is for the therapist to recognize that the individual may choose to take the music into a new direction.

Building the Model

1. First, we divide a circle by a horizontal line, to differentiate the *action element.*

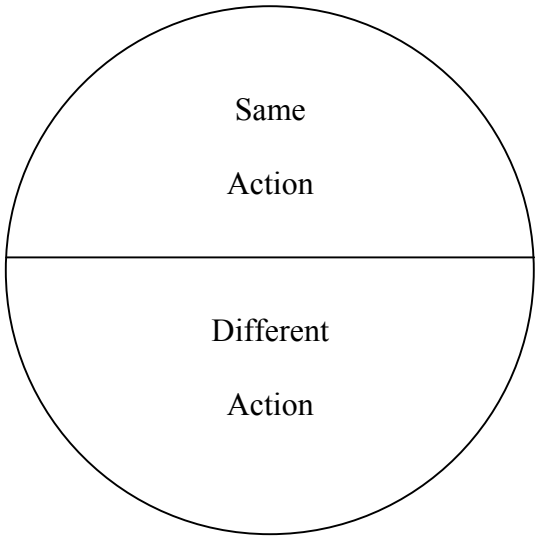

Figure 1: *Same Action and Different Action*. In the top half of the circle we place all same actions --in other words, in this half the therapist and the individual are doing the same action. In the bottom half of the circle, we place all different actions--here the therapist and the individual are each doing an action that is different from the other.

2. We now divide the circle with a vertical line to identify the *time element*.

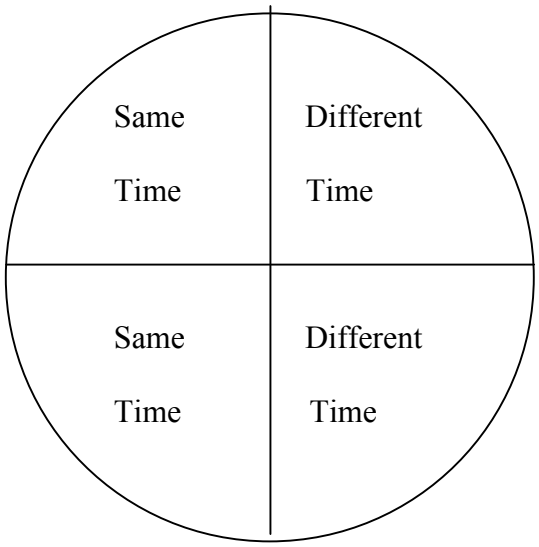

Figure 2: *Same Time and Different Time*. In the left half of the circle, all actions take place at the same time (simultaneously). In the right half of the circle all actions take place at a different time.

3. We now divide the right half of the circle, top and bottom, with a diagonal line, to divide Different Time into actions which happen *before* or *after*.

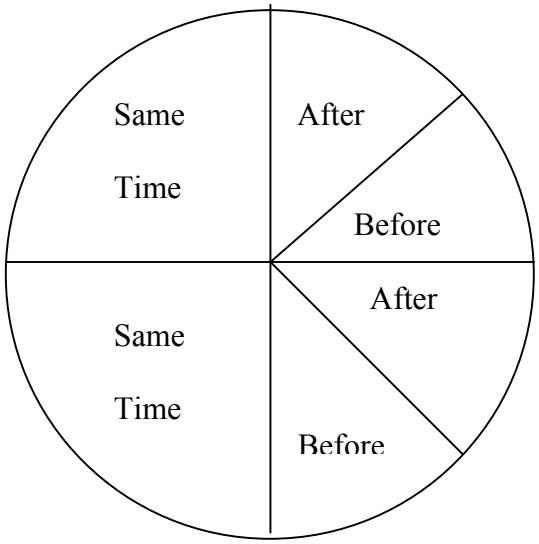

Figure 3: *Different Time divided into Before and After*.

4. We now divide the left half of the circle with a diagonal line, to differentiate between an approach that is *supportive* or an approach that is *redirective*.

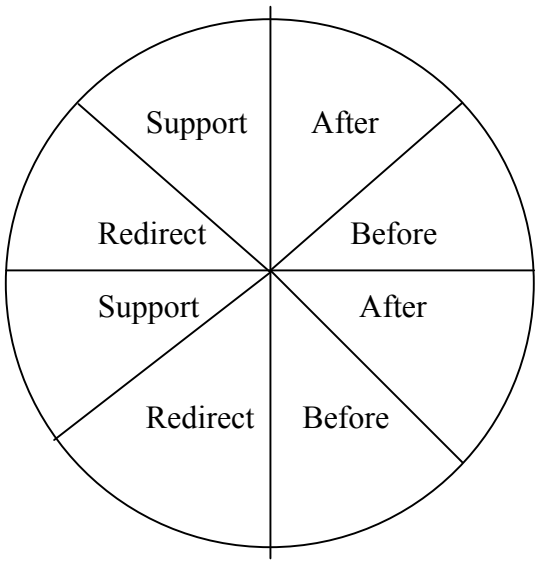

Figure 4: *Same Time differentiated as either Supportive or Redirective*. It is important to identify whether a technique is one where the therapist basically supports the individual, following their lead, or whether the therapist is now attempting to redirect the session, move it into a new direction. Observe how the *supportive* approach for same time actions is similar in intent to the therapist doing the action *after* the individual. Likewise, the *redirective* approach for same time actions is similar in intent to the therapist doing the action *before* the individual.

The Playwheel

Since we have already passed the cognitive "rule of 7" by one--there are now 8 sections to our model--we will number, name and describe them. It is useful to refer to the visual Playwheel Model (Figure 5) while reading the following descriptions.

1. MIRROR Same Action / Same Time / Supportive

To do the same action at the same time in a supportive manner is to *mirror* the individual. The therapist is saying "I hear you, and I am doing what you are doing". This technique sounds simple but is actually quite difficult musically, especially if the tempo begins to pick up.

2. ALTER Same Action / Same Time / Redirective

One may be doing the same action at the same time as the individual and begin to *alter* it musically in several ways, such as in changing the dynamics (loud/soft), the style (legato/staccato), or the timbre (smooth/harsh). The therapist is saying "We are doing this together, but let's change it up".

3. ECHO Same Action / After / Supportive

If the therapist performs the same action after the individual, she is saying "I hear you, and now I give you back that which you have given me". This is a supportive stance, sometimes called *repetition.*

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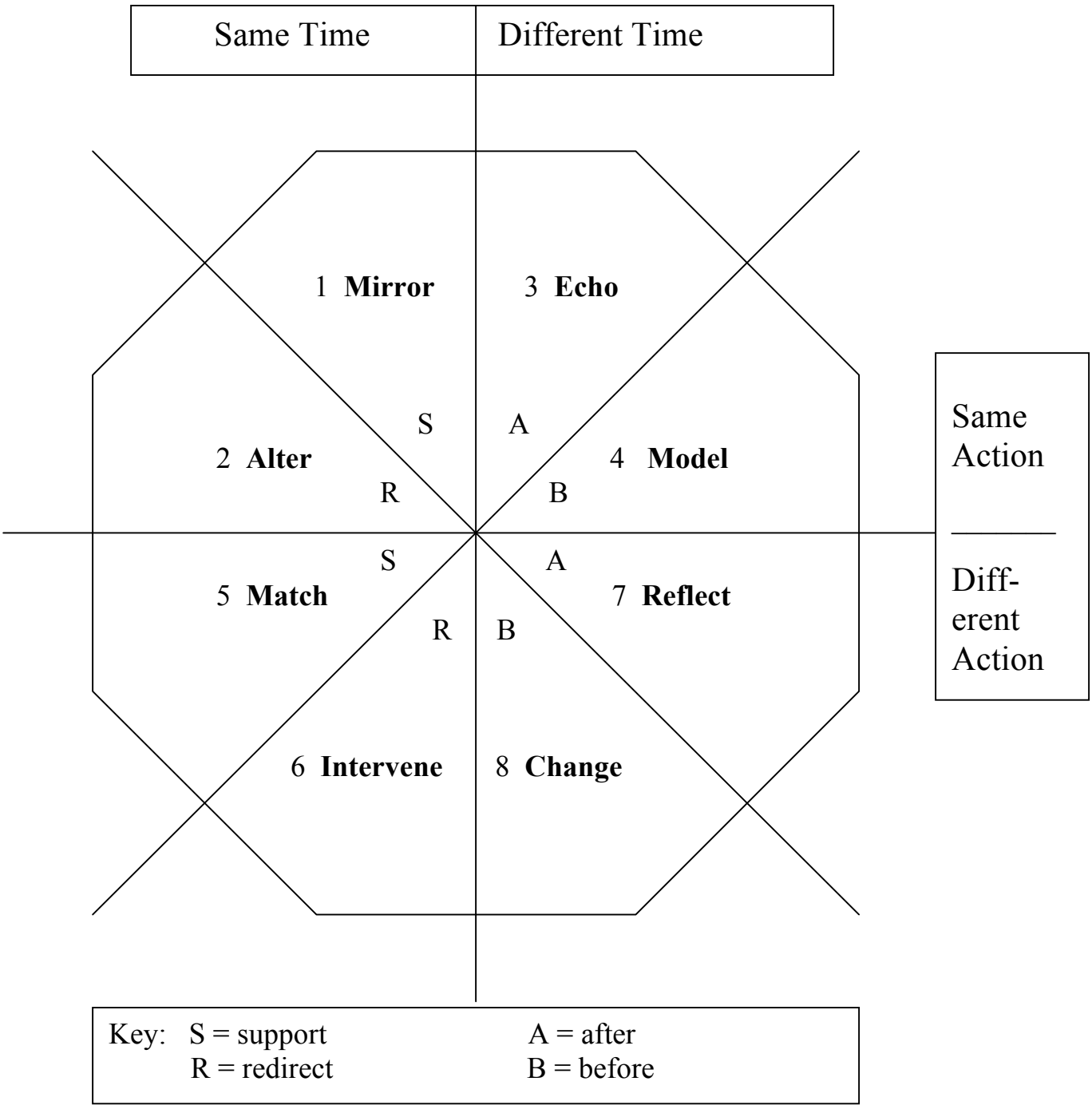

Figure 5: *The Playwheel: A Model for Therapeutic Improvisation*

4. MODEL Same Action / Before / Redirective

The therapist does an action that she would like the individual to do. She is redirecting the session as she *models*. There are many strategies for *cueing*. The therapist is saying, "Watch me now, listen to me, and do as I do".

5. MATCH Different Action / Same Time / Supportive

A different action done at the same time in a supportive way is a *holding* technique. These can also be considered *accompanying* techniques--for example, the individual is singing while the therapist is playing the song on the guitar. The therapist says, "I hear you and I am playing with you. You have your voice and I support it in this way".

6. INTERVENE Different Action / Same Time / Redirective

A different action done at the same time is a technique of redirection. The therapist could be saying, "This activity is not leading anywhere, let's go in this direction". Motivations for *intervening* can cover a wide range of therapeutic concerns, including the behavioural, social, emotional, cognitive, etc.

7. REFLECT Different Action / After / Supportive

For example, the individual has played a phrase and the therapist takes that expressive passage and plays a variation of it, weaving it into a larger musical whole that is emerging from the overall improvisation. She is saying, "Listen, you said this and I am repeating it and we are continuing on this musical and personal journey, creating as we go". She is reflecting the individual's mood.

8. CHANGE Different Action / Before / Redirective

In any model of improvisation, there needs to be a place for the unexpected to occur. The therapist is saying, "Here is something new, let's try it". It is a technique of redirection that allows the therapist to be totally spontaneous, musically and therapeutically alive to the moment.

Note: All of the odd-numbered techniques 1, 3, 5, and 7 are *supportive*, and the even-numbered techniques 2, 4, 6 and 8 are *redirective.* There is an immediate and natural connection between all supportive techniques. There is also an easy flow between all techniques of redirection. I have not referred to the supportive techniques as *empathic.* Ideally, all of the work we do, whether supportive or redirective, is empathic in both quality and intent.

Nomenclature

It is my view that this Model provides a set of categories that is useful for the understanding and placement of the wide range of musical techniques used in clinical improvisation. In the last 30 years, various authors (Nordoff and Robbins, 1977; Boxill, 1985; Bruscia, 1987; Pavlicevic, 1997; Ruud, 1998; Wigram, 2004; Smeijsters, 2005) have each presented their system of talking about clinical musical improvisation. Three approaches which recur again and again in the literature are *mirroring, matching,* and *reflecting.*

As an example of how the Playwheel Model functions, I suggest that it allows for the following placement of these 3 techniques:

1. *Mirroring*: This is generally understood as "doing what the client is doing at the same time". In section 1 MIRROR, the therapist supports the individual as they perform the "same action" at the "same time". In section 2 ALTER, the therapist redirects the mirroring activity by changing the musical parameters.

2. *Matching:* Wigram defines this as, "Improvising music that is compatible, matches or fits in with the client's style of playing while maintaining the same tempo, dynamic, texture, quality and complexity of other musical elements." (Wigram, 2004, p. 84). In 5 MATCH, the basic situation is one where the therapist is supporting the individual by playing music to match what the individual is presenting, at the same time. In 6 INTERVENE, the therapist is using this matching technique to redirect the individual. In this Model, other common techniques which would fall into the category called *matching* would include: *accompanying, grounding, containing, holding* and *pacing*.

3. *Reflecting:* Bruscia defines this as, "Matching the moods, attitudes, or feelings exhibited by the client" (Bruscia, 1987, p. 540). In the Playwheel Model, 3 ECHO, the therapist simply repeats the *same* musical phrase or rhythm presented by the individual. In 7 REFLECT, the purpose is not to repeat the music note for note, but rather to, "understand and reflect back the client's mood at the moment" (Wigram, 2004, p. 90). In other words, the therapist is receiving the personal and musical materials provided by the individual and she is *composing* them into a larger whole. There is ample opportunity here for musical *dialoguing.* In 8 CHANGE, the therapist is encouraging the individual to *reflect* something new, which the therapist is bringing forward.

Using the Playwheel

This Model has been designed to organize musical techniques of clinical improvisation according to the 4 basic elements of:

1. WHO: the dyad of therapist and individual with whom she is working
2. WHAT: the same action or a different action
3. WHEN: the same time or a different time, that being before or after
4. WHY: the therapist is either being supportive (following), or redirective (leading)

It is meant as a technical reference that can be used to teach the music therapy student the eight basic approaches, as well as a mnemonic device for the professional music therapy clinician. The music therapy educator is encouraged to refer to Tony Wigram's excellent guidelines concerning the teaching of improvisation skills (Wigram, 2004, pp. 27-34).

In the Music Therapy Program at Acadia University, Nova Scotia, we have been using the Playwheel Model in the experiential ensemble as a teaching tool. We begin with *mirroring*, with and without instruments, and gradually move through all of the techniques one by one. Eventually, we create scenarios where the students play the role of therapist or individual (with specific presenting conditions), and are asked to move through a specific sequence on the Playwheel. From this work we can understand how both therapist and individual lead and follow within a music therapy session. The student experiences the dynamic and shifting nature of therapy, by engaging in both the receptive and expressive stance, as therapist and as individual. One benefit of the concentrated work involved in clinical improvisation is a growth in the ethical

realization of the value of the other in all their expressions, no matter what the presenting conditions might be.

Another positive use of the Playwheel for the educator is to ask the students to take Bruscia's list of "Sixty-Four Clinical Techniques" (Bruscia, 1987, chap. 37) and to see where they might fit into the Playwheel Model. This process has lead to an ongoing dialogue concerning the nature, development, and uses of the techniques of therapeutic improvisation in music therapy.

Future Directions

Most definitions of music therapy contain at least 3 aspects: it is seen as a process in which the clinician helps to bring about a 1) *positive change* in the individual by using the 2) *elements of music* and the 3) *therapeutic relationship* that emerges from this process. In the Playwheel Model we see the elements of music woven into the dyadic relationship of therapist and individual. In this model we have categorized the basic techniques of therapeutic improvisation according to time, action, and clinical function. The question emerges as to how we could expand the effectiveness of this approach. Could the model be used as a tool for ongoing assessment of the individual? What criteria would be appropriate?

One possible direction for gaining a deeper understanding of this process would be to use the concepts as outlined in Bruscia's (1987) Improvisational Assessment Profiles (IAPs). He speaks of these profiles as, "intended to provide a model of client assessment based upon clinical observation, musical analysis, and psychological interpretation of the client's improvisation"

(Bruscia, 1987, p. 403). The therapist could adapt the concept behind each of the 6 IAPs to examine the effectiveness of the Playwheel after an improvisational session with an individual. The IAPs include: 1) *Integration* deals with how the simultaneous elements work together, with how the "elements are similar, separate, and independent from one another", 2) *Variability* examines the extent to which the sequential elements change or do not change through time, in a continuum from "rigid" to "random", 3) *Tension* describes the extent to which each element, "accumulates, sustains, modulates, or releases tension", 4) *Congruence* deals with how consistent the elements are, "with regard to levels of tension and role relationships", 5) *Salience* looks at how much "prominence and control" each element is given, and 6) *Autonomy* deals with the "kinds of role relationships formed between the improvisers", as to who is leading and who is following (Bruscia, 1987, pp. 404-405). These are useful and important concepts for the meta-analysis of therapeutic improvisation: how the elements (parts) fit together, how they change or not, how they create tension/release, how this tension/release is in agreement with therapeutic roles, how to prioritize the elements as to prominence and control, and how the elements impact on role relationships in the therapeutic dyad. With application of these concepts to the Playwheel Model over several sessions, the music therapist could assess the appropriateness, or not, of the various concepts in creating a clear and useful assessment of the individual. Also, it would give the music therapist another tool for examining the improvisational approach she has undertaken with that individual.

It is my hope that the process described in building the Playwheel Model, and the subsequent speculations about possible applications for this model will stimulate dialogue concerning clinical improvisation in the wider music therapy community.

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