

The Use of Improvisation in a Student's Music Therapy Practice with Older Adults in a Residential Setting

An exegesis presented in partial fulfilment for the degree of

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Luke Stothart

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Abstract

As shown in the research literature, improvisation is a less common approach to music therapy practice than the use of familiar songs or group singing when working with elderly people in residential settings. This research explores the ways in which improvisation in music therapy could benefit elderly participants in a residential setting. A secondary analytic process was conducted involving a careful analysis of existing clinical data by the student music therapy researcher. Data was analysed using thematic analysis. The findings consisted of three core themes which captured the ways in which improvisation was included in music therapy sessions: these were improvisational approaches described as anchoring, reflecting and dialogue. These core themes were strongly influenced by writings on improvisation method by the late Tony Wigram. Results showed improvisation has potential in its use among older adults in a residential facility. Conclusions could be used to help other elderly residential facilities that are willing to implement similar models of practice.

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Ethics Statement

My research supervisor was given approval from HEC for this research to take place. The approval read: Ethics Approval: 22131 NZSM Master of Music Therapy Programme ethical template for student research in NZSM 526 undertaken as observational studies, theoretical or case study research or action research. This ethical approval covered my study.

My research followed the Code of Ethics for Practice of Music Therapy in New Zealand (Music Therapy New Zealand, 2012). I was also familiar with the Victoria University Human Ethics Policy & Guidelines.

1 Introduction

This research explores my clinical practice as a student music therapist working with older adults at a residential setting.

1.1 The Setting

My research took place at a retirement facility situated in a peaceful, community based area of New Zealand. At any one time, there were around 100 residents spread across three areas (ranging from lower to higher needs) at the village: independent 'flat' living, rest home, and a hospital wing.

Respite and day care was also provided by the facility. The majority of my work as a therapist was in the hospital wing and the rest home. Residents included those who had: reasonable independence (usually lived independently), mild-severe stages dementia (rest home or hospital wing), and medical frailty i.e. stroke/heart disease /arthritis (hospital wing).

There was one diversional therapist whom I liaised with frequently, as well as a part-time qualified music therapist. I worked at the facility two days a week for a period of six months. I met with the part-time therapist, who was also my clinical supervisor, once every fortnight for an hour-long supervision. Throughout the course of my placement I ran two group sessions every week, one in the hospital wing and one in the rest home. I also worked individually with residents who were either referred to me by the diversional therapist, nurses or other staff members.

1.2 Background of researcher

Music and its impact among the elderly is something I have found interesting, even before beginning my MMus Therapy degree. Playing the violin at many retirement facilities over the years, I have seen the positive effects that music can have among older adults. When given the opportunity to undergo a full year's placement in a retirement setting, I knew this was my chance to take my interest further – using therapeutic techniques I have developed and will extend throughout the course of my placement. Furthermore, I believe that the regular inclusion of music is an essential part of anyone's diet, regardless of age.

I have a special interest in improvisation and creativity through my experience and training in sonic arts as a music student. In many ways, composition and improvisation have a strong relationship – both involving invention, creativity, and developing new sounds, patterns, pieces or songs. I consider myself a music-centred therapist and with a history of composition and an interest in improvisation, I think this approach will be well suited to my research. I feel the information above has been the foundation of my interest in pursuing what might be considered in the literature below as a less typical approach when working with the elderly.

1.3 Research question

How did I use improvisation as a music therapy student among older adults in a residential setting, and what specific strategies and approaches were employed?

2 Literature Review

2.1 Definitions

This literature review covers various issues prevalent for older adults as well as literature on music therapy practice with this particular population. Improvisational literature in other domains is also included with a further focus on why it might be important among older adults. I briefly discuss music therapy and older adults living in residential settings in New Zealand. Electronic searches on Te Waharoa (Victoria University Library), Cochrane Library, Journal of Music Therapy, and Nordic Journal of Music Therapy were conducted. My search strategy involved searching all terms relating to my research question: improvisation, music therapy, older adults, residential setting. As well as these terms I searched for like terms such as: spontaneity, elderly people, rest home. As I became familiar with authors relating to this topic, I searched for other literature written by them that might have been significant to this research.

According to the Music Therapy Association of Ontario, music therapy can be defined as,

‘The skilful use of music and musical elements by an accredited music therapist to promote, maintain, and restore mental, physical, emotional, and spiritual health. Music has nonverbal, creative, structural, and emotional qualities. These are used in the therapeutic relationship to facilitate contact, interaction, self-awareness, learning, self-expression, communication, and personal development (1994).’

This definition correlates strongly with the study at hand given the importance of hauora (mental, physical, emotional, and spiritual well-being) at the residential setting where the research occurred. Hauora is something I learnt about at high school and it is something that I continue to incorporate in my everyday life including my practice as a student music therapist.

Bruscia (1987) defines music therapy as,

‘A goal-directed process in which the therapist helps the client to improve, maintain, or restore a state of well-being, using musical experiences and the relationships that develop through them as dynamic forces of change.’ (p. 5)

This definition by Bruscia has more of an emphasis on the therapeutic process using phrases such as ‘goal-directed’ and ‘dynamic forces of change.’

Music Therapy New Zealand define music therapy as ‘the planned use of music to assist with the healing and personal growth of people with identified emotional, intellectual, physical or social needs’ (Music therapy, n.d.). I felt that a New Zealand perspective was important to consider

because the research took place in New Zealand. We can see that some of the ideas of hauora are also in this definition¹.

2.2 Research in Music Therapy with Older Adults

Gerontology is a science involving the knowledge of multiple individuals in different fields about what it means to grow old (Ridder & Wheeler, 2015). In comprehending what music therapy practice among the elderly might involve, a deeper understanding of what it means to be an older adult is required.

Wosch (2011) defines Music Therapy for older adults as, ‘cooperation between client and therapist to support the client’s psychological, mental, and social resources by using music experience in goal-directed, knowledge-and evidence-based, and participatory approach’ (p. 23). Wosch’s definition suggests that music therapy aims to support three key issues in the health of older adults,

1. Psychological
2. Social
3. Mental

There are many psychological problems that can arise for older adults as a result of death of lifelong friends or spouse, loneliness, or loss of social stature after retirement (Ridder & Wheeler, 2015; Werner, Wosch & Gold, 2015). Similarly, Powell (2006) suggests that elderly, even those living in non-medical settings, can experience many physical issues and emotional difficulties in relation to loss, isolation, and major life change. Isolation appears to be the most prominent social issue among older adults (Aldridge, 1996; Darnley-Smith & Patey, 2003; Ridder & Wheeler, 2015; World Health Organization, 2017). As friends and family members (i.e. husband or wife) pass away, older adults will lose social functioning and in turn experience this isolation - with those outliving their peers being most likely to experience social isolation (Ridder & Wheeler, 2015).

Mental Health among older adults encompasses five main areas:

1. Dementia
2. Depression
3. Anxiety Disorders

¹ Hauora is a Maori philosophy of health that is unique to New Zealand culture. Maori people are native to New Zealand. Hauora encompasses the four tiers of wellbeing, suggesting that each of these four dimensions rely on each other to achieve good health. It is a well-recognised and respected philosophy among many New Zealanders.

4. Substance Abuse
5. Self-Harm (World Health Organization, 2017)

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) suggests that a person with major neurocognitive disorder (dementia) will experience a decline in one or more of the following: learning and memory, language, executive function, complex attention, perceptual-motor, social cognition (American Psychiatric Association, 2013). The DSM-5 further suggests that the cognitive deficits of dementia affect the independence and everyday life those living with it - needing assistance at the very least to carry out everyday tasks and activities (2013). A Kowalska et al.'s (2013) research reported 72% of residents living with dementia and 65% of residents living with depressive symptoms in a residential facility. The research at hand was also conducted in a residential facility, hence the relevance of these percentages. From a New Zealand perspective, Jones (2016) stated that 2011 saw approximately 48,000 people living with dementia, with that number expected to triple by 2050. There are various disease processes that can lead to dementia, the most common being Alzheimer's disease, vascular dementia, dementia with Lewy bodies, and frontotemporal dementia (Jones, 2016). As it stands, there is no known cure for dementia (Jones, 2016). Depression can also co-occur with dementia (Werner et al., 2015) which is no surprise given the effects of dementia mentioned above.

Dementia and depression most commonly occur in older adults, but other disorders such as anxiety and substance abuse/addiction can easily be overlooked. The World Health Organization (WHO) presented an alarming statistic suggesting that ¼ of all deaths resulting from self-harm are of those aged 60 or over (2017). They also state that 3.8% of older adults live with anxiety and 1% suffer from substance abuse (2017). The trouble with lower and even higher (i.e. depression) percentage mental health issues among older adults is that people tend not to talk about it - the stigma around mental health (particularly for people born pre-1960) means they are reluctant to seek help (World Health Organization, 2017).

There are a variety of therapeutic techniques or approaches that are used by music therapists when working with older adults. McDermott, Crellin, Ridder, and Orrell (2013) present several methods specifically tailored towards the use of music therapy in dementia care:

1. Group Music Therapy (singing, requests, listening of live music)
1. Improvisational Group Music Therapy
2. Group Music Therapy focused on the use of drums
3. Music Listening
4. Individual 'play-along' sessions
5. Musical Reminiscence

6. Individual Sessions
7. Group Music Therapy (with carers)

From the examples above, group music therapy appears to be a more commonly used approach (Castelino, Fisher, Hoskyns, Zeng & Waite, 2013; Jones, 2016; Reuer, Bernstein & Crowe, 2007; Werner et al., 2015). Although there is little research on why this might be, one can only assume lack of funding is an issue - although from a positive perspective, groups are social in nature which could be reasoning for their dominance in music therapy among older adults. Ip-Winfield and Grocke (2011) suggest therapists almost always sing with reminiscence 46% of the time and facilitate instrument playing along with music 31% of the time in music therapy groups with older adults. Alternatively they reported almost always improvising vocally 4% of the time and with instruments 12% of the time. Therapist's reported they would almost never improvise vocally (31%) and instrumentally (23%) in sessions. The only approach less than the use improvisation in Ip-Winfield and Grocke's research was song-writing which 0% of therapists reported almost always using in sessions. In their research, Ip-Winfield and Grocke suggest that improvisation of any kind in music therapy is considerably less likely to occur compared to other approaches in music therapy among older adults. Given that the research was conducted in Australia, these statistics are relevant to New Zealand, given that both countries are from the same continent and share some connected aspects of modern day Westernised culture.

2.3 Improvisation and Music Therapy

Defining the term *improvise*, one must '...make, invent, or arrange offhand.' (Merriam-Webster, 2017).

A wider understanding of the term *improvisation*, independent of its therapeutic context, is needed for a more holistic overall understanding moving forward through the literature. At its most fundamental level, the term 'improvising' means to simply make something up as one goes along (Bruscia, 1987). Bruscia goes further to suggest that improvising is also creating or formulating something from various resources that are available to the improviser.

The first and most common form of improvisation in everyday life is the communication of language through conversation. Sawyer (1999) argues the majority of daily conversation is improvised, that is, not scripted and therefore unpredictable. Language can be defined as 'the words, their pronunciation, and the methods of combining them used and understood by a community' (Merriam-Webster, 2017). In a way, the use of improvised language is an art form in itself: using sound or voice as a means of communication in an unpredictable manner.

The literature above provides an important understanding of improvisation without including the words *music* or *therapy*. Improvisation has been an important component of music over many centuries (Kennedy, 1985) and can be performed in many different ways. The Oxford Dictionary of Music describes improvisation as, ‘A performance according to the inventive whim of the moment, i.e. without a written or printed score and not from memory’ (p. 348). Similarly, The Harvard Dictionary of Music defines improvisation as, ‘The creation of music in the course of performance’ (p. 406). There are many different forms that improvisation can take in music. For example, improvisation can occur within a structured framework such as a solo in a jazz ensemble.

Improvisation is an integral aspect in the practice of Music Therapy in many countries. Wigram (2004) defined musical improvisation as, ‘Any combination of sounds and sounds created within a framework of beginning and ending’ (p. 37). This definition is broad, yet still definite. This is because Wigram, clearly set improvisation within a framework (i.e. any *sound*, beginning and end). What is lacking in this definition is a therapeutic perspective of musical improvisation. If a music therapist was to follow Wigram's original “musical” definition, there would be no issue with implicating it into their sessions. However, Wigram doesn't address at this stage in his exploration what improvisations role might be in music therapy as well as the understanding that is required for its effective usage. From a neurological perspective, Tomaino (2013) suggests that improvisations role in music therapy is targeted toward: (1) developing a deeper therapeutic relationship between the music therapist and client(s) and (2) as a means of elevating any limitations or inhibitions affecting clients in sessions. Tomaino's ideas suggest that improvisation can be used to develop something that otherwise could not be addressed in other music therapy frameworks.

2.4 Clinical Improvisation

As suggested above, musical improvisation per se does not specifically apply to developing a therapeutic framework. When referring to improvisation in a contextualised framework, the term 'clinical improvisation' is often used. Wigram (2004) defined clinical improvisation as, ‘The use of musical improvisation in an environment of trust and support established to meet the needs of clients.’ (p. 37). This definition is far more concrete in a therapeutic context, referring to both motivations (trust and support) and the client. Similarly, Bruscia (1987) suggests in a clinically therapeutic context, improvisation is ‘inventive, extemporaneous, resourceful, and it involves creating and playing simultaneously’ and an acceptance of whatever level of music making the client is capable of (p. 5). Both Wigram and Bruscia address the wellbeing of the client in their definitions. Bruscia (1987) further includes ideas of wellbeing by suggesting clinical improvisation can help the client become more aware of and attentive to themselves and others, aiding in self-expression and communication, and promoting insight and personal and interpersonal freedom.

Pavlicevic (2000) suggests that music therapy doesn't aim to produce 'good music' as might be the case for other contexts for musical improvisation, but instead aims to 'create an intimate interpersonal relationship between therapist and client' (p. 272). Pavlicevic furthers this idea suggesting that clinical improvisation can produce 'unmusical sounds' and still be of therapeutic authenticity (2000). Bruscia (1987) also suggests that clinical improvisation isn't necessarily 'music' but rather a process and production of sound forms.

Carroll and Lefebvre (2013) discuss different processes that might be used in various scenarios in music therapy. Some of these are tailored toward: establishing contact, eliciting responses, structuring responses, guiding the client toward greater freedom of expression, and working with the client on deeper interpersonal levels (Carroll & Lefebvre, 2013). This is important because although improvisation encompasses what might seem like an endless variety of possibilities, there is still consideration and planning needed in clinical sessions. Carroll and Lefebvre's (2013) interpretation of a clinical approach correlates with Wigram (2004) when they suggest that the definition mentioned above was in part due to the need for a 'frame' to work within for clinical improvisation. Wigram (2004) references the ideas of Mary Priestley who suggested that once entered the room, (or frame) any sounds made by a client can be interpreted as musical and improvisational. The literature suggests that clinical improvisation can be very broad and abstract, however, it continually aims to develop a deeper therapeutic relationship between therapist and client.

There are many technical methods that are used in clinical improvisation. Various authors have coined their own terms for these therapeutic methods, typically including matching, mirroring/imitating, grounding, holding, containing, empathic improvisation, reflecting, dialoguing and accompanying (Bruscia, 1987; Carroll & Lefebvre, 2015; Wigram, 2004). These methods are usually tailored toward the client and collectively aim to elicit response and/or communication.

Literature suggests the piano is a commonly used instrument in clinical improvisation (Bruscia, 1997; Wigram, 2004; Simpson, 2000b;). The use of percussion is effective in improvisation because clients can play without any technical skill (Darnley-Smith & Patey, 2003). Literature also suggests a combination of the two in clinical improvisation, with therapist playing piano and client playing percussion (Darnley-Smith & Patey, 2003; Simpson, 2000b; Wigram, 2004). In more general contexts, not specifically improvisational, Oden (2014) suggests that the guitar is one of the most used instruments in music therapy and important for student therapists to learn.

2.5 Why is Improvisation an Important Topic among Older Adults?

Among older adults, there is research to support the use of improvisation (Bruscia, 1987; Darnley-Smith, 2002; Darnley-Smith & Patey, 2003; Odell-Miller, 2002; Ridder & Gummesen, 2015; Wigram, 2004; Wigram 2012)

Ahn and Ashida (2012) argue that music therapy can elicit memories, movements, motivations, and positive emotions among older adults. A similar idea is supported by Ridder and Wheeler (2016) who argue that participation in musical activities such as choir and singing can improve health and well-being among older adults. Furthermore, it has been suggested that music might be the best way to encourage active involvement (Ferrero-Arias et al., 2011). This in particular is an important benefit for elderly as anyone who has spent any time at a residential facility will know that many residents are unhealthily inactive.

As stated above, Tomaino (2013) suggests that the role of improvisation in music therapy is targeted toward: (1) developing a deeper therapeutic relationship between the music therapist and client(s) and (2) diminishing any limitations or inhibitions affecting clients in sessions. Tomaino alone is enough to justify the use of improvisation among elderly participants. Building a deeper therapeutic connection is important when working among elderly in a residential setting as many residents are likely to be living with dementia, depression or other psychological disorders and will likely require much trust and understanding between client and therapist. In referencing Charles Limb, Tomaino (2013) suggests that during improvisation, the medial prefrontal cortex turns on - a region of the brain associated with self-expression and sense of self.

Interactive music therapy suggests an element of creativity or improvisation given that clients are participating at their own will and in their own manner - this is different to singing of familiar songs where clients are merely 'following' the therapists lead or even less, not singing/participating at all. Odfield (2006) describes interactive music therapy as an 'an interactive, positive approach, which involves live and mostly improvised music making' (p. 22). Comparison between interactive therapeutic approach and other less interactive techniques has been examined in different studies (Werner et al., 2015 & Jones, 2016). In some cases, interactive music therapy has been reportedly more effective in reducing depressive symptoms among older adults living residentially compared with other musical approaches such as group singing (Werner et al., 2015).

Darnley-Smith (2002) supports the use of musical improvisation and a general improvisational approach in her work with older adults. She further suggests that moving between ideas and structures within a therapeutic session is an improvisation in itself - whether this be improvised sound or pre-composed song, both are prompted by spontaneity (Darnley-Smith, 2002). This particular idea of spontaneous improvisation resonates with Irish music, and in particular, the type of musical atmosphere found in Irish pubs. Although this is not a music therapy setting, important ideas and concepts were inspired Darnley-Smith's approach to music therapy. Darnley-Smith

(2002) credits this idea of spontaneity and improvisation in part through observing Irish pub musicians playing while on holiday in the Republic of Ireland. This feels relevant among older adults in New Zealand especially, as many have direct Irish bloodlines, and songs from Irish culture are popular and requested often.

Rycroft's (1979) psychoanalytic technique of free association shares a close link with improvisation in suggesting that in following the musical direction of a client wherever it may lead us, allows for authentic self-expression between therapist and client (Darnley-Smith, 2002). This is important when working with the elderly who at the very least deserve such authenticity obtained from a deeper therapeutic connection as a result of improvisation. Darnley-Smith (2002) discusses a similar concept of 'acoustic dreaming' where the music discovers its own form as the improvisation progresses.

Aldridge (2000) suggests that elderly people's quality of life and emotional well-being can be improved with the help of music therapy. Given that elderly people can experience emotional difficulties (Powell, 2006) and psychological problems (Ridder & Wheeler, 2015), it is clear that music therapy has powerful potential to aid the gap found in the wellbeing of older adults. Aldridge (2000) also suggests that music therapy can lead to an improvement in health, memory, and sense of identity. Ahn & Ashida (2012) suggest that loss of memory can lead to personality change in people living with Dementia. These deteriorating symptoms are undoubtedly going to affect the sense of identity of those living with Dementia. This further proves the need for music therapy among elderly.

The research at hand explores how improvisation can be used among older adults living in a residential setting. This literature review has highlighted interest and some research from specialists in the field in the potential for improvisation as a therapeutic method. For various reasons, this widely-used approach for building deeper connection and meaning between therapist and client appears to be underutilized despite interest from therapists. Literature exploring the use of improvisation among older adults conclude that more research is needed in this field (Aldridge, 1996; Odell-Miller, 2002; Ridder & Gummesen, 2015).

3 Methodology

3.1 Methodology and Theoretical Grounding

A qualitative research study was undertaken in exploring how I used improvisation as a music therapy student among older adults in a residential setting. Qualitative research can be defined as,

“An interdisciplinary, transdisciplinary, and sometimes physical interdisciplinary field. It crosscuts the humanities and the social and physical sciences [...] it is multiparadigmatic in focus. Its practitioners are sensitive to the value of the multimethod approach. They are committed to the naturalistic perspective and to the interpretive understanding of human experiences. At the same time, the field is inherently political and shaped by multiple ethical and political positions.”

(Denzin and Lincoln, 2000 as cited by Wheeler, 2005, p. 63)

In practice, Bruscia defines qualitative research as “a process wherein one human being genuinely attempts to understand something about another human being or about the conditions of being human by using approaches which take full advantage of being human” (1995b, as cited in Wheeler, 2005, p. 63).

Acting as clinician and researcher, I analysed my own clinical data that was originally used for the purpose of clinical work rather than research. The clinical data was then re-analysed, looking for themes and techniques used in clinical work to support the use of improvisation. After re-analysing my own clinical data, various themes and patterns emerged. This created basis and meaning for the clinical work and served as foundation for research exploring the use of improvisation among older adults in residential settings in the future.

Secondary analysis of data was used as the methodology for this research. Secondary analysis is the re-analysis of data to answer a previous research question with a stronger analytical approach or to answer a new question with previous data (Glass, 1976). Secondary analysis is best tailored toward this research because it implies that previously obtained data will be re-analysed, something that other methodologies don't consider.

3.2 Data Collection

Data was obtained from my own clinical work as a student music therapist, including: transcript, clinical notes, supervision meetings, documents, reflective journals.

Despite clinical practice occurring at the residential facility from the beginning February to the end of July, for this research, data was collected from the 15th April through to the 15th of June. This

came to a total of two months' worth of data for analysis. Data was chosen between these dates because, (1) I had settled into the placement setting and individual sessions at this point, and (2) the closure of the facility in August made for a disruptive last month altering my role and approach in music therapy sessions.

3.3 Data Analysis

Through the course of this research, I explored how I used improvisation as a music therapy student among older adults in a residential setting. Analytical meaning was constructed through an analysis of themes and patterns found in the data. Thematic analysis was used to search, review, and define patterns and themes of this research. Schwandt (2007) defined thematic analysis as,

“A common general approach to analysing qualitative data that does not rely on the specialized procedures of other means of analysis such as grounded theory methodology, discourse analysis, and semiotic analysis. In this exploratory approach, the analyst codes (marks or indexes) sections of a text (e.g. a transcript, field notes, and documents) according to whether they appear to contribute to emerging themes.” (p. 292)

When analysing the data, I employed Braun and Clarke's (2006) six-phase process as a framework to highlight main themes:

1. Familiarizing myself with the data.

The collected data was read through thoroughly a number of times to fully grasp all ideas covered. While carrying out this process, I decided to remove clinical and reflective notes from all group sessions. Therefore, all information was obtained only from individual clinical work.

2. Generating initial codes.

Using Google Sheets, I rigorously extracted the relevant pieces of data from clinical and reflective notes and began coding. Breaking these extracted phrases down even further, I was able to form initial codes. I identified a correlation between Tony Wigram's improvisation framework and the data I obtained. This led me to add in a separate 'category' column where I conducted a deductive process of Wigram's (2004) framework. Finally, I decided to add another column explaining how each code/category relates to its relevant data source, creating a clear understanding for analysis. Ideas and insights relating to the data and research were added as separate analytical memos on the spreadsheet.

3. Searching for themes.

I created various themes inductively, through similarities of various categories. Themes were established upon the ideas of and similarities between categories.

4. Reviewing themes.

I continued to review codes and categories, so to with themes. Starting broadly, I narrowed the amount of themes down gradually. Thinking of how each theme related back to the research question as well as my analysis of coding and categorizing helped me group ideas together and form themes. I constantly reminded myself of the research question and began to answer how I used improvisation in my clinical work via the three key themes.

5. Defining and naming themes.

The process of naming and renaming occurred until I found the perfect title for each theme. As the main themes emerged, codes, categories, and themes continued to be reviewed, altered, and grouped.

6. Producing the scholarly report.

I continued to examine my analytical process and throughout my findings questioned how the themes related back to the research topic. I continued searching for relevant literature.

I used Braun and Clarke's (2006) framework to analyse the themes shown above. With these themes, I developed a framework of my own – one that could be used by other music therapists working in residential settings. The framework gathered from this research could support the use of improvisation with older adults in a residential setting.

3.4 Ethics

For this research, I acted as both the student music therapist and researcher. My research followed the Code of Ethics for Practice of Music Therapy in New Zealand (Music Therapy New Zealand, 2012). I was also familiar with the Victoria University Human Ethics Policy & Guidelines.

My research supervisor was given approval from HEC for this research to take place. The approval read: Ethics Approval: 22131 NZSM Master of Music Therapy Programme ethical template for student research in NZSM 526 undertaken as observational studies, theoretical or case study research or action research. This ethical approval covered my study.

Along with an ethics approval, the following was included and/or considered:

- Consent forms outlining research risks and benefits, rights of participants, etc. (see *appendix* for information (1) and consent forms (2)).
- Confidentiality of clients
- Feedback of results to clients in a comprehensible manner

- Client's best interest were *always* at heart, as well as being well informed and looked after by researchers, organisers.

Pseudonyms were used to protect the confidentiality of all residents involved in this research. Any potentially identifiable information of residents was only included if relevant to the research topic.

This research included a case vignette, meaning that a client was specifically mentioned and I therefore required informed consent from this person. The person in question was cognitively able to understand the implications of the research. I prepared an easy-to-understand sheet of information and read it with him (*Appendix 3*), and left it with this person to read and think about further in their own time. His son also read over the information sheet with him when I wasn't present to ensure fairness for this person. There was a separate information sheet for carers/family members (*Appendix 4*) that his son read through. Consent was also required from this person's power of attorney (his son), giving them the opportunity to revoke permission to include information in this research if they were not happy with any aspect of it.

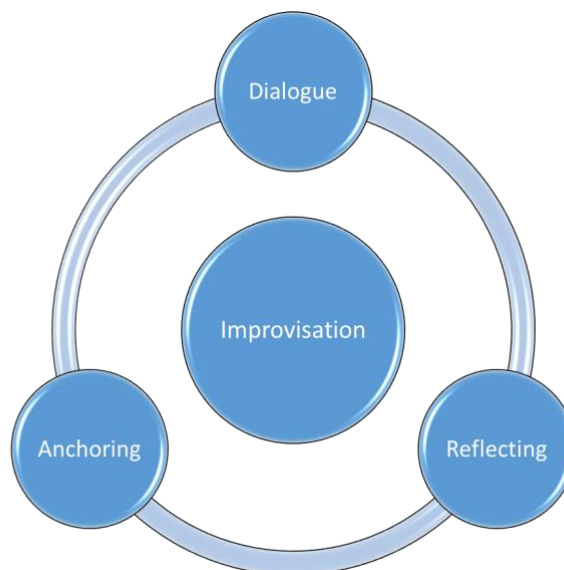
4 Findings

4.1 Introduction

The findings below were drawn from my coded data of clinical notes and reflective journal. This included data from dates April 15th to June 15th 2017. Any significant data from clinical notes or reflective journal outside of this analytical period have been reserved for the discussion session to ensure equity.

4.2 How did I use improvisation?

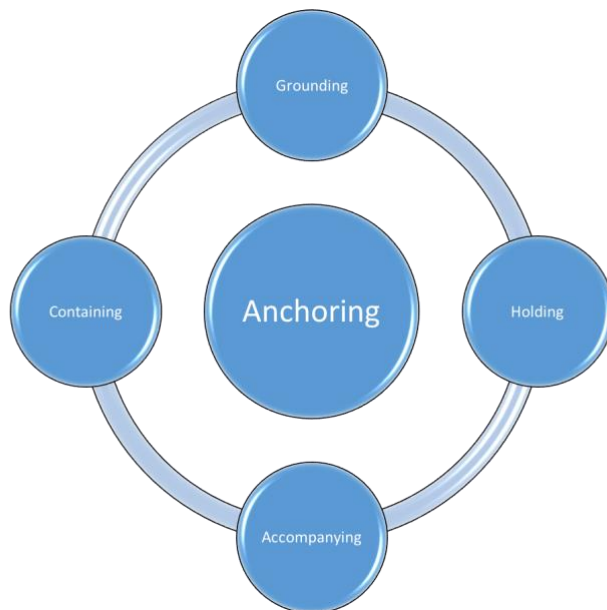
In using improvisation among older adults in a residential facility, I sorted my coded data and categories into three primary themes: anchoring, reflecting and dialogue. Each theme consists of categorised 'methods' and were produced deductively. Each theme and the subsequent categories contain direct quotes from my clinical notes and reflective journal in an attempt to honestly capture my work as a student clinician.



4.3.1 Anchoring

In this analysis, anchoring is understood as the fathering term for four areas - grounding, holding, containing, and accompanying. In the musical sense, anchoring addresses the client's need for comfort and validation, and something solid; metaphorically dropping an anchor for them. This could be something like humming in time with the breathing pattern of a frail client or playing a

steady pulse for somebody when you sense they are anxious. Wigram (2004) suggested that



grounding, holding and containing are helpful when used with clients who exhibit randomness both musically and in their way of being. I observed many residents at the facility showing rather unpredictable, random behaviour, particularly those living with dementia. Memory loss and confusion seemed to cause this unpredictable behaviour - and providing some stability

through musical anchoring may confront this by alleviating confusion and supporting with the client musically. Anchoring is also a word used to describe the both grounding and holding by Wigram, and it is something I found resonated in my clinical and reflective notes.

Grounding

Wigram (2004) associated grounding with stability and containment, in an attempt to create a musical anchor for the client and their improvisations. Working in a residential setting, I found grounding to be useful with clients who tended to show signs of instability. Resulting from the loss of independence, I saw instability as a precursor for other various issues such as depression and vulnerability among residents. Depression and vulnerability were evident in sessions; clients would sometimes verbalise their distress or cry - which wasn't necessarily problematic if crying was upon reflection and nostalgia. However, clients also cried as a result of distress and/or depressive symptoms and needed encouragement and frameworking to improve mood and elicit musical response. Through grounding techniques, letting clients know that somebody was present with them in the moment, and responding to their music in a containing manner in the improvisation, addressed some of these issues mentioned above.

Key ideas found when grounding:

When grounding, I found rhythm and melody to be important. One particular technique that included both rhythm and melody was vocalised humming. I did this through rhythmically

humming in time with a client's breathing as well as introducing an improvised melody once I became comfortable with the rhythm and aura of the client:

16/05/17: "...noticed John's breathing straight away, it was very much forced - with noticeable space between each breath. I sat with him for a while before naturally progressing into soft humming, using his breathing as an anchor for improvisation. He was able to rhythmically dictate the improvisation while I improvised melodically, I attempted to match with his breathing."

Grounding was very useful working in palliative care. Residents were often very frail or unconscious, making it difficult for their musical participation. One way that I managed to stay connected with somebody in this position was through responding to their breathing patterns. There were varying ways that I implemented the use of grounding in improvisation, for example, when working in palliative care I hummed in time with residents breathing. I used their breathing as an anchor for improvisation. This ensured that clients, though very frail or unconscious, were still offering something musically that I could rhythmically and melodically mould into improvisation.

Additionally, I used instruments with more active and physically well client, with a focus on rhythm. In the following example, grounding occurs through the rhythmic theme shown in figure 1, initially provided by myself and continued by the client:

12/06/17: "When I moved to playing guitar from percussion, Tom was able to hold the rhythm I established moments earlier on his own drum. I found myself switching roles from providing stability through rhythm, to following the rhythm of Tom."



Like many of the clients I used grounding with, the example above required musical encouragement and frameworking to elicit response. Providing stable and regular musical support allowed clients to feel relaxed and comforted in a session. As a result, some clients that I worked with went from minimal musical participation, to improvising each session.

Holding

Wigram (2004) used the example of a musical anchor when defining holding, ‘containing’ clients tonally and rhythmically. Similar to grounding, the use of holding in improvisation allowed me to be present in the moment. Holding differs from anchoring in that it depends on the client’s improvisation, and the way in which the therapist responds to this in a musically reassuring or ‘holding’ manner. In my experience working in a residential setting, I used holding to comfort and reassure clients of my presence in an improvisation. I was able to address issues such as isolation through reassuring rhythmic and melodic techniques.

Key ideas found when holding:

Similar to other techniques used in anchoring, the use of holding primarily occurred through rhythm and melody. Like the grounding example above, the example below draws direct attention to the client’s improvisation. To give context, this improvisation occurred directly after a song we had played together - an elderly man Tom continued to play an irregular rhythm on his drum, that I eventually addressed by playing drawn out single notes on my own drum. I felt like stopping Tom’s music-making may have made him feel isolated, uncomfortable and/or not musically important. Taking this into account, I joined him in his music-making, holding together what was quite an unstructured improvisation,

16/05/17: “...and then Tom begins to play a staggered rhythm on a drum which I at first attempt to mirror - this is too difficult due to the inconsistency of the rhythm, I decide to pull back and act more in a holding manner playing the drum - giving structure through drawn out notes in response to the client’s drum rhythms.”



It is worth noting that the figure above was an approximation of the rhythm when trying to notate in my clinical notes later that day.

Another way I held rhythmically was through Tom's feet tapping,

18/04/17: "Began to play a Jig in 6/8 time, watching Tom's feet as they were tapping in time with the Jig. After playing the round through twice, I continued to look at his tapping and improvise in a similar manner. I used his foot tapping to dictate my own improvisation, keeping to 6/8 style of Jig but playing with rubato at key moments on the violin to accommodate the client's variability of tapping."

This example was the first instance of improvisation with Tom. Given that he preferred not to use an instrument at this point, I used tapping to instigate improvisation. Although it might seem like this was my own improvisation, the fluidity of the music-making depended on his rhythm. Reading the example above, it might seem like Tom was the one holding through his tapping, but we were both holding each other's music-making, as I used techniques such as rubato to accommodate variation of his rhythm.

I was also able to hold improvisation melodically particularly through vocalisation,

01/05/17: "I started on the guitar, supporting Gabriella's glissando vocalisations but quickly realised the two instruments were not moulding together. I started to vocalise myself in a similar way with her, doing this an octave lower and quieter in an attempt to hold their vocalisation - allowing Gabriella to dictate improvisation herself."

I worked with Gabriella for a short period of time, but I noticed that she seemed to communicate vocally rather than verbally. Holding, I was able to address and support her vocalisations. Vocalising in the same style, an octave lower and much quieter meant that I was meeting her musically, creating a meaningful and comforting interaction.

As previously discussed, holding created reassurance, containment, and comfort when used with clients in improvisation. The data above further suggest this, specifically through attention to Tom's music-making (i.e. 'foot tapping') and my own musical response to this.

In general, I didn't initially set out to use holding in improvisation. I often began with a more familiar technique such as matching or mirroring before realising that holding was more suitable. I put this down to two things, (1) my understanding (or lack thereof) of improvisational techniques during the earlier stages of practicum and (2) other techniques (like matching) were more

commonly used during improvisation, therefore I found myself naturally gravitating towards their usage in sessions.

Accompanying

Accompanying in clinical improvisation involves using rhythm, harmony or melody underneath the client's music-making, allowing them to have the role of a soloist (Wigram, 2000 as cited by Wigram, 2004). Accompanying allowed me to support clients musically, which facilitated and led to empowerment. In my experience working in a residential setting, loss of independence was a significant issue for clients. I found that facilitating musical interaction gave them a sense of empowerment, whether through the music-making itself, or particular aspects of it such as using an instrument. Through spontaneous exploration and communication of musical ideas, the use of improvisation furthermore empowered clients to lead their own musical pathway during sessions - making it different to singing familiar/nostalgic songs or group singing. Take for example a solo, I would argue one of the most empowering musical acts from the soloist's perspective. Working in the context of a residential setting, my role was to support and facilitate a solo - more precisely *accompany*,

23/05/17: "The improvisation started after a song without much discussion beforehand [...] I was thinking in my head, 'this sounds like the blues' as I continually played major 7 chords on the guitar. I naturally progressed into a blues improvisation. Tom engaged better than I have seen thus far - usually he wouldn't play for a long time but he embraced the idea of a solo after I modelled one on the guitar first. He was playing staggered rhythms with two drums (tambour and tambourine with skin) and two mallets whilst fitting within the blues style well.

During this solo, I continued to accompany Tom in a blues style chord progression. I didn't stay in the same key, introducing unexpected chords to evolve and keep the improvisation interesting. Given Tom was familiar with blues and jazz probably contributed to his willingness to partake in solo. Staff had told me that this client was quite isolated, so empowering him through accompanying his music-making was an integral part of improvisation with Tom.

I was surprised by the finding that I used my voice to accompany clients during improvisations. Typically, when considering the use of accompanying, we think of instruments such as the piano supporting a leading instrument(s). Wigram (2004) depicted accompanying in improvisation as a pianist's role. Given that the piano isn't my strongest instrument nor is it easily accessible, I usually

found myself using the guitar when accompanying clients. This being said, there were instances where I only used my voice to accompany clients during an improvisation,

24/04/17: “I began to hum slowly, long notes in a major key. I tried to capture the atmosphere of the moment. I entered into my falsetto continuing the long notes. Mark’s breathing was long and there was a noticeable gap between each breath. I started to imitate his breathing - each hummed note representing a breath. I picked up my guitar and played an E chord [...] At end of session I returned to humming softly in time with his breathing much in the same way as I did when I began the session. I started a humming a gradual decrescendo until there was nothing and waited for a few minutes before saying goodbye...”

In this particular example, Mark’s breathing became the *lead* or *solo* of the improvisation. Although Mark was awake as we maintained eye contact very briefly on 2-3 occasions, he was very frail - with no chance of using an instrument or physically participating in the session. I chose to address his breathing, very softly accompanying in the same style and timing. This allowed Mark to have an important ‘lead role’ role in the session through his breathing. By accompanying, I empowered him to be present and musically contribute to the session.

01/05/17: “This week I heard Gabriella vocalising from the hallway, so I went to see her. [...] I played a D chord followed by A7 on guitar. This left a sense of openness to the glissando vocalisation. I started vocalise in tune with the chords - Gabriella didn’t follow this so I took a step back and continued to vocalise with her - this time an octave lower, much softer, and without glissando or guitar chords.”

Like other anchoring techniques, I was sometimes hesitant in the use of accompanying. Once I addressed the Gabriella's music-making via accompanying in the example above, the improvisation felt more holistic, mutual, and supportive. I directly responded to the client’s glissando vocalisations with low drawn out vocalised bass notes - similar to the way in which a bass guitar accompanies an electric guitar solo.

Accompanying is the elephant in the anchoring room, all other techniques (grounding, holding, and containment) were grouped together by Wigram (2004). I chose to include accompanying under anchoring umbrella because like its siblings, its purpose inevitably lead to the support, comfort, and containment of client’s music-making. Despite traditionally occurring on the piano, I was able to use other instruments including my own voice to accompany clients in improvisation.

Containing

Containing is an approach used by the therapist when a client is improvising in a loud and/or chaotic manner - the therapist's role is to acknowledge this and provide a musical container through playing loudly and confidently (Wigram, 2004). Although I didn't find it as useful as other anchoring techniques, I still found reason to contain in clinical improvisation. By and large, improvisation wasn't typically loud and/or chaotic in my experience working with older adults.

Wigram further suggests that containing is something that is likely to be used among children ('musical tantrum') - in saying this, I did find instances using containing in the data:

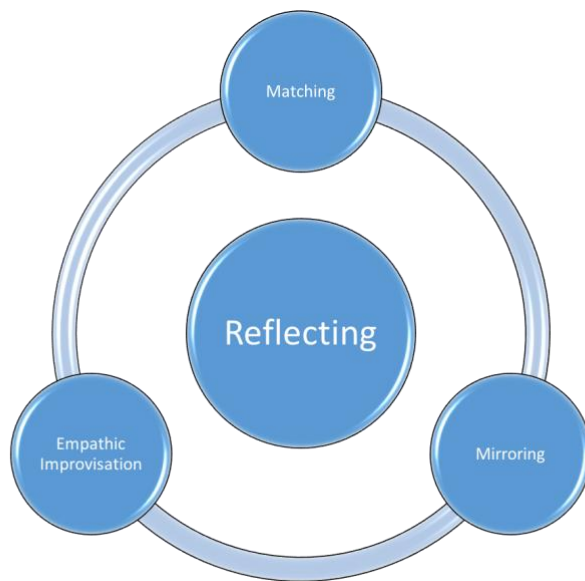
16/05/17: "...trying to mirror just seemed like too much and identically confronting his music making wasn't supporting him where he needed to be supported."

16/05/17: "...and then Tom began to play a staggered rhythm on a drum which I at first attempted to mirror - this was too difficult due to the inconsistency of the rhythm, I decided to pull back and act more in a holding manner playing the drum - giving structure through drawn out notes in response to his drum rhythms."

Though I identified this example earlier using holding, I was actually also containing as well. The two examples above are taken from the same session but highlight slightly different ideas. The first acknowledges that I initially attempted to use mirroring to 'confront' Tom's style of playing, releasing in the moment that this wasn't working because his music making was so random I couldn't keep up nor support him musically. The second shows how I actually contained the improvisation - through long drawn out notes. The client wasn't playing in the style of a 'musical tantrum' mentioned by Wigram, however, there was still a musical disjuncture that I felt needed to be contained through long and confirming drawn out notes on percussion.

4.3.2 Reflecting

When thinking of reflecting in relation to my practice, I was attempting to capture the moods, emotions, attitudes, and feelings of clients, but also physically and emotionally reflect what they were doing as well. I used reflecting in this context as if to look into a mirror and reflect not only physical, but emotional expression as well. After considering reflecting in this context, I noticed matching, mirroring, and empathic improvisation all shared these similar attributes. For example take mirroring, literally trying to imitate everything that a client is doing, physically *and*



emotionally. Although I might not exactly be imitating a client using empathic improvisation, I was still reflecting their physical and emotional expression, allowing this to formulate improvisation.

Matching

Wigram described matching 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, 1999 as cited by Wigram, 2004, p.84). Wigram suggested that matching was the most commonly used approach in improvisation - this was no different when analysing my own data. My research suggests that no matter what the age of clients might be, matching is a technique still very likely to be used. I found matching to be a form of mutual understanding, a way to connect with a client at the same or similar level. This was important in a residential setting; the most common response I would get from clients when first introducing an instrument was ‘I can’t play anything’ (even though some of them actually could). Matching was a good way of ‘meeting’ the client musically. Playing in a similar way and/or style as a client meant that it didn’t actually matter who could ‘play’ an instrument at all.

Key ideas found when matching:

In my experience working in a residential setting, matching was used the most frequently out of all the improvisatory methods and occurred in the majority of sessions using improvisation. Matching used rhythm and melody, often at the same time and on a variety of instruments including percussion, piano and voice. Other acts where I matched included dancing and lyric substitution and dance.

The example below showed matching being used during the first session with a client,

23/05/17: “First individual session with Gabriella - noticed she was unsettled moving from rest home to hospital. Gabriella vocalised long glissandi notes: “weeeeeeeow”. I did this also, opening a

dialogue with Gabriella. This was our first proper form of communication. I picked up the violin and matched Gabriella's vocalisations - adding in slight variations i.e. trills and turns around her vocal 'melody'."

I was initially dialoguing and mirroring in the example above when vocalising with the Gabriella - the matching began when I started to play the violin. Trills were played when she went to breathe in between vocalisations which created a sense of mutuality as she looked at me while I did this.

Below is an example of an improvisation stemming from a steady rhythm into a nursery style improvisation. The matching allowed for this progression, I played in the same style as Tom, 'challenging' the improvisation with fills and added notes on percussion. When challenging, I was testing the music-making to see if both Tom and the improvisation could 'handle the challenge'. When challenging him, I still played in the same style and therefore still matched with him,

30/05/17: "Tom and I began to play a drum rhythm together which at first was single notes with rests in between but I gradually challenged the improvisation, experimenting with a jollier rhythm (see below) I felt a nursery rhyme in the rhythm. Tom and I matched with this rhythm, he continued to

The image contains two musical staves. The first staff is labeled 'Drums' and the second is labeled 'Violin'. Both are in 4/4 time. The first staff shows a steady rhythm of quarter notes with rests. The second staff shows a melody that starts with a whole rest and then moves to a sequence of quarter notes. A small number '4' is written below the first staff.

Drums

Violin

4

Dr.

Vn.

play as I picked up the violin and improvised melodically, allowing the client to continue and lead in percussion."

30/05/17: "The improvisation ended with a mutual rallentando - maintaining meaningful eye contact as we finished together."

The mutual rallentando occurred toward the end of the improvisation above – this was something that frequently happened with Tom and others at the end of songs, but this was one of the few times it was used to conclude an improvisation. We would often strum or bang whatever instrument we were each playing until the music came to a complete halt. It was like a game, which strum/bang was going to be the last? We would do our best to ensure we both played these drawn out concluding strum/bangs in sync with each other.

At the piano, I matched frequently with clients,

14/06/17: “It took a while for Jason to engage with the piano, but he eventually did very briefly. Jason played the C chord, chuckled and said, “I think that’s how it goes.” I played a G7 chord, as it is the Dominant chord of the C major scale. This created a resolve when client played the C chord in response.”

Jason had learnt the piano when he was younger, which made convincing him to have a session sitting at one easier. In my experience at a residential setting, it was usually quite difficult to convince clients to do music in a room (i.e. where there is a piano) other than their own - sometimes this was because of frailty, confusion, or clients just plainly not wanting to. In saying this, I found the use of piano to be beneficial for those who agreed to play it.

Despite living with severe dementia, Jason was still able to remember aspects of what he had learnt on the piano in his childhood. I responded to this style in a way that encouraged him to play more (i.e. playing dominant 7th chord to encourage closure through a perfect cadence).

There were ways that I matched in improvisation that weren't ‘musical’ - an example of this was through movement and dance. Earlier I mentioned feet tapping, a very common example of movement in response to music, but a more depicting example was when Jason grooved playfully in response to music-making,

19/04/17: “After I finished playing a piece on the violin Jason clapped and pretended to whistle at me as if he was the audience and I was the performer at a local show. With the violin still under my chin, I began to improvise playing staccato notes in 6/8 time - making it sound similar to an Irish Jig. Jason started to groove, moving his whole body in time with the music while seated in his recliner. I started doing the same while standing with violin. He was moving his hands in time with me similar to a conductor.”

From an improvisational perspective, the matching occurred between Jason and I’s ‘groovin’ as I met with his style of dance. Although similar, our groovin’ wasn’t identical, Jason was sitting in a

recliner playing percussion and I was standing playing the violin - we met each other mutually through response to the music-making. It's also worth noting that an Irish Jig, literally a dancing style, stemmed this groovin'. This suggests that musical style also had a role to play, i.e. a jig is more likely to promote physical groovin' as opposed to classical music where listener's movements might be more reserved.

Lyric substitution was a commonly used approach in my improvisational work. I figured that the example below and many others used aspects of matching rather than mirroring. This is because there is more to lyric substitution than modelling lyrics for a client to mirror. Looking at the example below there were mutual instances, such as relative, in the moment lyrics. John enjoyed singing familiar songs during music therapy, so I matched with his musical style through a favourite song, and spontaneously changed the lyrics as we went along - also giving him the opportunity to think of his own on-the-spot lyric substitution,

19/04/17: "After a couple of rounds singing Drunken Sailor, I sang, 'what shall we do with John in the morning?' He laughed and quickly caught on, singing the lyrics along with me. I then stopped and asked, 'what *should* we do with John in the morning?' He responded, 'Get em out of bed!' - I then sang, 'get John out of bed in the morning.' After this I included both of us in the improvisation, 'We want breakfast in the morning.' He laughed and sang along. After this, I returned to the original lyrics."

Matching occurred in most of my improvisational encounters. It attended to the client personally and their music-making. Wigram's definition of matching was quite broad compared to other methods, leaving space for my own interpretation. Because of this, I was able to substitute lyrics and dance with clients when matching.

Mirroring

Wigram (2004) defined mirroring as, 'doing exactly what the client is doing musically, expressively and through body language at the same time as the client is doing it. The client will then see his or her own behaviour in the therapist's behaviour' (p. 82). In my experience working in a residential setting, I found mirroring provided comfort and reassurance for clients. Imitating exactly what clients were doing seemed to reassure them that their music-making was adequate and meaningful in improvisation. I believe that mirroring removed the perception musical ability when working with older adults - I met clients at their level, imitating and using their ideas to stem further music-making.

I typically mirrored during improvisation when using non-pitched percussion. There were a couple of reasons for this. The first and most important, percussion was perhaps the most easily accessible of instruments to play. The second reason being that non-pitched percussion eliminated melody and focused purely on rhythm and timbre, making mirroring much simpler (melodic mirroring would be almost impossible without a framework or model implemented by the therapist).

02/05/17: "After handing Tom two mallets he began to play a consistent 4/4 rhythm, which I observed then mirror on a different drum. He then started to play in twos (e.g. two semi-quavers simultaneously), which I continue to copy on my own drum."

Above was a common example of mirroring in a session. I would often leave space while the client developed rhythmic motifs before returning to mirror once they were established.

Another example highlighted how mirroring was used with more musically able clients,

10/05/17: "...Then Jason started to play snare rolls on one of the drums I provided. Using mallets for the first time, it was the most convincing example I had seen from him percussively. I start to play a different drum, mirroring his rolls. After a short time I noticed the improvisation had a marching feeling to it so I started to sing, 'When the Saints'..."

Jason already knew how to play the drums. His drum rolls were difficult to mirror, his technique was near perfect and I have never learnt the drums myself. I still felt that this and other similar examples used mirroring because I was at least attempting to play in the exact same technique and style, while also using the same instrument.

As opposed to the matching example of 'groovin' earlier, mirroring is used in the below example because movements are identical: we were both playing in the exact same style and instruments,

07/06/17: "He started playing a Foxtrot beat. I didn't know what this at the time so I mirrored what he was doing on a drum. Jason found this amusing, making a larger motion to play the drum, moving his body in time with the rhythm, I copied this in a playful manner."

This type of full body movement not only aided in fluidity, but also promoted movement and exercise among residents. Many of the residents I worked with spent most of their time in bed or sitting in recliner chairs. Movement whether sitting or standing is beneficial for older adults, aligning with the *active aging* module (World Health Organization, 2017). Plus, I only ever saw a smile on the faces of clients who were groovin'. Generally, clients smiled or laughed when I mirrored in sessions. I think this is because they found seeing their own movements become my

movements entertaining - as if the performance was a mime. Mirroring was one of the few improvisational methods where could consciously understand and appreciate what the therapist was doing - I think this added to the entertainment that mirroring usage providing.

Empathic Improvisation

Empathic improvisation is somewhat difficult to describe, mainly because it was one of the few methods that did not focus on client/therapist music-making. Instead empathic improvisation aimed to meet the mood of the client and the session as a whole. Wigram (2004) used Juliette Alvin's analogy that empathic improvisation responds to the client's 'way of being'. Wigram went on to explain that 'client's body posture, facial expression, attitude, personality and characteristics' (p.89) all contribute to how a therapist might empathically improvise in music therapy. In my experience working in a residential setting, empathic improvisation allowed me to personally and emotionally address a client in the moment. The unpredictability of residential care meant that I could work with a client who was in good spirits one week, but by the next week had moved into palliative care. Such work required an immense amount of empathy and understanding while also employing careful, gentle and thoughtful approaches to therapy.

I implemented empathic improvisation in my therapeutic work through the use of humming to meet a specific mood,

26/04/17: "...I sat for a while, but he didn't wake up, so I decided to play the guitar softly eventually after humming several songs I started an improvisation - in an attempt to capture the calm and relaxed mood. I felt improvisation was a good way to do this - communicating to him musically that I was with him. I hummed in a major tune softly, often repeating the same note several times before moving onto to the next. When he woke up he smiled and was happy to see me."

The continuity of soft hummed notes was key to the empathic improvisation above. I addressed the mood by not doing too much, I didn't want to wake him up by giving him a fright. Staying in a major key and humming soft repeated notes meant that when he finally awoke there was nothing confronting about my presence - I had essentially moulded the improvisation *and* myself into the mood and atmosphere of the moment.

Below is an example of empathic improvisation being used in palliative care,

24/04/17: "I began to hum slowly, long notes in a major key. I tried to capture the atmosphere of the moment. I entered into my falsetto continuing the long notes..."

There were a few times that I worked with clients in palliative care, and they mostly looked like the example above - humming to meet mood/breathing and the subtle use of an instrument which in this case was the guitar. In my experience working in palliative care, empathic improvisation was the most crucially used method.

In the example below, the client encouraged me to 'start us off' - I responded to this in a happy and playful manner,

14/06/17: "Toward the end of the session, Jason said, "You start us off and I'll follow." I started to play short staccato notes on the violin, but quickly moulded into Jason's rhythm as he began to play a rapid staccato like beat made from his fingers rapidly going to and from each hand - similar to a marching snare rhythm. The rhythm was somewhat consistent, but Jason included embellishments at random. I sometimes echoed these on the violin adding in melody."

The example above used the mood of the session that in turn led up to an improvisation. Jason's mood was playful, almost comedic - this was normal from him. When he asked me to lead, I took this as an opportunity to capture the moment. I played staccato notes because they are bouncy and promote a good sense of rhythm through short and detached notes - Jason had a 'bouncy' and bubbly personality, identifying with rhythm strongly in music from playing the drums throughout his life. He began to play staccato notes of his own after I was playing the violin and we met mutually in the session this way - both being able to capture the mood together.

This example highlights the playful re-enactment of a music concert with a client,

19/04/17 "I created a comfortable musical environment for Jason, 'playing along' with not only the music but also the entire mood and atmosphere of the session. Jason whistled and clapped as if it were a music concert, I responded by bowing and saying, "thank you very much!" after improvising on the violin with his drumming."

Allowing such playfulness during a session strengthened our therapeutic relationship and in turn created deeper musical understanding and mutuality. Jason had a history playing in bands at dance nights and concerts. I feel like these interactions allowed him to create an atmosphere of what this may have felt like for him.

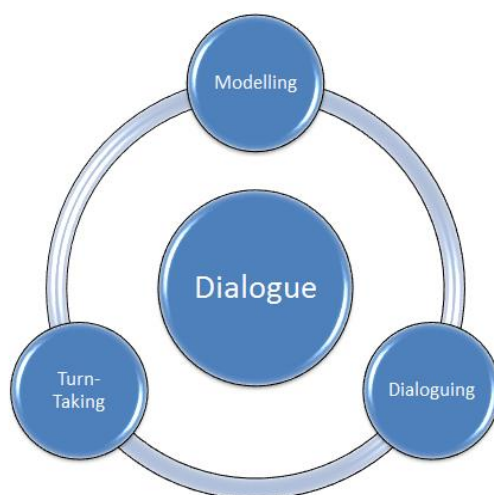
In the same session as directly above, a musical improvisation stemmed from the musical re-enactment, furthering the empathic improvisation,

19/04/17: “With the violin still under my chin, I began to improvise playing staccato notes in 6/8 time - making it sound similar to an Irish Jig. Jason started to groove, moving his whole body in time with the music while seated in his recliner. I started doing the same while standing with violin. He was moving his hands in time with me similar to a conductor.”

The jig improvisation addressed the mood of the moment, turning the whole improvisation into what looked and felt like much more than music. Being able to ‘go with the flow’ was important in empathic improvisation because emotions were unpredictable, and as a therapist I needed to be prepared for how I might have responded to these at any given moment.

4.3.3 Dialogue

The third and final theme that resonated through my analysis of improvisation among older adults in



a residential facility was dialogue. According to Merriam-Webster, dialogue can be defined as ‘a conversation between two or more persons’ (Merriam-Webster, 2017). Dialogue in improvisation captured the communicative process between therapist and client, whether it be musical, verbal, physical, emotional, etc. In my experience working in a residential setting, dialogue was used

frequently during the earlier stages of improvisation, establishing a personal therapeutic relationship that other themes struggled to do so. Methods in dialogue included: dialoguing, modelling, and turn-taking.

Dialoguing

The overarching theme of dialogue differs from Wigram’s inspired *dialoguing* which has a musically clinical focus. Wigram (2004) suggested that dialoguing is the musical interchange or

communication between therapist and client(s). Like matching, the use of dialoguing was very prominent in data analysis. Dialoguing was a way to communicate musically - I found this useful because it allowed conversation without speaking. There were people that I worked with who weren't necessarily nonverbal but struggled at times to communicate their thoughts and feelings with staff, including myself. I found that dialoguing was a way to address these thoughts and feelings through a variety of instruments and various techniques (e.g. between therapist and client each playing a drum). The improvisation could have involved a question and an answer or general variations of rhythm followed by response. The crux of dialoguing is that a *conversation* occurs between therapist and client.

As mentioned, dialogue in general was frequently used during the earlier stages of improvisation with clients,

23/05/17: "I started with familiar songs which she sang along with before I noticed her vocalising interesting sounds. I steered away from the use of song and zoned in on these vocalisations. I started to engage in her musical language of glissando vocalisations. This was our first session together and also the In the example above, I was able to connect with the client on her terms. In responding to the clients vocalisations directly, I established musical conversation as an introductory source of first time I personally addressed her - she showed little sign of verbal interaction prior to this. This particular encounter struck me because I felt like our improvisation was really the introductory form of conversation between us. It was us getting to know each other not through language but music..."

Dialoguing in the example below occurred through the exchange of Vocalised La's,

Jason
Luke

8

D G C G

10/05/17: "I started playing a Waltz rhythm in G on the guitar. Jason started to mix between the tambourine drum with rolls and a normal drum with a pulse to make a clear waltz rhythm (E.g.

emphasis on the first beat on the normal drum and using the tambourine for second and third beats) I started to vocalize, 'La la la La la la' Jason laughed and sang along with me in a playful manner. I started to play the guitar which in response to the pitch of the La's and there were a few moments where we exchanged back and forth 'La's' in dialogue."

As the figure above shows, I had a musical conversation with the client in the style of a waltz entirely through the use of La's.

23/05/17: "The improvisation started after a song without much discussion beforehand [...] I communicated with Tom musically by changing chords when he altered his rhythm..."

This particular form of dialoguing wasn't as obvious as others. I think this is because it occurred between two different instruments and in different style. Usually dialoguing is most obvious when the context and 'language' is the same between therapist and client (i.e. the exchange of La's or drum rhythms). However, in this example, the dialoguing occurred between guitar chord changes and a drum rhythm. This dialoguing is no less important than other styles, I found that it created comfort for clients who sometimes seemed 'exposed' playing an instrument by themselves - I was able to open up conversation making for less isolation in improvisation.

Sharing an instrument with a client was an effective means of dialoguing,

Introduced the Djembe drum and Tom was very intrigued by it - asking questions about its texture and origin. I sat by Tom and began to play a repeated note - Tom started to play with the rim of the djembe quietly exploring its timbre qualities (i.e. tapping the rim and feeling the texture of the skin), I adjusted my dynamic and playing style so his could be heard more. I started to echo Tom's tapping adding in extra notes - sometimes I lightly hit the centre of the djembe, creating a bass that was a tactile experience for both of us with our hands on the drum skin. The sounds became quieter and quieter, hitting the outer rim which made a twang sound. After a short while Tom stopped and said, "it's an interesting thing isn't it."

I found that the style of dialoguing above was perhaps the most personal form of conversation when dialoguing. Playing the same big drum allowed us to literally talk to each other as if it were over the telephone. Sharing the same instrument seemed to create a 'deeper' conversation and therapeutic relationship.

Dialoguing seemed to communicate therapist and clients' ideas when music-making. This was reassuring for clients, who I often felt were unsure of 'what to do' during improvisation -

communicating and conversing with them ensured personal importance and value during sessions. I found that this resonated through other aspects of therapy, clients seemed more comfortable and confident in music therapy (i.e. singing more regularly or playing a foreign instrument).

Modelling

In clinical improvisation, modelling is, 'playing and demonstrating something in a way that encourages the client to imitate, match or extend some musical ideas' (Wigram, 2004, p. 99). Working with older adults, I found that modelling encouraged musical play between myself and clients. It also allowed me to introduce clinical improvisation, as I would often model a familiar song or ideas for the client to imitate or extend further. Through modelling, I was able to establish meaningful moments of interaction and musical conversation. Modelling was one approach that I often used when transitioning from music playing into clinical improvisation. It seemed to subtly allow sessions into the 'unknown' - going from something very familiar (e.g. singing a known song) to something that is still familiar but presents an element of surprise and spontaneity (e.g. changing the lyrics to a known song). Modelling was frequently used with clients who I didn't do as much clinical improvisation with. This suggests that it is one of the few improvisational approaches that can be used with most clients in residential settings.

Modelling example:

19/04/17: "After a couple of rounds singing Drunken Sailor, I sang, "What shall we do with John in the morning?" He laughed and quickly caught on..."

Lyric substitution was an overarching technique used when modelling. This is likely because lyric substitution was always established in sessions by me, with the client typically responding by imitating the improvised lyrics I introduced. The example above also creates a dialogue through the client's response, 'I then stopped and asked, "What should we do with John in the morning?" They responded, "Get em out of bed!"'. As this session was in the morning and the resident was still in bed, the lyric substitution was also relevant and personal. Breaking this example down in response to Wigram's definition of modelling, I demonstrated lyric substitution, encouraging the client to respond by relating the lyrics to the mood of the present moment. I encouraged the client to extend the musical idea by asking them a question (what shall we do with John in the morning?) relating back to the song we were singing.

Another way that I modelled in my sessions was through vocalisation,

10/05/17: “I started playing a Waltz rhythm in G on the guitar. Jason started to mix between the tambourine drum with rolls and a normal drum with a pulse to make a clear waltz rhythm...”

I found modelling vocalisation to be more difficult than lyric substitution. I think that the familiarity of lyric substitution makes it an accessible approach for just about any verbal resident. This is not to say I didn't find vocalisation as effective as lyric substitution - modelling vocalisation was a subtle way of adding an extra element, for those who engaged well without too much prompting (like the example above) and challenged clients to musically multi-task.

Turn-Taking

Wigram (2004) described turn-taking as ‘Making music together where the therapist or client(s) in a variety of ways, musical or gestural, can cue each other to take turns.’ (p. 98). They further suggest that pausing is needed between the play of therapist and client. In my experience working in a residential setting, turn-taking was most useful during solo. Like modelling, turn-taking encourages musical play between client and therapist. Turn-taking was often used with familiarity as well, usually during a blues improvised solo,

23/05/17: “The improvisation naturally found its way into a blues progression through chords I was playing on the guitar. I asked the Tom to “give us a solo!” to which they started to play a random rhythm on the drum - during this time I played quietly on the guitar matching with the client's musical play. After about half a minute, they relaxed the randomness of the solo and began to play a steadier rhythm which allowed me to play solo of my own on the guitar.”

This turn-taking conversation is created very subtly, almost subconsciously. Although I instigated the solo, (“give us a solo!”) the actual ‘turn-taking’ process occurred when the client changed from solo to a holding rhythm – this allowed me to ‘take my turn’ at a solo. Turn-taking wasn't used as much as other improvisational techniques but is no less important – it allowed me to effortlessly connect familiarity and spontaneity within a framework.

To conclude, my findings showed improvisation has the potential to be used among older adults. It was used in a variety of different ways, highlighted in the themes of anchoring, reflecting, and dialogue. These themes contained more specific methods that were heavily influenced by the work Tony Wigram (2004). Improvisation was used with clients ranging from low-high needs, as well as playing an important role in palliative care.

4.3 Case Vignette

To conclude, I will present a case vignette exploring the use of improvisation with an older adult whom I worked with individually at a residential facility during my placement. Improvisation occurred in many shapes and forms, establishing the themes of anchoring, reflecting, and dialogue. Given the closure of the facility, consent was somewhat difficult to obtain. For example, improvisation was used frequently during sessions with Jason. However, I was unable to get in contact with him or his family and request consent. Someone who I was able to get in contact with was Tom and his family, so I chose to write this case vignette on our improvisational journey together.

Introductory:

I was introduced to Tom, a New Zealand man in his 90s, after a diversional therapist at the residential facility had referred him to individual music therapy. The therapist explained that it would be good for Tom's well-being and allow him to have more social interaction if I was to spend some time with him in music therapy. When I went to meet Tom for the first time, he was warm and welcoming, quickly looking for the remote to turn off the T.V. and gave me his full attention. Tom was in the hospital wing, where he required a higher level of care than residents in other areas of the facility. He was somewhat frail, but still able to walk with the help of staff members and his walker. From what I observed, Tom would spend most of his time in his recliner watching television in his room - I didn't often see him in group activities and he didn't attend the music group that I ran weekly with other residents from the hospital wing. In his room he always kept some sweets and on the wall there were several photos of him with his family, dogs, and other friends and staff from the facility.

First Session:

After requesting that I play violin, Tom relaxed back into his recliner as I began to play 'Green Sleeves' and 'Danny Boy'. He said that he knew both of these songs and liked the way that I played the violin. Noticing that Tom wasn't singing, I asked him if he would like to play a percussion instrument, to which he politely declined. I asked him because I thought musical interaction might help build a therapeutic relationship in the early stages. This didn't worry me too much as I noticed Tom showing interest and interaction through holding meaningful eye contact with me and my music-making at several stages throughout the session.

Progression of Sessions:

It took me longer than I did with other residents to introduce clinical improvisation with Tom. This was because I didn't automatically identify improvisation as a possible therapeutic approach with him. Tom didn't sing during sessions, he would often say something like, "I enjoy it just listening and watching you play." and do just that. I wasn't content with how our sessions were progressing - I felt there was something greater that I could offer therapeutically to elicit more interaction and musical response from Tom. In our eighth session, I introduced a djembe drum in an attempt to elicit movement and participation, Tom was very interested in the drum and I quickly realized that improvisation could be used in our sessions after all. I gradually introduced moments of improvisation during music therapy. Initially, I used the music making/movements of Tom (e.g. a foot tapping with a Jig) to direct the improvisation, but as sessions progressed, Tom went from merely listening and observing in sessions to improvising rhythms and embracing the use of different instruments.

Improvising in Sessions:

It took some time to introduce improvisation in music therapy with Tom. Given the closure of the facility part way through my placement, I also feel like I didn't have enough sessions with Tom to fully explore improvisations usage in our music therapy together. In saying this, the time we did spend was well worth-while.

I came to the realisation that implementing clinical improvisation in music therapy with Tom would allow for the type of social interaction and participation that, up until this point, I felt was missing. Yes, there were glimpses of these attributes in sessions, and one could even argue that being present in a session counts as participating, but I was looking for something more. I was looking for an interactive outlet for Tom, somewhere we could meet mutually - something that playing familiar songs was unable to provide. Again, this wasn't to say I did a complete U-turn in sessions, in fact, they were relatively unchanged - the only difference was the inclusion of improvisation.

I remember the first time I used improvised with Tom, this was before he was regularly using instruments in sessions. I was playing an Irish Jig on the violin, and I noticed his feet were tapping away in time with this. I smoothly transitioned into an improvised Jig, still in the same time (6/8) and style, but responding to Tom's tapping, adjusting tempo and playing with rubato where necessary. After reflecting on this session in my journal, I came to the conclusion that improvisation could be beneficial for Tom after all. The very next session I introduced the djembe, a drum native to West Africa. This was a good way of drawing in Tom's attention, he was very intrigued by the instrument and experimented with its timbre as I sat opposite him and did the same. We exchanged in a brief dialogue, consisting mainly of experimental sounds (i.e. tapping the rim and feeling the

texture of the skin). During the following session, when attempting to improvise more structurally and rhythmically, I noticed that Tom was struggling to keep up. It was obvious that reaching up and repeatedly playing the djembe was a difficult task for him to do - and even though I knew he wanted to participate, he would stop playing halfway through an improvisation and sat back, continuing to watch me play. I didn't want music to be a chore or something that was physically out of reach, so the next week I brought in a more accessible instrument to play - the tambour. Though not as glamorous or aesthetically pleasing as the djembe, I noticed straight away it was much easier for Tom to play - especially with mallets (which were not allowed to be used to play the djembe). Instead of using the force of his entire hands, he was now able to transfer this force and energy through mallets, making easier and more rewarding sounds. After a trial and error period for instruments, I found that improvisation started to become a more natural part of sessions.

Anchoring, reflecting and dialogue:

When improvising with Tom in music therapy, I anchored, reflected and engaged in dialogue. These three themes were equally represented in my work with Tom.

I found that anchoring provided stability and comfort, minimising any isolation or nervousness that Tom felt in music therapy. When given the opportunity to play percussion Tom was able play within whichever anchoring method I was using - this started happening vice versa toward the end of therapy which made improvisation even more interesting. For example, Tom would hold a rhythm on the drum while I improvised on the violin. Interchanging with other methods such as turn-taking, we were able to share the 'lead' anchoring role.

When reflecting with Tom, I almost exclusively mirrored and matched. I can't recall ever engaging in an empathic improvisation. I regularly used mirroring to bring our music-making back together - playing the exact same rhythm for a short while before moving onto a new idea or method. I found that this style of mirroring was a subtle transition from improvised phrase to phrase. It gave our music-making structure and reassurance which is important as I felt like clients including Tom sometimes didn't know what to do in improvisation - mirroring was a simple means to combat this; a visually and aurally stimulating method that was easy to play along with.

During Dialogue, Tom and I most frequently engaged in turn-taking. As I mentioned above I often used turn-taking interchangeably with other methods. I had been using blues as an improvisational tool since the early stages of therapy with Tom but towards the end, I started to introduce solos. A solo would usually last a couple of rounds, with myself on guitar and Tom on percussion. During Tom's solo (usually introduced by me saying 'give us a solo!') I would play the guitar very quietly (palm muting) allowing him to musically speak. The first couple of times I introduced this, he

seemed a bit hesitant so I transitioned the solo into mirroring and kept trying in further sessions where he eventually became more confident and independent with his solos.

Tom's Transformation:

The biggest transformation I saw in music therapy with Tom was his willingness to musically interact in our sessions together. I have no doubt this was a result of clinical improvisation. Tom went from not playing any instruments at all, to playing a variety of instruments – eventually improvising with them as well.

Conclusion

This case vignette demonstrated the use of improvisation during music therapy with an older adult living in the hospital wing of a residential facility. I was able to use anchoring, reflecting, and dialogue when working with this client. I used improvisation with Tom in music therapy to encourage and elicit musical response and interaction. Through the use of improvisation, I was also able to engage with Tom communicatively, which I felt helped with isolation. Toward the end of my placement, a nurse commented on my work with Tom, 'He's going to really miss music therapy with you, he always looks forward to seeing you each week.' Improvisation was a tool I used to encourage participation, communication, and reduce isolation. Reflecting on my work with Tom, I believed this worked and brought about much fun and playfulness in the process.

5 Discussion

First of all, my findings suggest that improvisation can be used effectively among older adults who live in residential settings. Tomaino (2013) suggests that clinical improvisation can develop a deeper therapeutic connection and minimise inhibition and/or limitation in music therapy. In a case vignette, I showed how improvisation allowed a client to participate and express himself in music therapy. The client preferred not to sing or play instruments, the introduction of improvisation changed this preference as he became more interested in music-making, actively participating in sessions.

Secondly, my findings suggest that improvisation doesn't necessarily take place in the early stages of music therapy with clients. Simpson (2000b) didn't introduce improvisation with an older adult until their fourth session together. He described how meeting a client musically is important during the early stages therapy. I found that music therapy was confusing for some clients who had never experienced it before, especially those living with dementia. Therefore, meeting clients musically in a safe and containing manner helped them to feel comfortable, gradually easing into improvisation. In the same case study, Simpson (2000b) noted that the client that he was working with first showed musical interaction by tapping his feet. I used clients tapping as an introductory form of participation, and on several occasions, as an inspiration and anchor for improvisation. I found that this was a good way to gradually introduce improvisation, musically addressing clients who showed less interaction in sessions.

Thirdly, the use of nonverbal communication as a form of improvisation provided mutuality and allowed clients to be heard in music therapy. Nonverbal communication can be described as 'those aspects of communication, such as gestures and facial expressions, that do not involve verbal communication but which may include nonverbal aspects of speech itself (accent, tone of voice, speed of speaking, etc.)' ('nonverbal communication,' n.d.). From a therapeutic perspective, this definition suggests that nonverbal communication involves any sounds that are not spoken. During clinical improvisation, clients were essentially communicating through their music-making. Pavlicevic (2000) describes clinical improvisation as 'human communication in sound' furthering that elements such as facial expression, tempo, gestures, and rhythm attribute to its communicative nature. The therapeutic methods described by Wigram (2004), served as a means of communication for me with my clients. Given that Sawyer (1999) argues the majority of daily conversation is improvised, it could be assumed that the majority of nonverbal communication in music therapy is also improvised. Aldridge and Aldridge (2008) suggest improvisation is a musical language that clients can understand. During my data analysis I found that I was able to understand and connect with clients through the use of improvised nonverbal communication. This was especially evident

with nonverbal clients, who I felt could only communicate with me through music. An example of this in my findings was when a client and I communicated through an acapella vocalisation.

Responding and communicating through vocalisation was far more fluid than any verbal conversation I ever had with them. Darnley-Smith and Patey (2003) described in a case vignette how a therapist was able to read signs of isolation through the use of nonverbal communication when improvising with an older adult who was verbal, but unable to verbalise his feelings with Darnley-Smith. This idea of vocalised dialoguing presented a familiarity found between a mother-infant relationship and a therapist-client relationship particularly highlighted in the work of Pavlicevic (2000). In one particular example during data analysis, I acted as perhaps a mother would in response to her children's vocalisations, though not clear what they might have actually meant, I opened up a vocal dialogue as a way to reassure the client of my presence musically and communicatively.

Finally, I found that speaking with clients in music therapy was important and should be considered in the overall therapeutic process. Darnley-Smith (2003) and Pavlicevic (2000) suggest that improvisation shouldn't purely be restricted to the playing of music in therapy, but rather should be an interpersonal experience. Simpson (2000) conducted research investigating the significance of verbal communication in creative music therapy. He concluded that the 'verbal relationship must play a part, simply because it exists: *it would be unnatural not to speak*, it must be allowed to integrate naturally into the therapy' (p. 90). Speaking and connecting with clients, I built deeper therapeutic connections while also learning their history, culture, and preferences to inform and aid in following sessions.

Acknowledging the significance of verbal conversation, Simpson (2000) argues that it isn't always appropriate to use music at all times in therapy. He suggests that ignoring the significance of verbal conversation in music therapy doesn't treat the person as a 'physical, emotional, mental and spiritual' whole being (p. 90). The Music Therapy Association of Ontario argues that music therapy aims to restore physical, emotional, mental and spiritual health of clients, therefore conversation should be included in the therapeutic approach of therapists.

I was influenced by Kitwood's ideas of a person-centred approach working in dementia care. Although originally from a nursing context, there is research that supports Kitwood's model in music therapy (Allen & Hoskyns, 2012; Kirkland, Fortuna, Kelson, & Phinney, 2012; Simpson, 2000b; Sherratt, Thornton & Hatton, 2004). Kitwood (1997) presented five core areas of psychological focus when caring for elderly people living with dementia: identity, comfort, inclusion, attachment, and occupation. These areas are all centred with love. I feel that all of these core areas were addressed through the different improvisational methods in music therapy. For example, identity was addressed through participation in improvisation - allowing clients to explore

themselves through sound and me myself supporting them as a student therapist to do so. Kitwood's (1997) idea that the person comes first before any diagnosis helped me a lot when considering my approach to music therapy and how improvisation could address the person first and foremost. I believe that having a person-centred approach helped the use of clinical improvisation among older adults to be successful. Sometimes not knowing if a client lived with dementia (or any other underlying issues) straight away was a good thing - I got to know them as a person first.

The use of anchoring and dialogue strongly resonated with Wigram's (2004) model of clinical improvisation, however, the birth of reflecting differed slightly from Wigram's model. Bruscia defines reflecting as 'Matching the moods, or feelings exhibited by the client.' (1987, p. 540). Carroll and Lefebvre (2013) go slightly further, suggesting that 'client's moods, emotions, attitudes, and feelings' are all matched when reflecting (p. 13). Wigram (2004) argued that mirroring or matching technical priority to visually imitate differs from reflecting because the therapist is connecting with the client in the mood and/or moment. Basically, music-making doesn't necessarily have to be the same or similar between client and therapist when reflecting, provided the client is being met in the mood and/or moment according to Wigram. When exploring reflecting in my findings section, I was influenced by the definitions of Bruscia (1987) and Carroll and Lefebvre (2013) because they addressed the client holistically, aligning with physical, emotional, spiritual, and mental reflection.

5.1 Limitations and recommendations for future research

Reviewing the data analysis in this research, I concluded that the 2 month period wasn't a long enough time frame for data collection. Given that improvisation in music therapy aims to develop a deeper therapeutic connection between therapist and client, a longer period for data collection could have truthfully shown the development of this relationship. Due to complications with my placement I was unfortunately unable to do this. The use of improvisation in music therapy to develop a deeper therapeutic connection among older adults living in residential settings could also be a topic for future research.

During data collection, I felt that my lack of understanding of the different methods in improvisation such as extemporizing and lack of experience and/or confidence using basic researched methods such as containing and holding limited the level of the therapeutic encounter. If I had been more of an expert before I began using clinical improvisation in session my findings would most likely have been different.

My research was limited to the data collection of improvised individual music therapy - improvised group music therapy was not included. This was because I mostly ran group singing at the residential facility.

Given the extensive research on group music therapy for older adults, future research could include both an analysis of improvised individual and group music therapy, or an entire focus on the use of improvisation in group music therapy among older adults living in a residential setting. Further, a research could compare the use of improvised individual and group music therapy among older adults, exploring which could be more beneficial.

At times I felt that this research was broad, ambitious even, covering the whole spectrum of eldercare. As the literature review and discussion explored, there are a wide variety of needs and issues among older adults. Future research could choose to focus more specifically on a particular aspect of eldercare (i.e. palliative care, clients with depression, clients with dementia, etc.) as there is research to support the use of improvisation in some of these specific fields (i.e. the use of extemporization among older adults living with dementia).

6 Conclusion

The purpose of this research was to explore how clinical improvisation was used by a music therapy student among older adults living in a residential setting. A literature review explored the research of music therapy with older adults and the use of improvisation in music therapy. A small number of authors have explored the use of improvisation in music therapy among older adults in case studies. Research in this topic is scarce and often inconclusive.

The use of improvisation in music therapy among older adults in this study was found to cluster around three core themes: in the domains of anchoring, reflecting and dialogue. These themes drew on and related to the improvisational writings of Tony Wigram. The improvisation approaches encouraged participation, movement and interaction while also having the power to establish a deeper therapeutic connection between therapist and client. This qualitative study was based on a student music therapist's experience during a placement at a residential facility and the findings shouldn't be generalised. In saying this, the use of improvisation among older adults in music therapy was perceived to be particularly beneficial in the context of this student research.

7 References

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8 Appendices: Information Sheets, Consent Forms & Analysis Process

Music Therapy Department, Tel: 04 463 5233 x 35807/35808

Date: 25 August 2017

Information Sheet for Third Party to Read to Residents

Topic: The Use of Improvisation Skills in a Student's Music Therapy Practice with Elderly Participants in a Residential Setting

Researcher: Luke Stothart

Supervisor: Assoc Prof Sarah Hoskyns

As you may be aware, Luke is a university student learning to be a music therapist. He has been doing music therapy sessions with residents at XXXXXX this year as part of his training. Luke has been writing notes about the music-making with residents and what he observes in sessions, as well as his meetings with supervisors and staff members.

Luke would like to use some of this information in a book for the university library. The book will be about how musical improvisation was used during music therapy with you and other people but it will not have your actual names in it, to protect your privacy. Luke will be presenting this book to his university lecturers who will assess it.

Luke would like to include information about the music therapy sessions he has had with you, in the book. You do not have to agree to this if you don't want to. Please ask questions whenever you think of them or talk to Luke or I if you have any concerns. If there is something personal you wanted to ask or are worried about anything to do with Luke's book, we can arrange somebody for you to talk to.

If you agree that information about you can be used in this book, Luke might need to store some notes about you in another place. All information will be safely stored at the university lecturer's office. All information will be destroyed after being stored for 10 years at

the University. Luke will provide a summary of his book about music therapy to you and/or your family. When you have had time to think about whether your information can or can't be included in this project, please sign the consent form attached. Thank you for your help!

Best wishes,

Luke

Luke Stothart

Researcher Tel: XXXXX

Sarah Hoskyns

Research Supervisor: Tel: 04 463 5233 (ext 35807)

Consent Form for Resident

Title of Project: The Use of Improvisation Skills in a Student's Music Therapy Practice with Elderly Participants in a Residential Setting

1. I understand that Luke Stothart is writing a book about music therapy at [REDACTED], where I have previously lived including information from our sessions together.
2. I understand that the book will be presented to Luke's university lecturer as part of his training.
3. I know that the book will be available for other people to read.
4. I also understand that Luke will present a case study of our work together in private session to his university examiners.
5. I have had a chance to ask questions about this project and I am happy with the answers.
6. I know that real names will not be used in the book.
7. I have had enough time to think about whether information about my music therapy sessions can be included in the book.
8. I give consent for information about my music therapy sessions to be included in the book

YES / NO

I..... (name of resident), hereby give consent for information about my music therapy sessions to be used in this project.

Resident signature:

Date:

Project explained by:



TE KŌKŌI NEW ZEALAND SCHOOL OF MUSIC
VICTORIA UNIVERSITY OF WELLINGTON, PO Box 600, Wellington 6140, New Zealand
Phone + 64-4-463-5369 Email music@nzsm.ac.nz Web www.nzsm.ac.nz

Music Therapy Department, 88-90 Fairlie Terrace, PO Box 600, Wellington 6140.

Music Therapy Department, Tel: 04 463 5233 x 35807/35808

Consent Form for Family Member

Title of Project: The Use of Improvisation Skills in a Student's Music Therapy Practice with Elderly Participants in a Residential Setting

1. I understand that Luke Stothart is writing a book about music therapy at the [REDACTED] where [REDACTED] previously lived.
2. I understand that the book will be presented to Luke's university lecturer as part of his training.
3. I know that the book will be available for other people to read.
4. I also understand that Luke would like to present a private case study of the work he did with [REDACTED] to his university examiners.
5. I have had a chance to ask questions about this project and I am happy with the answers.
6. I know that real names will not be used in the book.
7. I have had enough time to think about whether information about the music therapy sessions can be included in the book.

8. I give consent for information about the music therapy sessions to be included in the book

YES / NO

I..... (name of family/friend/guardian), hereby give consent for information about [REDACTED] music therapy sessions to be used in this project.

Family/Friend/Guardian's signature:

Date:



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Research Title: The Use of Improvisation Skills in a Student's Music Therapy Practice with Elderly Participants in a Residential Setting

INFORMATION SHEET FOR CARERS

Researcher Introduction

My name is Luke Stothart and I am a Music Therapy student at Victoria University. As part of the Master of Music Therapy programme, I am undergoing an exploratory research project to better understand the benefits of musical improvisation during my clinical placement.

Project Description and Invitation to Resident

The project is an exploratory study on when and how improvisation was used during music therapy sessions. Data will be obtained from clinical notes, reflective journals and supervision reports. I am reaching out to you because I would like to use the data obtained from clinical practice, to write a case study/vignette about the work I did with [REDACTED]. This vignette will illustrate themes from my research analysis, helping to illustrate answers to my research questions. The research will be published in a book and electronic file in the university library. I would also like to present a case study of my work with [REDACTED] which will be in private session with my examiners and not used for any other purposes. Please kindly consider your consent for also doing this private presentation when signing the consent form.

Privacy and Confidentiality

All information will be safely stored in the medical files at the facility or secure electronic drives at the university lecturer's office. All information will be destroyed in a secure manner, after 10 years. If you would like it, I will provide you with a summary report of the research upon completion. To ensure confidentiality, all names of people involved in music therapy as [REDACTED] will be changed and the name of the facility will be not be revealed. Despite these measures, there is a slight risk that [REDACTED] might be identified given that the Music Therapy community in New Zealand is small.

Resident and Family' Rights

There is no obligation for you to give permission for his data to be used for research purposes. If permission is given, you as a family member have the right to:

- Ask any questions about the study,
- Provide information to clarify further that his or her name will not be used,
- Withdraw information from research up till the end of the data analysis,
- Access a summary of the project findings when concluded.

Project Contacts

If you or the resident have any questions about the project, you may contact me or my supervisor, Assoc Prof Sarah Hoskyns.

Compulsory Statement

This project has been reviewed and approved by the New Zealand School of Music Postgraduate committee. The VUW Human Ethics Committee has given generic approval for music therapy students to conduct studies of this type. The music therapy projects have been judged to be low risk and, consequently, are not separately reviewed by any Human Ethics Committees. The supervisor named below is responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research, please contact the supervisor or, if you wish to raise an issue with someone other than the student or supervisor, please contact the Victoria University of Wellington Human Ethics Convenor AProf Susan Corbett, email susan.corbett@vuw.ac.nz, telephone +64-4-463 5480)

Contact details of supervisor

Name: Assoc Prof Sarah Hoskyns

Tel: 04 463 5233 ext 35807

Email: sarah.hoskyns@vuw.ac.nz

Contact details of student

Name: Luke Stothart

Tel: XXXXX

Email:

Example of Coding:

	A	B	C	D	E
1		Clinical Notes	Category	Code	What was happening in terms of improvisation
2	No. 8: 18/04	Began to play a Jig, watching T's feet as they tapped in time with the Jig. After playing the round through twice, I continued to look at his tapping, improvise in the same key. I used his tapping as an anchor for the improvisation. This is the first instance of improvisation in session with T.	Matching	Improvised Irish Jig	Improvisation using the style (e.g. 6/8 timing) of Irish jig music
3			Holding	Foot Tapping	Using tapping foot as an anchor for rhythm and the improvisation as a whole
4	No. 9: 25/04	Introduced the Djembe drum and T was very intrigued by it – asking questions about its texture and origin. I sit by T and begin to play a repeated note – T starts to play with the rim of the djembe quietly, I adjust my dynamic so his can be heard more. I begin a very short dialogue making similar quiet sounds hitting the outer rim before T stops and says, "it's an interesting thing isn't it."	Matching	Timbral Experimentation	Exploring the sonic quality of Djembe through improvisation
5			Dialoguing	Timbral Experimentation	Exploring the sonic quality of Djembe through musical conversation
6	No. 10: 2/05	Tom showed good rhythm with the tambourine drum I introduced for the first time. After handing him two mallets he began to play a consistent 4/4 rhythm, which I observe then mirror on a different drum. He then started to play in twos (e.g. two semi-quavers simultaneously)	Mirroring	Drum Rhythm	Copying exactly what client is musically doing
7			Dialoguing	Mutual conversation between two instruments	Mutual musical conversation between two different instruments
8	No. 11: 9/05	T starts to play somewhat consistent rhythm on drum - I start to play an Irish style jig. He quickens the tempo and I follow, trying to create mutuality between our musicking. I slow the tempo and he also follows. The improvisation ends with meaningful eye contact and expression as we finish at the same time.	Dialoguing	Mutual conversation between two instruments	Mutual conversation between two instruments
9	No. 12: 16/05	T begins to play staggered rhythms on the drum which I at first attempt to mirror but it was quite inconsistent so I decided to take a step back and act more in a holding manner - giving structure through drawn out notes matching T's rhythms.	Mirroring	Drum Rhythm	Copying exactly what client is musically doing
10			Holding	Drum Rhythm	Providing an anchor with drawn out beats on percussion to providing lead for client
11	No. 13: 23/05	T banged the drum rapidly while I strummed the C chord on the guitar in time with his rhythm. I changed between chords - particularly when T significantly altered the rhythm. The improvisation naturally found its way into a blues progression through chords I was playing. I asked T to "give us a solo!" to which he started to play more random notes - I followed with a solo on the guitar.	Matching	Changing chords in response to rhythm	Meeting the improvisation

Example of Categorising:

	A	B	C	D	E
62	Category: Turn-Taking				
63	Nearly an entirely improvised session. J looked at the pan drum I provided him and said, "Ooh a tom-tom." Started to play a blues rhythm on guitar, purposefully changing in tempo and dynamic to elicit response. J responded well everytime adjusting and sometimes adding in fills on the tambourine drum. When I noticed these fills I took a step back playing a little bit quieter and allowed him to experiment more - which he did, playing rolls mostly but also quickly changing between the two drums like a drummer would with tom-toms. We exchanged in solo on guitar and percussion. I asked J to give a marching rhythm and I picked up a marracca and a tambourine and joined him. Playing underneath his advanced style in an attempt to hold a pulse.	Dialoguing/Turn-Taking	Blues Solo	Exchanging in improvised blues solo	
64	J banged the drum rapidly while I strummed the C chord on the guitar in time with his rhythm. I changed between chords - particularly when J significantly altered the rhythm. The improvisation naturally found its way into a blues progression through chords I was playing. I asked J to "give us a solo!" to which he started to play more random notes - I followed with a solo on the guitar.	Dialoguing/Turn-Taking	Blues Solo	Exchanging in improvised blues solo	
65	Category: Modelling				
66	After a couple of rounds singing Drunken Sailor, I sang, "What shall we do with Jason in the morning." He laughed and quickly caught on singing the lyrics along with me. I then stopped and asked, 'what should we do with John in the morning?' He responded, 'Get him out of bed!' - I then sang, "Get John out of bed in the morning." After this I included both of us in the improvisation, "I want breakfast in the morning." He laughed and sang along. After I returned to the original lyrics.	Modelling	Lyric Substitution	Modelled a musical phrase for client to follow	Analytical Memo 14/10/17: Modelling and frameworking ideas very similar in the way that the therapist provides something musically for the client to then further elaborate on/work with. Modelling definition even suggests, 'Providing a musical framework'
67	I asked Jason what types of music he played in his Saturday Night Bop band, to which he responded, 'Ohh the Waltz.' I started playing a Waltz rhythm in G on the guitar. I started to mix between the tambourine drum with rolls and normal drum with a pulse to make a clear waltz rhythm. I started to vocalize, "La' La' La la la la!" Jason laughed and sang along with me in a playful manner. There were a few moments where we exchanged back and forth 'La's' in dialogue. Session ended earlier than usual as J needed to be attended to by nurses.	Modelling	Melodic Vocalisation	Creating a melody for client to follow	
68	I began to sing "She'll be Coming Round the Mountain" and John joined at some points. I gave him the tambourine to play but he said it was "too heavy." I join him beside and assist him while we continue to sing. I changed the words, "He'll be wearing blue pajamas when she comes" and "We'll be playing the tambourine when she comes." And then, played the drum in between the yippl yis. John didn't sing as much as last time I tried changing lyrics.	Modelling	Lyric Substitution	Modelled a musical phrase for client to follow	
69	I used the lyrics and made them relevant to the situation at hand - I didn't plan this - only thought to do it once I started playing the song and saw neighbours getting out of bed and eating their breakfast etc. He seemed to really enjoy the playfulness of the lyrics and joined in with me as soon as he got the jist.	Modelling	Lyrical Substitution	Modelled a musical phrase for client to follow	
70	Category: Grounding				
71	I have noticed over the course of using improvisation with J - it has become more mutual between us. It is no longer me leading the session, rather us playing off each other's musical ideas. When I moved to playing guitar from percussion, J was able to hold the rhythm I established moments earlier well and I found myself following him rather than me leading.	Grounding	Holding Rhythm On Instrument	Therapist provides musical anchor for client to build upon	Analytical Memo (4/10/17): More 'holding' despite grounding being the fathering technique/concept
	Noticed J breathing straight away. It was very much forced - with noticeable space between each breath.		Humming in		6/10/17: Anchoring as the fathering term for the three areas - grounding, holding, containing. In a musical sense anchoring addresses the clients need for comfort and validation, and something solid, literally dropping an anchor for them. It might be something like, taking vocalisation and slowly humming with the