

Playing with Distinction? Music Therapy and the Affordances of Improvisation

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ABSTRACT

In the United Kingdom (UK), improvisation seems to be regarded as central to, and even definitional of, the practice of music therapy. This article considers reasons why improvisation might be professionally prized in this way but also turns to Tia DeNora's (2003) notion of musical affordance to consider what in practical terms improvisation may have to offer within music therapy practice, focusing on two vignettes from a mental health environment.

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INTRODUCTION: IMPROVISATION WITHIN MUSIC THERAPY

Ask a UK-trained music therapist what they do, and they will almost certainly describe their work in terms of improvisation. Music therapy's association with improvisation has become enshrined in the UK by the Health and Care Professions Council (or HCPC, formerly the Health Professions Council or HPC), which approves music therapy training programmes and registers music therapists. Its "Standards of Proficiency", revised every few years, are mostly generic, applying to all their regulated professions (a vast range from radiographers to paramedics). But some are specific to particular professions; of these, few are specific to the practice of music therapy, and fewer still address modes of musical activity. In twelve pages of (mostly cross-disciplinary) requirements from 2007, the following five points represent the sum total of information pertaining to what a music therapist should be able to do in musical terms (Health Professions Council, 2007, pp. 11, 15):

- be able to use a range of music and music-making techniques competently and be able to help a client to work with these
- be able to improvise music in a variety of styles and idioms
- be able to use musical improvisation to interact and communicate with the client
- know a broad range of musical styles and be aware of their cultural contexts
- be able to play at least one musical instrument to a high level

In 2013, the Standards were rewritten more verbosely, with those uniquely applicable to music therapists appearing thus (Health and Care Professions Council, 2013, pp. 15, 17):

- recognise that different approaches to music therapy have developed in different cultures and settings, and be able to apply a coherent approach to their work appropriate to each setting in which they practise
- understand the practice and principles of musical improvisation as an interactive, communicative and relational process, including the psychological significance and effect of shared music making
- know a broad range of musical styles and genres and be aware of their cultural contexts
- be able to play at least one musical instrument to a high level, and to use their singing voice and a keyboard / harmonic instrument to a competent level
- be able to use a range of music and music-making techniques competently including improvisation, structured musical activities, listening approaches and creation and composition of material and music technology where appropriate and be able to help a service user to work with these

Compiled by committee, the formulation of these standards can be critiqued on a number of levels. But what clearly survives from the 2007 version is the central

position awarded to improvisation. The newer version does name other modes of musical activity, but improvisation is identified repeatedly and even equated with “shared music making”, itself invested with “psychological significance and effect”. Only improvisation is described as “an interactive, communicative and relational process”. From a regulatory perspective, therefore, improvisation has become a marker not only of musical proficiency but also of professional proficiency.

BUT IS IMPROVISATION REALLY SO HEGEMONIC?

Apparently contradicting this regulatory emphasis on improvisation, the recent articulation of “Community Music Therapy” (Pavlicevic & Ansdell, 2004; Stige, et al., 2010) suggests that music therapy practice incorporates diverse manifestations of musical interaction. Furthermore, none of the early pioneers of improvisatory practice exclusively improvised. Documentary film footage of Nordoff and Robbins’ work reveals a spectrum of forms of musical activity, ranging from ‘purely’ improvisatory means of establishing contact and musical relationship with an individual child, via the use of structured songs, to the rehearsing and performance of complex musical plays, often in front of an audience. In his study of the work of Nordoff and Robbins, Aigen (1998, pp. 234-235) notes a tendency in many cases for there to be movement over the course of therapy from a predominance of improvisation towards the use of song and song structures, but also acknowledges the inter-relatedness of improvisation and composed music. This seems an important consideration to set alongside the all too often black-and-white rhetoric of the discourses surrounding contemporary music therapy. In musical terms, improvisation is rarely, if ever, a discrete practice separated from other modes of music making. Improvisation needs resources: often it develops out of the playing or singing of pre-composed music. Pre-composed music, likewise, can be a ‘firming up’ of improvisation.

REASONS WHY IMPROVISATION MIGHT BE RHETORICALLY VALUED

Why, despite evidence to the contrary, might improvisation have been awarded this apparently special place among potential musical interaction modalities within music therapy? Perhaps improvisation can be seen as a means of claiming ‘distinction’, historically and currently, as part of what Bourdieu (1984, p. 479) calls the ‘classification struggle’.

(I) AS A MARKER OF HISTORICAL DISTINCTION

Bourdieu describes efforts that “aim at retrospectively reconstructing a past fitted to the needs of the present” (1989, p. 21). Music therapy faces a particular challenge here since – in the sense of music being used in the social service of health and well-being – it can reasonably be said to have been practised (in a predominantly non-professionalised form) since time immemorial (Horden, 2000). Yet the contemporary Western profession of music therapy tends to present itself as a new arrival (commonly described as emerging in the USA in the wake of World War One and later elsewhere), implying that this is part of ‘scientific progress’ rather than ‘folk tradition’. As an old-yet-new form of work seeking to account for (and perhaps thus retrospectively create) its re-emergence, music therapy has needed to mark the transition from ‘historical’ to ‘modern’.

The pioneers of music therapy in the UK (Paul Nordoff and Clive Robbins, Mary Priestley and Juliette Alvin) all identified improvisation as a key feature of their work in teaching and publications (Bruscia, 2004, p. 13). Alvin and Priestley offer professionally conventional accounts of the value of improvisation by emphasising its 'liberating' aspects, which they suggest permit exploration of the unconscious:

The use of free rhythmical atonal improvisation liberates the player from obedience to traditional rules in tonality and musical form which he may not be willing or able to follow. He may let himself go on a musical instrument needing no specific technique without offending any convention and express himself directly often at subconscious level, as one may do in art therapy. (Alvin, 1975, pp. 105-106)

Music being an acceptable activity to the superego, it relaxed its hold on the repressed ideational content from time to time to allow us to see some of the generators of the anxiety behind her symptoms. (Priestley, 1994, p. 128)

Such language positions improvisation as a 'new' practice that permits access to the unconscious, thus associating music therapy with psychoanalytic prestige.

Nordoff and Robbins (1977; Robbins and Robbins, 1998) take a less speculative approach, focusing on the detailed observation and description of musical participation, and emphasising the coupling of conscious intent and practical skill on the part of the therapist. Indeed, a substantial number of their publications, as well as a significant portion of their teaching, focus on developing these skills. They initially described a range of improvisatory techniques for therapy under the heading of "Clinical Techniques and Procedures" (Nordoff & Robbins, 1977, pp. 89-174). Their procedures seem to have been taken up across the profession as 'clinical improvisation'. The now ubiquitous use of this term can itself be seen as a further bid for distinction, apparently emphasising that this is not just run-of-the-mill improvisation like *any* improvising musician could do – this is specialist professional improvisation. The specifically medical linkages of the word 'clinical' also bring an aura of distinction by association.

(II) AS A MARKER OF PROFESSIONAL DISTINCTION

Just as music therapy needed to mark the transition from 'historical' to 'modern', so too it needed to mark the difference between 'folk' and 'professional' practice. In particular, the demand for a public display of professionalisation in pursuit of state regulation made it imperative for music therapy to claim specialist expertise and specialist technologies. Where a speech and language therapist can demonstrate a practical knowledge of speech functions and a radiographer can show that they understand the interaction of radiation and living organisms, what can a music therapist show? An appropriate answer might be a practical knowledge of the interaction of musicking and well-being, but in fact improvisation (or 'clinical improvisation') has been widely presented as music therapy's expertise and technology (defined here as the practical application of knowledge). This idea is generally backed up by some kind of explanatory discourse rooted in one psychological tradition or another – for example, behavioural, humanistic or psychoanalytic – which purports to connect improvisation with desired outcomes.

Once again this achieves distinction by setting what music therapists do apart from what music teachers might do or the ways in which untrained people might ‘amateurishly’ use music to help themselves (or others) regulate their well-being. Improvisation is conveniently mysterious to the uninitiated and acts as the ‘black box’ (Jackson, 2008) in the middle, something that the layman could not possibly understand and therefore should be left to appropriately trained ‘experts’.

An eyewitness account describes how the UK profession established a committee to define ‘clinical improvisation’ and distinguish it from ‘musical improvisation’. The results of their labours were as follows:

Musical improvisation: Any combination of sounds and sounds created within a framework of beginning and ending.

Clinical improvisation: The use of musical improvisation in an environment of trust and support established to meet the needs of clients.

(Wigram, 2004, pp. 36-37)

Since the distinction focuses on context rather than content, the foregrounding of ‘clinical’ improvisation can be seen both as part of a broader claim to specialised expertise and as a territorial claim on the context (‘only *we* do this *here*’), and hence ultimately as a response to the rhetorical demands made of professionals.

(III) AS A MARKER OF SOCIO-MUSICAL DISTINCTION

Moore (1992) points out that only relatively recently have improvisation and ‘classical’ music been considered mutually exclusive (given the importance of extemporisation as part of classical practice until the mid-nineteenth century), and Nettl (1974) regards improvisation as an aspect of classical performance (essentially viewing improvisation as analogous to interpretation). Yet most literature on musical improvisation focuses on its ‘otherness’ from musical activity based on pre-composed material. Nooshin (2003), pointing out Western musicology’s historical dismissal of improvised non-Western musics as ‘primitive’, links this othering to Foucault’s (1977) work on power relations and fields of knowledge. Yet improvisation is also widely seen as a means of ‘going beyond’ classical music’s apparent mere replaying of the same notes.

Improvisation is also often equated with jazz, whose gendered perception as masculine (McKeage, 2004, Wehr-Flowers, 2006) may contribute to a sense of supremacy around improvisation. Jazz is idealised as “spontaneity ... modulated by the discipline of true respect for the ensemble” (Barker, 2002, p. 10). It is portrayed as inherently eclectic, integrating otherwise disparate musical disciplines (Sarath, 1993), and, in a hierarchy of improvisatory forms of music making, ‘classical’ music comes firmly at the bottom with various forms of jazz occupying the higher positions (Zack, 2000, p. 233). Meanwhile Goldstein (2008, p. 510) points out that jazz, which has origins in struggle, illegality and non-acceptance, has been ‘white-washed’ out of its black origins in its conversion to social acceptability (and presumably also commercial marketability). In an ethnographic study of improvisation learning, Della Pietra & Shehan Campbell (1995) show how improvisation can be experienced as having inherent meaning, which borders on the therapeutic.

A FREUDIAN INTERLUDE: MUSICAL CO-IMPROVISATION AS A SUPPOSED PARALLEL TO FREE ASSOCIATION

Having considered improvisation's function as a marker of distinction in the articulation of music therapy as professionalised practice, I now examine a story that the profession itself often tells about improvisation. It is a story rooted in a system of values that sees classical Freudian psychoanalysis as the ultimate form of therapy: other therapies therefore claim authenticity by asserting their bloodline to Freud.

Freud's work spanned many years, and it would be fallacious to consider it an unchanging continuum of unidirectional thought. There is, as Thwaites (2007, p. xi) puts it, "a multiplicity of Freuds". Nevertheless, it would probably be acceptable to all his various proponents to suggest that underpinning Freudian psychology is a desire to open up the hitherto occluded unconscious to conscious examination. Freud's first technology for attempting this was, with Breuer, the use of hypnosis (Breuer & Freud, 1974). Later, hypnosis was replaced by 'free association', whereby analyst and analysand make an impromptu chain of words that permits a view of the analysand's unconscious. The analyst's 'blankness' facilitates the development of transference, through the interpretation of which the analysand's unconscious processes can be explored. The claim made by many music therapists is that 'clinical improvisation' is a musical analogy of free association (Odell-Miller, 2001; Darnley-Smith & Patey, 2003). Siegal (1984, cited in Penfield, 2001) makes the same claim for the improvisation that occurs within Dance Movement Therapy, and Austin (1998) develops the idea further into her concept of 'Free Associative Singing'. Therefore, the claim goes, improvisation opens up access to the client's unconscious, lending music therapy legitimacy as a psychoanalytic therapy. It's an intriguing claim, and a professionally convenient one. However, there are at least three clear differences between verbal free association and musical improvisation.

First, words carry semantic meaning in a way that musical sounds generally do not: words are freely associated on the basis of semantic meaning, and the analyst's resulting route to the unconscious is a semantic one. Free association conducted purely on the basis of how words sound would seem quite odd in a psychoanalytic context – it would probably be viewed as avoidant or schizophasic if not downright deviant – yet this is essentially how musical improvisation develops.

Second, the ways in which the two happen are likely to be different. Verbal free association usually takes the form of exchanges: analysand and analyst take turns to speak. Or there may be long stretches where the analyst says nothing, leaving the analysand to his or her self-exploration. But generally, only one of them can be speaking at once. In musical improvisation, on the other hand, it is much more likely that the two (or more) people will be making sounds at the same time. This different sense of turn-taking makes for a very different kind of relating, even if verbal free association were to be considered in purely prosodic terms.

Third, people who come to music therapy report that their reason for coming has less to do with 'getting better' than with the music-making itself (Ansdell and Meehan, 2010). Improvisation can thus be seen not simply as a means to an end, but as both the means and the end, subverting the medical 'diagnosis / treatment / cure'

progression. Many clients describe improvising as ‘exciting’ or ‘fun’ – a significant achievement for someone who is depressed, for example – and others talk of being ‘drawn in’ by the making of music itself even if at first they were uncertain or simply ‘not in the mood’. Music inhabits familiar structures within which we can find ourselves surprisingly able to do things that might seem impossible outside of music (Ansdell, 2005). This is not magic: it is phenomenologically accountable to the structures of music with which, even if we cannot describe them verbally, we feel ourselves familiar and by which we find ourselves being organised or even physically ‘moved’. And finally, there is the role of the aesthetic: the way in which an improvisation between two or more people unfolds may well have less to do with individuals’ unconscious processes than with a shared, emergent aesthetic. This brings potential for satisfaction: again, no mean feat for someone whose ‘mental illness’ may render satisfaction an elusive commodity.

Thus there are real differences, not only between the forms of verbal free association and musical co-improvisation, but also between their potential roles in a therapeutic context, particularly in relation to the development of shared meaning. So what *does* improvisation bring to music therapy?

EXAMPLES OF IMPROVISATORY PRACTICE

Let us turn to music therapy practice for possible alternative accounts of the value of improvisation. What follows are my descriptions of two situations that have arisen in my work as a music therapist in a community mental health setting. These are neither randomly selected nor in any way representative: I have chosen them because I consider them to exemplify somewhat contrasting occurrences of improvisation within routine music therapy practice. The descriptions here are necessarily brief and reconstructed from notes made immediately after sessions and from listening back to recordings of the sessions.

(I) MARCUS

Marcus is clearly in a psychotic state: people in the public area are alarmed by the way he seems to be arguing with himself or swearing violently into the air, perhaps responding to voices. I suggest coming with me to the music room and he readily follows, immediately pacing from instrument to instrument. At first it seems to be primarily sensory – he gives the cymbal an exploratory strike, then repeatedly beats a drum hard. He continues using words, sometimes perhaps triggered by the instruments: the words he sings or recites are recognisable but they aren’t strung together in a way that I find comprehensible. He seems to be choosing words on the basis of their sounds rather than their meaning – sometimes producing long rhythmical lists of rhyming words. A psychiatrist might call this schizophasia, yet it strikes me as a musical capacity akin to rapping. I try to involve myself in what might otherwise be an isolated experience. At first, my musical contributions seem superfluous: he is clearly able to sustain a stream of words and musical sounds without me: what I play is non-committal as I strive to get the ‘feel’ of his music. Rather than presenting him with the usual reactions to such a presentation of self, I am endeavouring to ‘accompany’ him in every sense, to enable him to feel my presence and to help articulate the musicality and expression that is happening here. He’s hard to accompany – it’s difficult to stick with him. Yet as I interject on the piano, there is a sense of him leaving

room for me. I find myself drawn into using a lot of rhythmic dissonance: soon there is a real sense of our 'playing together'. Of course, I have used what I understand as my core professional skills of listening, responding and offering structure to try to bring this about, but also he is being musically responsive to me. This music is not imposed by either one of us but developed between us: his responsiveness is called out of him not so much by me as by the emergent music itself. It is the structure, the tonality, the rhythm, the dissonance (of all of which he is co-author) that engage him and enable him to be responsive in a way that seemed so unlikely.

The result is 50 minutes of sustained 'seats-of-our-pants' improvising. On listening back, I am struck by the intensity with which we both worked and by his healthy artistry in the midst of psychosis. This is unquestionably musical expression, and musical collaboration, even if the words don't tell me what is being expressed, or how this experience links to his situation in life.

Afterwards we return to the public area: he shakes me by the hand and declares himself 'sing song sanged'. He seems quieter, more settled. At lunchtime he is able to eat with others. As I pass, he greets me with a wink.

(II) GLORIA

Gloria suffers from chronic depression. She has spent the last twenty years of her life in and out of the hospital and has attempted suicide on a number of occasions. Writing poetry is something she has found can help her to express herself. She has also discovered that reciting her poetry helps her to feel alive and creative and to have hope. She's proud of her poems and carries them around with her. In the music therapy group, whilst others mostly choose to sing well-known songs, she chooses to recite her poems – I am expected to improvise music to the words she has already written. Here there's another kind of improvisation going on between us. The prosodic aspects of the poems suggest some aspects; other aspects are more rooted in the moment-by-moment interactions between us.

She stands to recite. There is an expectant air as the others watch her. It's a new poem: at once I hear that it has a coherent sense of phrase and that she doesn't need encouraging to finish lines. I get up from the piano and reach for my violin. The sound of her poetry matters for Gloria, and I feel I shouldn't interfere with it by playing over (or even under) it. Instead, I intersperse her lines with melodic fragments on the violin, complementing the melodic shapes of her lines. Although she's very serious about her poetry, I can see a smile and I sense that I'm doing OK. Once she gets to the end of the poem she starts again, and this time I sense more space, more time. I do little interjections mid-line, and eventually I summon up courage not simply to stop as the new line starts but to drop down to a sustained note, thus effectively "sewing together" the performance. And as I do, I can hear her voice adapting. I've tried to use pitches that match her recitation, but in turn her voice is becoming more tuneful, more modulated. She's reading the words, but also she's improvising. The reading is never musically the same twice.

Finally she slows to a clearly signalled end and I provide a musical coda. There's applause from our audience. She acknowledges me. "Aw," she says. "You do that real nice."

ASPECTS OF IMPROVISATION OBSERVED FROM THE EXTRACTS

So what observations can be made concerning the role of improvisation within music therapy on the basis of these two extracts? Here I identify four aspects of ‘improvisation as practice’, which might be considered to offer something of value in a therapeutic context whilst simultaneously challenging professional norms and markers of professionalism as commonly constructed:

(I) THE “EVERYDAYNESS” OF IMPROVISATION

Neither Marcus nor Gloria has been trained in improvising, or in any other form of producing music: they are ‘just’ doing it. Nor are they doing it as ‘art’ for external consumption; although Gloria is certainly consciously ‘working at it’, both are doing broadly what comes naturally, and I’m trying to support them in doing it. Whereas the profession of music therapy may tout improvisation as something highly specialised that requires particular training and thus defines the status of the profession, these people are just doing it! Perhaps then, we can think of improvisation in another way, as something really rather ordinary – ordinary in the sense of the everyday drawing on expertise which is both broader and more widespread than usually acknowledged. Maybe there is a sort of folk expertise in improvisation, which sits alongside the conservatoire expertise more usually associated with it. Maybe it is even a sort of expertise that survives the ravages of psychosis or depression and comes to the fore when other forms of expertise are held at bay.

One explanatory (or at least allegorical) concept here is Malloch and Trevarthen’s notion of ‘communicative musicality’ (Malloch, 1999; Trevarthen & Malloch, 2000; Malloch & Trevarthen, 2009). Whereas it used to be believed that babies were born as blank slates, ready to absorb any stimulation offered, detailed observations of mother-infant dyads show that the baby also stimulates the mother, resulting in the sort of multimodal interactions that characterise healthy infant development. Developmental psychologists seeking to describe these pre-verbal interactions inevitably talk of shared phrasing, tempo and attunement. We are hard-wired for this, and it is through these exchanges that we develop our earliest perceptions of, understandings of and relationships with all that is around us. This is improvisation in every sense: we really are ‘making it up’ – building our sense of self-and-other as we go along via our experiences of the world around us as music. Later, of course, we learn to use words to communicate semantically, but our pre-verbal musical capacity for interaction (and hence constructing our worlds) remains and seems to stay with us even in the face of psychosis, dementia or stroke. Perhaps, then, it is this very ‘ordinary’ and yet remarkable capacity that makes music therapy possible.

There has been increased recognition of the ways in which ‘untrained’ people make use of music (or, to put it another way, enable music to do its work) as part of their everyday lives (DeNora, 2000; Frith, 2003). Yet this kind of expertise is rarely related to what happens in music therapy – as if the two were unconnected. This epistemological disjuncture is highlighted by the work of authors who draw on ‘non-therapeutic’ knowledge to support ‘non-therapeutic’ uses of music in pursuit of well-being (e.g., Laukka, 2007; Sixsmith & Gibson, 2007), perhaps in order to ward off accusations of having invaded professionally protected turf. But neither Marcus nor Gloria seems to be switching into any sort of special ‘music therapy mode’: rather

music therapy is a space whereby what they do ‘normally’ is welcomed, supported and actively re-contextualised in order to maximise its chances of success in doing its work. How this is done is of course a matter of expertise: to suggest that improvisation is in some way ‘everyday’ is not at all to deny that what music therapists do is skilled – rather it suggests a need for this skill to be examined and unpacked to get at its real nature. As Bittner’s work on policing (1972) underlines, assumptions held by professionals and public alike as to what happens within a particular kind of work do not necessarily stand up to the observational examination of that work.

(II) THE “NON-BLANKNESS” OF IMPROVISATION

It is very clear to me, as the therapist in these extracts, that my participation is active rather than passive. I am exercising a discipline in regard to my participation which means that it does not sound as it might if I were freely ‘jamming’ with the other person – i.e., doing ‘musical improvisation’ as opposed to ‘clinical improvisation’ (cf. Brown & Pavlicevic, 1996). Nevertheless, I am inevitably drawing on my own palette of musical resources and cultural experiences. While wishing to foreground the client’s participation, I do this by being actively responsive, not by being silent or musically ‘vague’ (e.g., being endlessly tonally or rhythmically indeterminate). This again recalls the work of Malloch and Trevarthen: a mother who withholds herself from active musical interaction with her child, due to depression for example (Marwick & Murray, 2009), is likely not only to frustrate the child in that particular interaction but also to impact negatively over time on the child’s communicative development and emotional wellbeing. It also contrasts with the psychoanalytic requirement for the analyst to act as a ‘blank screen’ in order to “maximize the opportunity for projection on the part of patient, for the development of irrational or unrealistic perceptions – in other words, for the development of transference” (Patterson, 1959, p. 201).

In music therapy it is clear that *how* the therapist plays has significant implications for the unfolding of the improvisation, and therefore the therapist’s role has to be considered as part of the interaction (Procter, 1999). It is clear in both extracts above that the musical nitty-gritty of what I do (using dissonance at one point, or a melodic line on the violin at another) directly impacts on what happens, not simply by changing how it sounds, but by influencing the client (whether consciously or otherwise) in terms of what they do. This in turn opens up new possibilities for me, and so together we (the client and I) are creating our experience. In order for this to happen, however, I am constantly making choices about what to do and committing myself to musical participation, mindful of the potentials for action of each musical gesture. These choices are not random: I can act only within my own musical resources and drawing on my own musical experiences. In this sense, then, this is a good deal of ME playing with each client. I experience what I do much more as participating than as holding back.

(III) THE “NON-DISCRETENESS” OF IMPROVISATION

Improvisation is touted by the profession of music therapy not only as its skill but also as its technology: just as a nurse will administer an ‘injection’, so a music therapist will do ‘improvisation’. This gives the impression of fitting neatly with

generalised expectations of paramedical intervention: it is something that practitioners need to have been trained to do, and it is apparently definable and discrete (in the sense that it has a clearly predictable beginning and end). We have already found the first of these assertions (the need for training) to be problematic, and the second (definability) is almost a contradiction in terms (especially given the 'everyday' sense of improvisation as 'making it up as you go along'). What about the third, however? Can improvisation be considered a discrete intervention? This too is problematic, and not simply because the course of improvisation is, by definition, not entirely predictable. My improvisation with Marcus lasted 50 minutes and only ended because the room had to be cleared for something else. My improvisation with Gloria lasted about 7 minutes. I did not know in advance, however, how long either would last. It might be argued that this is of no consequence: a session can be of a pre-determined length, so this constitutes the length of the improvisatory 'intervention'. However, my experience as a music therapist, especially when working with acutely mentally ill people, is that many don't come for sessions – they come to 'do with' (whether in a public or private space), and when this 'doing with' comes to a natural end, so does the session. Thus, my meaningful interaction with someone is utterly unpredictable in length.

Furthermore, improvisation is also non-discrete in the sense that it is not always clear when music-making is or is not improvisation. Sometimes a song being sung in an open group will 'disintegrate' (or perhaps 'integrate') into a free improvisation. At other times, a period of improvisation might 'resolve' (or perhaps 'solidify') into a familiar piece of music. My improvisation with Gloria was followed by some verbal consideration of what we had done and then some re-capping and re-working of it as she sought to sculpt it into something she was proud of. In music at large, improvisation and pre-composition do exist in relation to one another. Compositions form from improvisations just as improvisations grow out of compositions, whether in the form of the soaring guitar solo which emerges from the rock anthem, a cathedral organist's extemporisation on a hymn tune or in a drumming circle.

Finally, it may not be clear (even in retrospect) when an improvisation started or finished. Often I have had the experience of hearing someone whistling much later in the day a melody that had been a theme in a group session earlier – whether it was originally part of a song or apparently improvised. Music has a life of its own, and is not contained by walls or timetables.

So improvisation need not be seen as antithetical to pre-composed music or to structure. On the contrary, improvisation, both within music therapy and outside, can relate more or less closely to pre-existing music and can be more or less structured. This has been recognised in the music therapy literature: for example, Brown (1994) hails the suitability of music (by which she means improvisation) as therapy for people with autism:

Because music contains the same paradoxical elements of fixed organisation and creativity that are needed in all our dealings with the world, we as therapists can use its inherent structures and potential creativity to help the person with autism develop more coherent and adaptable responses to other world structures. (Brown, 1994, p. 18)

(IV) THE “CONTEXT-RELATEDNESS” OF IMPROVISATION

Musical improvisation, like any other form of human interaction, occurs in contexts: in particular places, at particular times and between particular people with particular relationships and histories. In my role as therapist in the two extracts presented above, I am striving to facilitate a useful experience not only within the music but also in terms of the context. I decide to take Marcus across the courtyard to a private space, but remain downstairs with Gloria in a public space.

I am also aware that as part of my role as a music therapist within the institution, I strive to nurture an atmosphere where music and musical activity is accessible and acceptable. In this sense, I am not just waiting for some kind of music-making (such as improvisation) to occur, but am constantly preparing the ground for it.

THE AFFORDANCES OF IMPROVISATION WITHIN MUSIC THERAPY

DeNora (2003) outlines the notion of musical affordance – ways in which music offers opportunities for things to *happen* in our social worlds. *What* happens is not simply random but has to do both with the musicking itself and with its social contexts. This concept therefore offers a useful socio-ecological means of considering not only *what* improvisation might have to offer within music therapy, but also the how, where and when of it. To put it another way, we may be in a position to bring to bear upon improvisation in music therapy some of the multi-dimensional facets of contextualised observation, description and meaning-making which ethnography has to offer.

Here I can but speculate on the basis of the observational material presented above as to the affordances of improvisation for music therapy, both as practice and as discipline:

(I) FOR THE PRACTICE OF MUSIC THERAPY (AND HENCE FOR THE CLIENT)

- Improvisation affords experience of form and structure, ebb and flow. This can be seen in the way that Marcus ‘falls’ readily into the loosely framing structure I provide. Likewise Gloria’s poetry readily responds to musical phrase structure by creating stanza-like shapes of its own. This is a social action, musically enacted. But it is also a musical action (conceived in musical thought and achieved by musical means, using specific musical elements and devices) with social outcomes. Marcus’s chaotic self-presentation alienates him from his peers: the degree of organisation that he subsequently displays eases the sense of chaos and so ‘oils’ the social context. Gloria is able to realise in audible aesthetic practice her perception of herself as creative once the music aids her in shaping her own creation.
- Improvisation affords access to aesthetic self-experience and satisfaction, as well as to altered self-presentation and social interaction. This is particularly pertinent here because mental illness hampers people’s opportunities for exactly this kind of experience. Indeed it might even be argued that improvisation has the potential to appropriate certain aspects of mental illness in the service of a person’s experience of wellness. Marcus could be described

as highly disinhibited: however, this disinhibition (in many ways a significant handicap in life) facilitates his taking up of the offer of improvisation. Many 'sane' people would shy away from such activity, or attempt to talk their way out of it. Marcus, on the other hand, dives straight in. Gloria's poetry writing appears obsessive to others, but her commitment to her poetry has eased her way into improvisation and her active musical engagement facilitates a changed responsiveness both to the music and between her and the other people present: they are able to perceive her as genuinely creative and give her feedback on the basis of this to which she, in turn, can respond differently.

- Improvisation can be heard as bridging the gap between 'music' and 'not music'. Whilst some people come wanting to sing songs, for others who find this daunting, embarrassing or simply not possible due to the states in which they find themselves, improvisation offers a way in. As with Marcus, improvisation can be woven around something that is already happening, whether or not it is intended as 'music'. Likewise, improvisation can act as a funnelling back into 'not music': Gloria emerges at the other end of her singing as someone in some way different, surrounded by people who have witnessed this difference and will acknowledge, acclaim and support it.

(II) FOR THE DISCIPLINE OF MUSIC THERAPY (AND HENCE FOR THE MUSIC THERAPIST)

- The lack of clarity as to where improvisation starts and stops can be useful, permitting music therapists to consider everything they do as improvisation as they pursue the affordances described above on behalf of their clients. Did my improvisation with Marcus start when the door was shut in the music room? I only started playing the piano then, but maybe that's simply because that's where the piano was. Even my initial approach to him was improvisatory. Before that, when I saw him from afar, I was thinking how to interact with him – and conceiving of this in musical terms related to pulse, rhythm and phrasing. I was able to make use of an improvisatory attitude to all that we did, whether 'music' or not; this is perhaps comparable to Arnason's conception of an 'improvisational attitude' (2003, p. 133) within a music therapist's listening. Surely it is this attitude writ large that equips music therapists to work so responsively to the needs of individuals, settings and communities, as claimed by proponents of Community Music Therapy.
- This 'fuzziness at the edges' also reminds music therapists of the musical nature of what they are doing, and hence of its potential affordances for clients. It is largely unacknowledged in the literature that the nature of improvisation is hard to reconcile with professional rhetoric, and in particular with the rhetoric of regulation. For example, the regulator demands that music therapists must "get informed consent to give treatment (except in an emergency)" (HPC, 2008, p. 3) – updated in 2012 to reflect the inclusion of 'care' professions to "get informed consent to provide care or services (so far as possible)" (HCPC, 2012, p. 3) – and also "keep accurate records" (HPC, 2008, p.3 and HCPC, 2012, p. 3). These rules are presumably made with the administration of drugs or physical procedures in mind; music simply does

not work in the same way. It is inconceivable that I could have required Marcus to read an information sheet, ask questions and sign a form to indicate informed consent before taking him over to the music therapy room. The process of engaging him in improvisatory music making was itself an improvisatory one, which had to do with “the nonconformist power of improvisation” (Metzner, 2005, p. 155). In addition, it is doubtful that either Marcus or Gloria would describe what they did with me as ‘treatment’ (not least because it really was ‘what they did with me’ rather than ‘what I did to them’). This issue has perhaps been evaded in the literature precisely because it offends the notion of music therapy as ‘properly’ paramedical, which seems to demand that what it does be seen as treatment. As for keeping records, how am I to record my improvisations with Marcus or Gloria? I could put a copy of the minidisc in the notes – but nobody would listen to it. I could try to describe the improvisation at length – but nobody would read it. I could write very briefly that Marcus or Gloria sang or played – but what does that convey of what actually happened? Perhaps a long-term approach is to inculcate the setting with an attitude of musical understanding – once again, this is part of building the contexts that support musical affordances. Nevertheless, the awkwardness of the fit serves to remind music therapists of the ‘musicness’ of their work and, in particular, the centrality of musical affordance in what music therapy has to offer.

- By extension, improvisation affords music therapists a constant reminder that all they do matters, that they have a musical responsibility for offering opportunities to clients to gain from musical affordances. This responsibility has to do with what happens in the music and what musical resources music therapists make available to clients as well as what happens around the music in terms of providing an environment in which music-making is accessible and its affordances can be appropriated by those who stand to benefit most from such appropriations.

CONCLUSION – IMPROVISATION AS SOCIAL LIFE

Improvisation is a multi-faceted phenomenon: it is therefore unsurprising that its roles in relation to music therapy are many and varied. Improvisation affords music therapists the adoption of an ‘improvisatory attitude’ to all of their work which goes beyond temporal chunks of ‘music’ or ‘not music’ and emphasises the cultivation of a social context in which musicking is accessible and its affordances appropriatable. Those of us who seek to reflect on and theorise about music therapy need to view all music therapy work as a kind of large-scale improvisation that is sufficiently capacious to incorporate pre-existing music as well as physicality and verbal interaction.

Such a stance offers an over-arching focus on the practical task of facilitating the appropriation of musical affordances, rather than trapping music therapy in an ultimately leaky attempt to justify comparisons with non-musical work such as psychoanalysis. On such a scale, improvisation becomes part of life itself, with its unregulated (yet regulated) sharing of musical (yet also non-musical) initiative. This is not a complex system of symbolism – this kind of improvisation does not ‘reflect’

life. Rather it is the doing, the dynamic creation of our social selves in the context of others. It is living itself.

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