

**GROUP IMPROVISATION WITHIN MUSIC THERAPY:  
A MEDIUM FOR INTERVENTION AND CHANGE**

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**INTRODUCTION**

Music therapy can be a tool with which allied health professionals can observe a patient's behavior. In the group, the patient will interact with group members as he interacts with others in life. He will display his maladaptive behavior and his interpersonal style will eventually appear in his transactions. Not only does the music therapy group provide the social microcosm in which these forms of behavior are displayed, but it is also a living laboratory in which professionals can understand the dynamics involved. The therapist can view the behavior, the events that triggered it, and sometimes the responses of the other group members. Some laymen, and even professionals, may feel that the patient is acting in a specific way associated only with the music therapy group; that the group is unusual, not real, and artificial. After all, a once-a-week session of 30-60 minutes in a small room clothed with primitive musical instruments does not represent the "real world". However, through this aesthetic experience, positive changes on various academic, social and emotional levels can be seen. The behavior required by group norms will aid the patient in his relationships outside the music group; thus, the group may be more beneficial to his life and "real world" than meets the eye.

Successful patients have attributed their improvement to certain factors during the course of therapy, regardless of the particular discipline used and the specific theoretical orientation of their therapist. Successful therapists resemble each other in several areas of personality and therapeutic intervention. There must then, be some

other force at work which enables patients to embrace therapeutic change and success. This mystical idea has preoccupied the minds of many researchers over the years. Especially today, when societal fashions and creative marketability have given birth to so many new forms of "self-help" and "cookbook therapy" groups, which seem to be as successful as the more traditional verbal and expressive therapies, one must question what factors are responsible for therapeutic change and success.

This paper will explore the treatment modality of group improvisation within music therapy as a form of therapeutic intervention and a dynamic medium for positive change.

One researcher, Dr. Irvin Yalom (1975) states that all groups have a "front" and a "core". The "front" includes form, modality, techniques and specified language. The "core", however, consists of the aspects of the experience that are intrinsic to the therapeutic process, i.e., the mechanisms of change. These Yalom refers to as the "curative factors". Therapy is a deep human experience and there is an infinite number of pathways through its process. Sometimes the curative factors refer to actual mechanisms of change, while at other times they may be described as conditions for change. Yalom outlines eleven factors: the instillation of hope; universality; the imparting of information; altruism; the corrective recapitulation of the primary family group; the development of socializing techniques, imitative behavior; interpersonal learning; group cohesiveness; catharsis; and various existential factors.

#### THE CURATIVE FACTORS (YALOM, 1975)

Hope is needed to keep the patient in group therapy. Regularity is necessary for other curative factors to take their effect. Faith in the treatment mode itself is therapeutic. The instillation of hope facilitates the patient's coping mechanisms. It is interesting to note that as new members join the group, older members often offer testimonials. These words of wisdom help to provide a source of relief; they reflect universality. Unfortunately, by attempting to meet the individual cognitive and psychosocial needs of patients, we often have, in fact, isolated them. The confirmation that the patient is not unique is a welcome reprieve. As he perceives his similarity to others in the group

and shares his feelings and concerns, he begins to accept and be accepted.

However, anxiety-producing maladaptive behavior can thwart this process. Anxiety can increase ambiguity by distorting perceptual acuteness, but information can decrease anxiety by removing ambiguity. The imparting of information can be employed in a variety of fashions within the group. In its simplistic form it is the transference of much-needed knowledge. Didactic instruction used to structure the group is sometimes the initial "binding" until other curative factors take effect. In this fashion the therapist may guide the patient toward understanding his state of mental health and the course of improvement and amelioration. But, more so, the process of advice-giving by patients to patients is beneficial and implies mutual interest and caring. The act of giving also implies receiving. When patients help one another they are, in effect, offering support, reassurance, suggestions, and insight collectively called altruism. This curative factor clearly comes into play when the group has the opportunity to perform some task or service in the community. To be successful they must learn to live together as one — as a family.

Many patients carry with them poor family histories including unsatisfactory primary relationships. It is clear that patients interact with other group members and the therapist as they would with their parents and siblings. The therapist is the living personification of all parental images, authority figures, and established tradition. The group format enables patients to explore their competitive strivings and conflicts in the areas of assertiveness, intimacy, greed, and envy. Primary familial conflicts can be recapitulated in order to relive them correctly. Growth inhibitory relationships are not permitted to freeze into rigid maladaptive behavior and must be constantly challenged and new behavior encouraged.

The simple recognition and deliberate alteration of social behavior, that is, the developing of socializing techniques, is instrumental in the initial phases of therapeutic change. Patients obtain information about themselves through open channels of feedback and model themselves on aspects of others including the therapist. Imitative behavior enables the patient to clothe himself with various garments which lead him to the understanding of what he is, as well as what he is not. Interpersonal learning within the group is analogous to insight which may occur on four levels: the objective perspective of HOW the patient's behavior is

viewed by others; the understanding of WHAT he does with others; the learning of WHY he does what he does with others; and the genetic perspective of WHERE why he does what he does with others, began. Non-threatening conditions and peer support aid the patient in his confrontation of previously unsuccessful situations. Group support, inter-member trust, and acceptance are termed group cohesion and increase the patient's self-awareness. Group cohesion is a pre-condition for effective therapy. The more cohesive the group, the more the hostility and conflicts aimed at each other and the therapist come to be expressed. As in the family, there is internal warfare yet there are strong loyalty bonds. Provided that the patient adheres to the group norms, the group will accept him regardless of his past history, transgressions, and perceived failure. Group acceptance and self-acceptance develop side-by-side. The expression of strong emotions – catharsis – is a part of the interpersonal process. This and other existential factors, such as responsibility, contingency, and recognition of mortality, contribute to therapeutic success.

### GROUP IMPROVISATION

Group improvisation provides a unique experience of oneself in relation to others. "Using improvisation effectively in music therapy is complex, but no more so than the complexity of the interpersonal therapeutic relationship it reflects" (Stephens, 1983). The way we act interpersonally is analogous to the way we act intermusically – these styles mirror each other dynamically. Improvisation is "a mutual exploring and sharing of random sounds produced on musical instruments or by voice" (Brown, 1975). One author (Brown, 1975) compares it to the cathartic experience which occurs in individual analysis and in group psychotherapy. With the use of percussion, melodic percussion, and stringed folk instruments, improvisation can become available to everyone regardless of his prior musical training. The group's accent is on action and interaction. "By focusing on one particular mode – sound – one focuses on the core of interaction" (Stephens, 1983).

Some authors (Priestley, 1975) view the purpose of group improvisation as "basically to achieve growth and truer self-knowledge through self-expression within the group". Improvisation seems beneficial to all individuals that are willing to clothe their feelings in

sound, allow others to do the same, and explore these feelings. Yet another author (Stephens, 1983) views improvisation as special because it allows the patient to experience himself in relation to others on two levels – the actual and the symbolic. The actual level is the very real interaction of sound with others, and the symbolic is the expression of emotions, thoughts, and memories all contained in the music itself.

The literature about the use of improvisation is very limited, and even more sparse is that which relates to aspects of improvisation within a group framework. However, one author that deals with this latter subject used the group improvisation modality for developing “relatedness”. Gillian Stephens (1983) delineates three levels of relatedness: sense of self; awareness of others; and ability to communicate. One’s sound repertoire, improvisation structure, and the emotional quality expressed in the improvisation represent one’s sense of self. One’s awareness of others can be seen in differentiating another’s sound and recognizing similarities to one’s own sound. One’s ability to communicate is viewed through a desire to share with others one’s own sound and trust that it will be accepted.

Apart from observing one’s level of relatedness, through improvisation the therapist is witness to a wide spectrum of responses. If patients feel angry, exploited, sucked dry, steam-rolled, intimidated, bored, or tearful – these are all data (Yalom, 1975). During an improvisation our responses to “an overpowering drum sound or delicate xylophone..., where we choose to play, where we choose to fade out, whose rhythm and musical dynamics we choose to follow, and whose we avoid, all mirror our style of coping in the world outside the music context” (Stephens, 1983). The improvisation experience involves the elements of trust, interdependency, competition, leadership, and communication among others. Since all members are exposed to the same stimulus, different responses can only be explained on the basis of individual meanings. Some responses are fixed emotional patterns (Priestley, 1975). Does one member always finish the improvisation? Does one member always have to control the others? Does one member always choose the loudest or softest instrument? Does one member always offer a crescendo or sforzando in the middle of another member’s soft delicate passage? Does one member always drop out prior to the final coda? Does one member always initiate the group climax? Music improvisation can shed light on these patterns of behavior as well as others.

The number of patients involved in the improvisation group vary according to the placement and patient population. Generally speaking, there are between four and eight patients in a group seated in a circle or semi-circle (Priestley, 1975). The instruments used are percussion (congas, bongos, snare drums, hand drums, cymbals, claves, marracas, woodblocks, etc.), melodic percussion (handbells, chimes, resonator bells, xylophones, etc.), folk instruments (kalimba, zithers, autoharps, melodicas, etc.), and other instruments used by the therapist for support (guitar, piano, etc.) (Brown, 1975; Priestley, 1975; Stephens, 1983). "As many different tone colors as possible should be offered to develop discrimination and add richness" (Priestley, 1975).

The therapist utilizes various techniques during the improvisation, including: modeling, leading, mirroring, grounding, and stimulating. The roles that the therapist has at his disposal are: as initiator, supporter, and guide (Stephans, 1983). Together these techniques and roles create a list similar in fashion to one outlining therapist behavior used during the course of therapy. The therapist should offer feedback, increase self-observations, clarify concepts and responsibilities, encourage risk-taking, and reinforce transference of learning (Yalom, 1975). Furthermore, it has been stated that the therapist "does" just by "being there" — he is therapeutic in his "presence". What more concrete a way to be present than in a musical performance?

It has been pointed out that different types of groups favor the operation of certain clusters of curative factors. Improvisation groups within music therapy utilize universality, the imparting of information, altruism, socializing techniques, interpersonal learning, imitative behavior, and group cohesiveness. It is clear that this group, as all groups, progresses through different stages in a developmental sequence. At different stages of the group different curative factors are required. Curative factors shift in primacy and in influence during the course of therapy (Yalom, 1975). As the patient's needs and goals change in therapy, so too does the process of change, thus group improvisation — like other interactional therapies — is dynamic.

### A CASE STUDY

One group of youngsters from the Rehabilitation Center for Youth (in Jerusalem, Israel) participated in group improvisation within music

therapy. The Center serves twenty-five youngsters between the ages of 14-18, all afflicted with minimal brain damage (MBD) and some have secondary emotional imbalance. The group consisted of six youngsters all having been referred to the group because of some interpersonal difficulty and a need to strengthen their individuality within a group setting. The seating arrangements and instruments used were similar to those discussed earlier. The group met on a weekly basis for fifty minutes at a time, over a six-month period.

In the early stages of the group, much imparting of information was used. The therapist acted as initiator utilizing modelling and leading techniques. Very quickly, the group's cohesiveness was developed and members offered help to one another in transporting the instruments, and participating in discussions regarding the musical encounter. Each member saw that he was equal to the others, although some were more musically inclined, while others were more interpersonally adaptive. As various members were able to "show off their talents", their popularity increased; while others may have felt that their talents were not being recognized by the group because of some unwanted personality characteristics. For example, the drums — the instrument of popular choice — became the "stage" on which only those popular, accepted group members could perform. The others could not "stand the heat" of ridicule. It became clear that for some members there was a discrepancy between self-esteem and public esteem, i.e., how an individual evaluates himself and his identity, as opposed to how the group evaluates him. Because of this discrepancy, a "state of dissonance" occurs (Yalom, 1975). A good drummer but poor group member may be voted to play on a triangle in spite of it all. The more the group matters to him, the more he will subscribe to the group rules, and will change accordingly, by adoption of socializing techniques and interpersonal learning.

In the group several forms of behavior were manifested: the non-atuned performer; the overconfident accompanist whose attempts to be recognized as a prodigy destroyed the group's grounding; the player who becomes threatened by the conductor's directions; the non-audible soloist; the compulsive performer, whose rigidity receives functionality in ostinato or drone accompaniment; and the non-initiating arranger.

Through the group's cohesiveness, development of inter-member and therapist-member trust occurred. These conditions allowed for risk-taking,

self-disclosure, feedback, working through various problems, and even constructive conflicts. Admittedly, not always was there smooth sailing and at one point improvisations were rejected, and were replaced by the less threatening music activities which did not involve "dealing with issues". Through these activities, the group members attempted to try their hand at performing, conducting, arrangement, maintenance of the instruments, vocalizing, performing solo, and taking part in a back-up group. Other activities included analysing song lyrics and identifying one's associated feelings. The factors involved during this stage were imitative behavior, and interpersonal learning.

Two months later, after the group returned to improvisation it appeared that the members had changed. One youngster did not want to play the drums any more. She preferred to play the bongos which added a supportive rhythm. As her percussive skills were not as developed as another member's, she preferred that he play the drums – "for the sake of the piece". Her ability to recognize her limitations but fulfill her responsibility as a second percussionist was a big step for her and indicated her willingness to "subgroup" without threatening her identity. On the whole, some members could now view themselves as performers of specific instruments within their ability, and hold various roles within the improvisation. Others developed improved skills of relatedness. One group member, though, did not change. After a year he still had trouble accepting the fact that the therapist/group leader was the sole authority figure. It was clear that within the same group, different members benefited from different curative factors.

### SUMMARY

From this experience, and others like it, these youngsters will mature. Their growth is enhanced by the "adaptive spiral" as outlined by Yalom (1975). As their interpersonal distortions diminish, their ability to form rewarding relationships increases. With less social anxiety and improved self-esteem, the patient has less need to conceal himself. Others respond to him more politely, and they show more approval and acceptance. These further increase self-esteem and enhance even further change.

To summarize, it may be helpful to put group improvisation in music therapy into the perspective of Interpersonal Relations Theory,



as delineated by Harry Stack Sullivan. Sullivan felt that "psychiatry is the study of processes that involve or go on between people" (Mullahy, 1952). Disability, its aberrations, and all its manifestations should be translated into interpersonal terms. Therefore, treatment should be directed toward the correction of interpersonal distortions in order to allow one to participate in more satisfying relationships with others. Sullivan further stated that "one achieves mental health to the extent that one becomes aware of one's interpersonal relationships" (Sullivan, 1940). It is with this orientation and philosophy in mind, that group improvisation within music therapy has been explored. As a treatment intervention it is based on the "curative factors", i.e. mechanisms of change similar to those found in verbal psychotherapy groups.

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