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Personal Experiences of Non-verbal Communication Through Musical Dialogue (Clinical Improvisation)

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Stepping into My Music Therapy Journey Abroad

My journey into music therapy began in Canada where English is one of official languages; the other one is French. As a non-English speaker, I frequently felt it was difficult to achieve academically due to my language barrier in the beginning of my studies. In particular, verbal communication in performing my music therapy practicum was challenging as I was required to be more formal and clinical. Notwithstanding the difficulty, I had a strong belief that that music would help me so that I could communicate with my clients in different ways. This belief came from the idea that music is a universal language and that it will serve as a communication channel. I was amazed by the experience that music not only communicated things which could not be done due to the language barrier, but also helped to communicate things beyond words.

Getting to Know Musical Communication Through Clinical Improvisation

When I was a music therapy student at Wilfrid Laurier University, the most difficult and interesting question was, "How do you communicate with a client musically and clinically?" The idea that I can communicate musically with someone with whom I am not able to communicate verbally immensely intrigued me. I often noticed that for pathological reasons, many of my clients were having difficulty being verbal and some of them were completely non-verbal. I felt a strong empathy toward them. Despite the difficulty posed by the lack of verbal communication between myself and my clients, I was quite inspired by a feeling of empathy caused by my sense of my own (English) language barrier. So I decided to dedicate myself to working intensively on non-verbal, but effective, musical dialogues through clinical improvisation so that I could communicate with my clients not only freely and proficiently, but also, musically and clinically.

As time went on, I was really into clinical improvisations and my motivation to explore and practice them grew stronger. Also, I became absorbed in finding a variety of resources, theories and techniques that would help me to become competent. I wanted to develop various techniques in clinical improvisation that could assist me in communicating with my clients. These techniques needed to be systematic, structured, architectural, and to allow effective musical interactions. I found guidance from Aesthetic Music Therapy (AeMT). Colin Andrew Lee developed AeMT. In his book *The Architecture of Aesthetic Music Therapy* (2003) he introduces AeMT as an improvisational approach that views musical dialogue as its core. Lee states that:

> Aesthetic Music Therapy (AeMT) considers music therapy from a musicological and compositional point of view. Looking at theories of music to inform theories of therapy, it proposes a new way of exploring clinical practice ...(p. 1)

> Interpretation of this process comes from an understanding of musical structure and how that structure is balanced with the clinical relationship between client and therapist. (p. 2)

This approach helped me gain insight and skills in both analytical and practical aspects of improvisation. Clinical improvisation is the most essential and significant therapeutic technique that is required to be proficient to understand theories and the clinical application of AeMT. In accordance with such requirements, I naturally set clinical improvisation into my primary and specialized techniques in doing music therapy.

Musical Dialogue and AeMT

I now think that I was too desperate in seeking a natural, meaningful and skillful communication with my clients while I struggled with the language barrier. Musical dialogue through clinical improvisation allowed me to overcome this language barrier and to find clear but subtle ways to communicate with my clients. I believe that the musical interaction through improvisation can generate not only a musical rapport, but also an interpersonal relationship. During improvisation the music and the client become unified and a great feeling arises which is inexplicably transcendent. I have been intrigued and inspired by this aspect of the clinical improvisation.

Establishing and developing a musical dialogue for the purpose of therapy has always been my first priority as a music therapist. Now and forever, this pursuit will foster and lead me to proceed in finding optimal clinical solutions for my clients. I have come to trust that AeMT holds musical dialogue as its nucleus.

I find Lee’s belief and view of music, and music therapy to be similar to my own. I have been deeply inspired by his music therapy philosophies and clinical applications of practice. Lee’s view is related to an understanding of musical structure and how that structure is balanced with the clinical relationship between client and therapist (p. 2). Lee believes that such a therapeutic process becomes clinically applicable only when we take the step of thoroughly analyzing and examining musical structure and considering music theory to enlighten music therapy theory. Personally, I strongly agree with his view.

The significant Role of "Bridging" between Client and Therapist in Improvisation

Clinical improvisation is just one of many therapeutic techniques used in music therapy. Not every client is suitable for treatment using clinical improvisation. In this case, I am naturally willing to utilize another clinically appropriate and effective approach and its techniques to meet what my clients optimally need beyond clinical improvisation. Nevertheless, it is not difficult to notice that this technique is extensively used regardless of what model or approach is discussed in music therapy. We might want to clarify the reason why. Here are my thoughts on this question of why clinical improvisation is universally utilized.

Establishing a relationship is crucial and central to a music therapy session. What makes the improvisation *clinical* is basically about the relationship that emerges through musical dialogue, interaction, and communication beyond other facts that are considered crucial. When the music therapist and client are able to create a shared musical space between them in the improvisation, both players can express themselves and create a highly intimate and dynamic interactive relationship. In general, the therapist needs to enable the client so that they can express themselves through the music. At best, both players share a reciprocity of intention while improvising.

While involved in interactive music making, music therapist and client are able to talk not only musically, but also clinically. This could also be interpreted as musical counseling. I believe that the therapist could provide therapeutic interventions to help with the clients’ struggles. A music therapist can provide a "bridge" to a client to escape the inner world in which they experience struggle. In clinical improvisation, the ability of a skilled and sensitive music therapist is an essential component since it is connected directly to both musical and clinical intervention in music therapy.

During the intervention, the client is also capable of playing music with free-will and

experiencing an alternative way of communication, self-expression, confidence, focus, structure, form, creativity, pleasure and meaningful dialogue. The improvisations are based either on an instrumental theme (for example, rhythm or melody) or on a vocal theme (for example, idea, emotion, or task) related to the client's mental, emotional and physical state. Music is linked with emotions (feelings) through the musical interaction in clinical improvisation and it is related to the use of music therapeutically. The music therapist can help the client to express his or her own feelings through improvisation by supporting them musically (or sometimes verbally). The musical structure and context of the improvisation may support the client to make him or her feel more safe and free. Appropriately, my clients have been given the opportunities to express themselves emotionally and physically on diverse musical instruments or vocalization while being musically and clinically supported.

Since clinical improvisation contains meaningful components of musical, clinical and therapeutic relationships through interactive music making, it has been frequently introduced and practiced in music therapy. It seems that clinical improvisation might be an essential part of the practice of music therapy, regardless of what approach is used.

Expanding The Universality of Musical Resources in Improvisation

As I was developing various resources for improvisations and musical interactions, I was able to work on creative ways to use elements of music such as idioms, genres, and rhythms. In fact, this effort was intended to meet my clients' musical needs of coming from different ethnic backgrounds. Canada has a rich multicultural context and knowing a variety of ethnic music genres was necessary for my clinical work. Personally, learning traditional ethnic music and applying it in my clinical work has been a pleasurable experience. Such attempts became essential clinical experiences and produced a very positive outcome.

I'll introduce several examples. First, I used a Korean traditional song or idiom with a geriatric population in Canada. This was a good medium to communicate with residents musically and clinically during different treatments including interactive piano vs. piano and piano vs. tone chime music making in both individual and group sessions. I played a rendition of Arirang which is one of the most famous Korean folk songs. I used main melodies of Arirang which is composed of a major pentatonic scale (C, D, E, G, A), while making accompaniment using chromatic chord progressions. This mixture of pentatonic and chromatic sound quality provided not only exotic and creative elements, but also a familiar and comfortable musical atmosphere. It was experimental, but brought out positive clinical outcomes as the residents participated in the treatment spontaneously and actively. Furthermore, such participation with therapeutic interventions eventually enabled them to become increasingly confident, reduced anxiety, decreased depression, enhanced fine/gross motor skills, created musical communication, increased social interaction, and other benefits.

Second, I conducted a group improvisation using the Tango idiom. This was very successful for a variety of non-Latin American background clients from the young to the elderly to meet what they needed during the drum improvisations. For example, the unique character of the Tango rhythm focused their attention, facilitated active participation, and encouraged structured, interactive instrumental playing and vocalizing. In particular, the Tango rhythm always brought out a strong level of group cohesion in doing drum improvisations.

Third, using a Hip-hop rhythm with adolescents from diverse ethnic backgrounds and developmental delays was an effective catalyst in doing both individual and group improvisations to motivate them to experience structure, form, confidence, free-expressions, and social interaction.

Fourth, forming improvisation structures using a Rondo form with various idioms was an effective approach. For example, the form of ABACA (A-Spanish idiom, B-Middle-eastern idiom, C-Japanese idiom) was successful in embracing all of the clients from diverse ethnic backgrounds due to the unique sound character of each idiom.

Fifth, using boogie-woogie, or blues melody and rhythm to meet vocal intervention (improvisation) was appreciated and successful with a group of students with ADHD. Through this intervention, the group members were provided opportunities to experience making themes and lyrics, and effectively increased not only their attention span, but also facilitated a focus on dynamic song making.

Sixth, tone chime improvisation treatment using the chord progression of Eric Satie's Gymnopedie and Chopin's prelude in E-minor (No.4 Largo) worked nicely, not only attracting attention, but also establishing a good group cohesion for elderly people with dementia while

experiencing creative musical expression, social interaction, and confident music making.

Seventh, a rendition of the Portuguese traditional Fado music (Cancao do mar) was used in vocal and instrumental improvisation for children with autism in drum improvisations. This music grabbed their attention and they were able to experience an alternative way of communicating while dealing with call and response interventions.

I regret that I cannot describe everything in detail that I tried in the use of musical components experimentally, creatively, and clinically during my practice here. However, I would like to present one specific example of how I used a march idiom and its variations as a clinical application of musical resources in order to enhance musical interaction and communication.

March and Its Variations

I think that marches have their own characteristics which enable us to advance or proceed. I would say that one of the best examples is a military march. As I experienced during military service in Korea, marches certainly did motivate and stimulate the soldiers to enhance their morale and confidence while parading. In Korea, every man except the one with special needs has to go to the army in terms of liability for military service and I was honourably discharged from the army in 1994.

Marches are, I believe, one of the best musical genres that naturally go with playing percussion instruments. In a music therapy session, at times the "morale" of clients appears to be elevated inexplicably while playing the drum accompanied by a march on the piano. The simple beat of the march was designed originally for a person's stride while walking. The nature of this simple action, which one experiences in everyday life, may generate the "willingness," "spontaneity," or "familiarity" while clients play the drum. Marches have been very useful for me to interact with my clients musically and therapeutically.

In particular, it seems to me that marches are more effectively applied if the clients play percussion instruments such as snare drum, djembe, temple blocks, or bongo. In general, 2/4 is the typical time for marches; furthermore, its variation, which offers diverse dynamics and rhythm changes, allows it to be used in a more sophisticated manner in order to communicate with clients during clinical improvisations. I have observed that many clients without physical difficulties (i.e. gross or fine motor skill difficulties) appear to enjoy playing constantly or "perseveratively" after being initially given percussion instruments. Of course, not everyone plays this way since it depends on each client's gross and fine motor skills as well as on their emotional conditions. Nevertheless, it appears to me that it is completely natural for people to play the percussion instruments constantly or "perseveratively", stemming from the unique shape of each percussion instrument, regardless of the client's age, gender, or disability.

Now, I would like to talk about the variations of the march. Using variations of marches is likely to make musical and clinical interaction not only very effective, but also an exciting experience for clients while they are playing percussion instruments. While communicating with my clients musically and clinically, I often attempt to "decorate" the march by changing the rhythm, tempo, tonality, or its key (transposition). I suppose that the variations frequently facilitate the duration of the interaction to be continued during clinical improvisation. Even though I am already aware that playing continuously does not necessarily have to be the therapist's goal, I believe that the continuity of musical and clinical interaction in a certain duration is crucial in order to process clinical performance for therapeutic purposes.

Regretfully, as I mentioned earlier, the march and its variations seem to be inappropriate for clients who have difficulties with gross and fine motor skills. I have experienced clients who were not able to perform due to physical challenges. Also, the atmosphere of the march's rhythm seems to overwhelm those who have these difficulties. I think that the application of marches and variations to each population of clients for appropriate therapeutic use needs to be researched further in order to provide an optimum condition for clinical music therapy. Lastly, I have used marches and I have attempted to connect to other musical idioms such as Spanish, middle-eastern, rock, or hip-hop during my clinical improvisation so far. Here is an example of a rondo form which has section A starting with a march:

A. March
B. Middle-eastern
A. March
C. Spanish
A. March

Conclusion

I have described how I became "obsessed" with clinical improvisation. Also, I introduced how I conceived clinical improvisation and my belief of what makes clinical improvisation so meaningful and clinically crucial not only formally, but also informally.

In doing therapy, successful communication between therapist and client is first and foremost in establishing a therapeutic relationship as well as therapy itself. In a variety of therapies, verbal communication is the most frequently used method to make communication happen. Of course, verbal communication is also crucial in doing music therapy. However, what differentiates our job from doing other types of therapies is that we use music as the primary therapeutic tool which enables us to establish a therapeutic relationship through its' use in communicating with the client. It is important to our identity as music therapists that we, through skillful use of music and its components, communicate with our clients.

Throughout this article, I avoided descriptions and discussions outside of my own clinical improvisation stories. This article was not written to examine improvisational music therapy as a whole. Rather, I wanted to share my personal experience as to how I was able to communicate with my clients through clinical improvisation not only non-verbally and clinically, but also musically and aesthetically. In addition, this article presents my personal and practical ideas about how to use musical resources in order to establish relationship and communication with clients.

I would like to clarify that I was not idealizing a role of clinical improvisation as the one and only therapeutic tool in music therapy. Clinical improvisation could be one of many therapeutic techniques utilized in music therapy. However, the impact and influence of clinical improvisation cannot be ignored or minimized because of the ability of these improvisations to create relationships between therapists and clients. I have focused on gaining the capacity for advanced clinical improvisation as well as a skillful use of music in order to ultimately understand, integrate, and apply information relating to the practice of music therapy.

I moved back to Korea in June, 2007 after spending approximately 10 years of living in Canada. I have already begun working as a music therapy teacher, supervisor, and a music therapist. It's exciting getting involved with music therapy in Korea. Nevertheless, I still feel music therapy challenging, but rewarding. I will continue to examine the quality of music and what this has to do with people in order to meet what they need, and to enhance their quality of life.

Let me finish with my favourite quote regarding music therapy by referring to Heinrich Heine, 19-century German poet and writer, who said, "When words leave off, music begins." (Daily Celebrations, 1999) I rephrase it and keep it always in my mind, "Where words end, music begins." What a poetic and meaningful quote it is!

Reference

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