HEALING SOUNDS: AN ANTHROPOLOGY OF MUSIC THERAPY

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Abstract

Music therapy has been recognized as a legitimate health practice in Canada since after the Second World War. While research shows the emotional, social and health benefits of music therapy, researchers have failed to agree on the reason music can be beneficial to health. I argue that affect could be the key to understanding the myriad ways in which music, and music therapy, can have a positive effect on health. Through the lens of affect theory, I explore embodiment, relationship-building and aesthetic creation as three areas in which music can allow the harnessing of affect towards health goals. I note music's powerful affect on the human body and movement, and the ways in which these affects are mobilized towards specific clinical goals. I explore the various human-to-human and human-to-sound relationships that are mobilized, created or strengthened through music therapy interventions, and how they relate to health and to the affect of "becoming". Finally, I note the strong evidence for musical and aesthetic creation as a part of self-care, both by music therapists and by their clients, and argue for a broader understanding of how creativity impacts health, by allowing people to affect their environments and "become themselves".

Introduction

One of my earliest memories is being handed two spoons and taught how to bounce them on my knee to keep the beat while my mother's cousin played the violin. When I was a little older my father sat me down at the piano and we played *Heart and Soul* and chopsticks together. I dabbled with the recorder and the clarinet, took some guitar lessons in high school, and taught myself how to accompany a singer on the piano from a Disney songbook. My father is a music aficionado, who was always introducing my brother and I to classic jazz, prog rock, and folk music (but not country music. Never country music.) My brother is constantly singing his new favourite songs around the house, and plays enough instruments to form an entire band all by himself. Growing up it was rare that I would go a single day without music.

On the other hand, my mother has worked in health her whole life. A veterinarian, it wasn't rare that she would serve as in-house physician when we were sick or injured. Later she transitioned into public health, and started working with people rather than pets. We discussed medical research we'd read about at the dinner table, and we debated the various public health initiatives she helmed. I followed in her footsteps too, in a way, training in first aid and becoming a lifeguard at sixteen, and then delving into medical anthropology during my undergrad.

It perhaps comes as no surprise that when I decided to do my master's I was intrigued by the intersections of music and healthcare. I was aware of music therapy before, but knew very little about it outside of "therapy that uses music", so I began doing some research into the subject. At first I felt that the key to discussing music therapy as an anthropologist lay in the conventional aesthetics of the music – how fast or slow was the beat, what kind of instruments were used, how *beautiful* a piece of music was perceived to be.

It increasingly became clear, however, that what I really wanted to talk about – where my interviews kept leading me, where I found the best grounds for reflection - was affect. I became less

interested in the specific aesthetic characteristics of the music I was discussing than in how music was felt. I also noticed that the therapists I spoke with emphasised the effects of music on their clients (clinical goals reached, emotions expressed, relationships built) more than the characteristics of the music itself (what they were playing and how.) When the specifics of the music were discussed, it was always in the context of how it *made someone feel*. Eventually, this led me to wonder:

How is affect relevant to health and therapy, and how is it mobilized by music therapists to help their clients? Furthermore, how is music uniquely positioned as a conduit of affect in a therapeutic context?

In order to explore these questions, it is important to understand a few concepts:

Affect

Affect is a contested concept. There are about as many definitions and perspectives of affect as there are people who write about it. Before we begin, it is important for me to define affect as I will use it, and draw a distinction between its sister concepts such as feelings and emotions, if only to prevent myself from getting lost in a fog of vague, blurry terminology.

Perhaps the most influential musings regarding affect in the social sciences today are the works of Deleuze and Guattari (1980) who posit affect as a non-conscious form of interaction with others. Affect, in this view, is an ongoing process of "becoming", where two or more entities interact with one another on an unconscious level to co-produce a new reality. Deleuze and Guattari use the example of a wasp and an orchid to explain their concept of "becoming" (Deleuze and Guattari 1980, 10). On their own, an orchid and a wasp are two distinct entities with very little in common, but through processes like pollination they "become" something very different: a wasp-and-orchid hybrid that cannot exist without its two component parts. Without the orchid the wasp cannot eat, and without the wasp the orchid cannot reproduce. While it is tempting to reduce these interactions to concrete actions – the wasp pollinates, the

orchid is eaten – Deleuze and Guattari consider that there is a deeper level of interactions happening on a non-conscious level, which fundamentally change the *nature* – not just the actions - of the orchid and the wasp. This other level of interaction is what they define as affect. The same metaphor can be applied to many situations, with two or more entities interacting: a man and his dog, a student and teacher, and yes, musicians and the music they play. This bilateral process can also be referred to as "becoming-with". It is important to note that affect according to Deleuze and Guattari is fundamentally deconstructive of the subject; the wasp and orchid do not exist as separate entities, and as such no experience of affect is truly subjective. It is through affect that entities, which are de-territorialized (in the rough sense of "taken out of context") by their conception as subjects, can be reterritorialized (or "put back in context"). An orchid cannot exist in a vacuum; if it did it would lack everything that we associate with orchids, if it managed to exist at all. It is only through its relationship with the wasp (and the soil, and the sun, and the rain), that the orchid as we know it, the orchid-in-context, exists.

Brian Massumi (1995; 2002) expands upon Deleuze and Guattari's reflections with a distinction between feelings, emotion and affect. He posits that whereas feelings are personal and emotions are social, affect is prepersonal, meaning that it consists of largely non-conscious moments of intensity, characterised by an increased potentiality – roughly, an increase in the potential for things to happen, either due to heightened possibilities, rapidly-changing circumstances, or a multiplication of contributing factors to the situation. These "accomplishments" can be actual or virtual, or both, or can fail to happen at all, but the fact that their *potential* to happen increased is what marks this phenomenon as affect. Ideas are also likely "accomplishments" of these heightened moments of potentiality: because affect allows for more possibilities, it also allows for the association of seemingly irreconcilable feelings (like sadness and pleasure, for example) and is therefore thought to lead to creativity and openness. Those moments of potentiality can be shared by many people, but they are not strictly speaking social. Massumi considers that in order for something to be social, it must be possible to readily describe it and share it through

language – because affect exists largely outside of consciousness, he considers that it is difficult if not impossible to express with words. Therefore, according to Massumi affect can be shared, but is not a social experience. For example, two dancers may well report similar sensations of anticipation or awareness during a dance, without having consciously done anything to communicate these sensations to one another at the time, or a crowd at a concert may become agitated all at once without any one member being able to determine the cause of the agitation.

Shouse (2005) uses the story of neurologist Oliver Sacks to demonstrate this pre-consciousness of affect: one of Sacks' clients had suffered a hip fracture and had been unable to feel or move her leg in three years. Sacks discovered that when the woman listened to music, her foot would involuntarily tap to the beat. Using this, he was able to devise a rehabilitation program that allowed her to fully regain the ability to walk (Shouse 2005). Shouse attributes the fact that music could move the woman's leg when she could not to affect – the leg had been disconnected from the conscious nervous system, but could be reached via pre-conscious affect felt through the body. This line of reasoning sees affect as preconscious, and therefore a sensation more akin to pain or cold than to sadness or conscious thought.

However, this is not to say that affect, feelings, and emotions are unlinked. According to Shouse (2005), emotions are often expressions of affect translated into a socially-shareable format, and feelings can be affect brought forward into the conscious mind. However, affect does not have to become either feeling or emotion in order to exist. This disconnect between what happens to us and what we are consciously able to *know* is happening to us is sometimes referred to as the affect-emotion gap (White 2017).

Deleuzian philosophy is not the only ways in which affect is understood in academic circles. In psychology and psychiatry, affect often appears as the flip-side of cognition; whatever is not thought consciously falls into the category of affect or affective motivation (Amaral et al. 2018; Lucas and Koff

2017; Carciofo et al. 2017; Whitehead and Bergeman 2016). However, affect in these situations is not distinct from feelings and emotions – rather, it is a concept that *englobes* feelings, emotions and mood as opposed to thought and reasoning. This is divided into negative affect (sadness, anger) and positive affect (happiness, satisfaction), as well as ranked by level of arousal – high-arousal affect includes emotions like anger, while low-arousal affect includes relaxation or depression (Whitehead and Bergeman 2016). Broadly speaking, positive affect is whatever makes people feel good and has a generally positive effect on them, and negative affect is what makes people feel bad and has a generally negative effect on them. This distinction is somewhat arbitrary, since some things – like stress – can be linked either to positive or negative affect depending on situations and opinions. This definition of affect is often what is meant when discussing affect in quantitative studies on the role of affect in music therapy: I intend to consider affect in its more philosophical sense here.

Recently the social sciences have entered a "turn to affect" or "affective turn", characterized by renewed interest in the "non-verbal, non-conscious dimensions of experience" (Blackman and Venn 2010, 8). This theoretical turn has been deeply linked to embodiment studies – Blackman and Venn even suggest that affect should be defined not as an entity, but rather as a process that happens to (and between) bodies (*ibid*, 9). Part of the general move away from the subject in social sciences, affect theory originally held that affect and emotion are the main way in which the subject is deconstructed (Clough 2009). Essentially, this holds that the subject cannot exist as a whole, distinct and individual entity if it is constantly the locus of emotions and affect which necessarily place it in constant co-operation with other beings. However, this shift away from the subject has in many cases circled back, through affect's link to emotion as a subjective state – back to "the subject as the subject of emotion" (*ibid*, 207) – where the subject is a whole, distinct and individual entity precisely *because* it is the locus through which emotions and affect are felt. There appears to be a line in affect studies between those that hold up affect's pre-conscious nature as proof of a disconnect with the subjective, felt experiences of the subject, and those

that consider affect as a process related to feelings and emotions – a subjective experience in and of itself, as much as it depends on relations with others. My own experiences draw me towards the later camp, mainly because the evidence that affect is completely disconnected from the conscious seems to rely heavily on a mind-body dichotomy that I find needlessly limiting in its scope, because it posits affect and emotion as being of the body rather than of the mind, with little to no overlap between the two spheres.

The affective turn in the social sciences also argues that affect can be mobilized and manipulated by political entities, governments, community organizations, and individual politicians, going as far as calling upon academics to mobilize affect themselves for political action (Hynes and Sharpe 2015). Some have also theorized affect as "sticky", in that it can be attached to objects independently of temporal factors (Ahmed 2009) – a person can associate the concept of "family" with "happy" affect, for example, regardless of their immediate feelings towards any individual family unit. This does not reduce affect down to an object, but rather argues that there can be objects of affect, and that affective processes do not disappear when the objects they are related to are not physically present.

Much has been said about this becoming process and its relation to the body. Some theorists, like Haraway, dispute the notion of "becoming" as a bridge between two otherwise closed entities, preferring to view bodies as already-intertwined processes whose relations, rather than interactions, vary simply by their intensity (that is, the degree to which they are interacting) in the moment. The becoming known as orchidwasp, for example, is entirely different from a marigoldwasp, and a humandog is not the same as a humanhorse, yet all these amalgamations are constantly changing and being reformed through the intensities of even their most subtle relationships (Haraway 2004). In this sense, bodies are inseparable from their environments and each other, constantly being made and unmade (Blackman and Venn 2010).

Anthropology has also produced its fair share of literature on affect. There is a trend in the discipline to discuss affect in the political sphere – Ngai (2005), Ramos-Zaya (2011), and Beliso-De Jesús

(2014) focus on the role of affect in the formation of marginalized bodies and identities, particularly racialized identities. Their research emphasises the effect of environment and expectations on the types of emotional and physical responses deemed appropriate for members of these racialized groups, and the shaping of both bodies and psyches in reaction to those factors – for example, the racialized affect of "animatedness", that is the perceived overabundance of emotion in racialized groups such as African-Americans (Ngai 2005) and the responses of African-Americans to these racialized perceptions. Interestingly, affect is also believed to be transmittable between individuals when people perform activities in large groups such as dancehalls (Henriques 2010) or political activities such as rallies (Mazzarella 2017; Ngai 2005; Ahmed 2004). Henriques' take is particularly interesting, as he likens affective transmission to vibrations, which by their very nature transcend any physical body and are therefore easily shareable between individuals and through shared spaces.

This has lead to a fruitful discussion of affect as a tool of political influence. Mazzarella (2017) points out the use of affective language by political actors to justify various types of ethical responsibilities, from the projection of "American" values to humanitarian foreign aid. Navaro (2017) explores the ways in which affective relationships go against and shape political sectarianism in Antakya, Turkey, in reaction to the Syrian civil war. Many more have explored the relations between affect and state-sponsored violence and war (Mazzarella 2015; Chesluk 2012; Fassin 2012). However affect in anthropology is not limited to discussion of the political sphere, or relationships between people. Some use affect to describe relationships between humans and non-humans such as plants (Archambault 2016), electricity (Anusas and Ingold 2015), formaldehyde (Shapiro 2015), or video-game design (Ash 2012).

Many anthropologists have criticized the strict mind-body dichotomy inherent in Massumi's definition of affect, pointing out that the line between the embodied and the conscious is far from clear (Ahmed 2004; Ngai 2005; Martin 2013; Skoggard and Waterston 2015; Navaro 2017). Various alternatives have been presented: in particular, Martin (2013) calls on researchers to reject the urge to generalize

neural processes to the entire human population. Instead, she suggests considering carefully the role of environments and particular circumstances when discussing any non-conscious process (such as affect), and recommends the use of vivid descriptions in order to draw the reader into the sensations of affect being felt by the researcher. She also suggests to mine ethnographic data from comparing the differences in situations rather than their similarities, therefore eliminating the risk of generalizing. Skoggard and Waterston (2015) contend that affect is at least in part social (that is, that affect can be shared and transmitted, making it literally possible to know what affect another person is feeling), and that evocative, poetic language, if used correctly, can make possible the expression of otherwise impossible-to-express sensations and experiences, rendering incomplete the notion that affect is necessarily outside the realm of conscious thought.

What all these definitions have in common is what they agree that affect is *not* – it is not cognition, it is not reasoning, it is not conscious. The question of what affect *is*, however, has been a lot more contentious.

I turned towards affect as a theoretical framework for the experiences that were described to me by music therapists precisely because affect theory allows for the existence and subsequent analysis of nebulous, hard to describe experiences that can exert lasting effects. As I will be working mostly from second-hand testimony I am limited in my ability to accurately describe the relevant affective experiences no matter how much evocative language I use, but I trust in the words of my interlocutors to express their own experiences – as such I will quote liberally when appropriate.

I face two challenges when discussing affect here: firstly, that of the medium of music. Aesthetics play a role in prompting affect during music therapy encounters. In speaking of aesthetics, I am not only referring to the inherent characteristic of art and space (rhythm, melody, pitch, etc.) or to a collection of characteristics socially agreed upon to be beautiful, as is common in anthropology (Layton 2011; Boas

1955; Malinowski 1922). Instead, I am specifically referring to characteristics that are beautiful, desirable and meaningful *for the people involved at a specific time*. While social consensus of what is beautiful remains a factor in shaping an individual's definition of the meaning of beauty, it is not the main factor in determining whether something is considered aesthetically pleasing. Instead, something aesthetically pleasing (or perhaps I should use a term with less specific connotation, like aesthetically *charged*) will be felt rather than simply consciously appreciated – more similar to how one feels an emotional connection to a piece of music than to the cold appreciation of a piece's technical difficulty. Massumi (2002) has already accepted that aesthetics can cause affect, though he does not explore this connection in detail in his work. In the realm of music therapy, playing with the aesthetics characteristics of music in order to produce something *aesthetically charged* (that is, desirable and meaningful) for the client *at that specific time* is the main way a therapist will attempt to create affect. Aesthetics, then, can be understood as a way for therapists to manipulate and mobilize affect for their clients.

Secondly, the highly codified nature of a therapeutic encounter needs to be considered. Therapy is conducted in a particular space (whether a community center, hospital, school, health center, etc.) during specific times and through particular means (that of sound and music). The people involved can vary; in its most basic form, the therapeutic encounter involves only the therapist and client, but there are situations where there are many clients (such as community or group music therapy), or where third-parties may be invited to participate (family members of the client, for example). In all cases, however, the process is a closed one, at least spatially: people cannot come and go as they please throughout the encounter, and there are limits placed on who can participate at any given time. Therapists also have professional rules that they must abide – it would be considered ethically inappropriate for a therapist to discuss their own personal life with their clients, for example. Because of these restrictions, the therapeutic encounter has been formalized – the people involved have roles they must follow, be they therapist, client, or helper.

Because the affect generated in the context of music therapy is so codified both by its medium and its context, we could almost speak of contrived affect, or manufactured affect – created under specific circumstances in pursuit of specific goals, but no less real or influential. The affect becomes the deliberate product of the therapeutic encounter, which must then be structured to allow the affect to be manufactured in the time and space provided.

The "becoming-with" metaphor is particularly apt for describing what goes on during a music therapy session, where client and therapist create and experience music together. Music is often described as the third participant in the therapeutic relationship and is created through interactions between therapist and client: even during receptive music therapy, where the client does not participate in music-making, the therapists often report that they pay attention to verbal and non-verbal cues from the client and change their performance accordingly, such as adjusting the music's tempo to the client's breathing. It might even be appropriate to consider the music a manifestation of the "becoming-with" of client and therapist as they interact on a conscious and unconscious level. Alternatively, perhaps we could also speak of becoming-music as the experience becomes embodied, leading to physical reactions (tapping, swaying, humming), or more abstract, unguarded emotional moments. Such a becoming would be worked out not between client and therapist, but between a person and the music they are playing/consuming, where the barriers become blurred between what is purely sound and what is movement, emotion, affect. Both therapists and clients bring their own relationships to music in with them during a therapeutic encounter – whether that be as simple as a preference in genre, or as specific as an emotional need for a particular song. While therapists will try to create aesthetically charged music for their clients in the moment, the clients may know of music (a song, an artist, an instrument) that is *already* aesthetically charged for them. Because of this, music is more than just a medium through which client and therapist interact – it is in itself an actor in the therapeutic encounter.

I don't agree with the prevailing notion that affect is an entirely pre-conscious phenomenon that lives only in the body, but it does seem difficult to deny that music has the ability to travel through the body in not-entirely-understandable ways. I myself am especially susceptible to foot-tapping and swaying when hearing nearly any piece of music, but of course individual reactions will vary greatly depending on the person, context and music being played. This ability can be used in music therapy, as discussed above, to encourage and develop motor skills in clients after an accident. Many music therapists also report a link between embodied responses to music and emotional expression, which could very well point to either a breakdown of the mind-body dichotomy or a specific type of affect-emotion interaction. The specific place of embodiment and its relationship with affect in the practice of music therapy will therefore be discussed as well. In which sense can music therapy be seen as an interaction, as a relation? How closed to one another are the bodies of therapists and clients, how does their environment link them, and are these relations limited only to the therapeutic intervention? How are these relations seen as part of a therapeutic process with specific clinical goals? Can affect be seen as either positive or negative when put in the context of clinical goals, or is it by nature a neutral process of change? Are therapists able to remain consciously aware of their surroundings and feelings while still participating in an affective relationship with their clients? How does the music fit into this relationship – as a glue between entities, as a manifestation of the interactions between them, or as a process of its own?

I also intend to explore affect's capacity to be consciously manipulated or mobilized (Mazarella 2017, 2015; Hynes and Sharpe 2015), however, for the purposes of therapy rather than politics. Much as politicians can use affect to influence their constituents and justify their actions in the narrow confines of behaviour afforded them, are therapists consciously mobilizing affect to influence their clients in the codified context of a therapeutic relationship?

In short, the particularity of the concept of affect is that it can account for both the intensely personal and the unconscious, or to borrow Mazzarella's phrasing, "the intimately impersonal and the

impersonally intimate" (Mazzarella 2017). Music in the modern world is a public experience whether we want it to be or not: we are all made aware of the same Top 100 billboard soundscape even as we curate our own musical worlds. Communities form around musical tastes, bands and artists, from metalheads to the BeyHive, and music is incredibly important in the way that we project our shared ethnic, religious and national identities. And yet music is also intensely personal: we assign meaning to music, regardless of the artists' original intent or the social context in which the music is generally consumed. Songs are associated to particular memories or relationships – think of how many couples have "our song", often a piece of music held up almost as a symbol of the romantic relationship itself. This personal dimension to music is also present in the action of musical creation, where people "become" music, so to speak, in order to affect themselves and their environments. Both these personal and social dimensions must be considered when music is used to heal, as is the case with music therapy. Affect is, I believe, the best jumping off point to explain the complexities of music in a therapeutic context.

In the context of my research with music therapy, I will employ the concept of affect as follows:

1. Affect is embodied. Affect is defined as much by its physical component as it is by its more emotional elements. Affect is felt and can be expressed physically.
2. Affect is a process. Rather than seeing affect as a "thing" that acts upon otherwise closed-off entities, I will look at it as a process of "becoming". Whether this process of change and becoming is constant, as per Haraway (2004) or only occurs during concrete interactions (Deleuze and Guattari 1980) will be examined in greater detail.
3. Affect is "sticky". We associate feelings and emotions, positive and negative, to entities, objects, and people. This sticky affect is more viscous than momentary feelings, and does not necessarily match our current opinions or feelings regarding the things it sticks to. Ahmed (2009) mainly looked at affect's potential to stick in political and emotional situations; in our case, we will mostly be looking at the way in which affect can stick to musical pieces, genres and styles. I might refer

to music that possesses this kind of "sticky" affect for clients and therapists as being *aesthetically charged*, because its aesthetic characteristics are meaningful and beautiful to those involved with the music at that time.

4. Affect is not fully distinct from feeling. Unlike Massumi (2002) and Shouse (2005) I will take affect as something that can be described with words, more akin to what they deem "feeling" than their version of an entirely pre-conscious affect. Also, while affect is subjective and often difficult to describe, I reject the idea that it is entirely pre-conscious. We can become conscious of our affects, though this is not a requirement.
5. Affect can be manipulated. Taking a page from Mazzarella (2017, 2015) and Hynes and Sharpe (2015), I will take affect as a process that can be manipulated, consciously or otherwise, by other actors. While the authors above mostly discuss politics, I will here be looking at the manipulation of affect by therapists in the pursuit of therapeutic goals.
6. Affect can be shared. Like Skoggard and Waterston (2015), I will look at affect as something at least partly social, that can be shared or transmitted in certain contexts. The ways in which this sharing of affect varies in the highly codified context of a therapy session will be examined.

The first – and perhaps most important - of these characteristics is that of embodiment. Affect cannot be affect without being experienced through the body. Because the topic is so vast, the next chapter will be dedicated to exploring the ways in which music is embodied for therapeutic purposes.

On Aesthetics and Experience

I mentioned aesthetics earlier when discussing the particularities of affect related to music therapy, but the topic merits a brief elaboration. In discussing music, perhaps the instinct would be to speak of *acoustics* rather than aesthetics. However, I find the term needlessly limiting in its scope: who is to say that our experiences of music are limited to what we hear? What we see and feel may be just as

important in our conception of the overall experience as the sound vibration themselves – and ears are not the only organ capable of sensing vibrations. As such, I will stick by my definition of aesthetics, and my use of the term in this work.

The concept of aesthetic experience is relevant to my work in this case: described by Dewey (1934) as the fullest and richest possible experience felt by humans, an aesthetic experience is concerned with the potentiality that exists between the subject and the world around them, and their awareness of that potentiality. Essentially, Dewey's aesthetic experience is comparable to Massumi's affect (2002).

The comparison is not perfect, of course. As opposed to the constant process of affect, an experience has a discrete beginning and ending – there is a time before the experience and a time after, which can be easily identified - despite that its memory can linger and have effects long after the fact (Dewey 1934). Also, unlike affect, which is quite ordinary and carries no particularly positive or negative connotation, *an* experience (in the singular, as opposed to *experience* in the broader sense) is characterised by a feeling of accomplishment or satisfaction once the experience is over (*ibid*). After an experience, a person will identify it as such, and will feel that something was changed during the experience, usually a deep, personal change that renders them different than they were before the experience (*ibid*). Despite these disparities between the notions of affect and of experience in the singular sense, the notion of an experience is important because it reflects the way in which people discuss their affective relationships, at least as it pertains to music. Often the people I interviewed will recall a specific time or event where music caused a noticeable change in either them or a client – very rarely do they discuss these changes as constant, never-ending processes of affect, but rather as finite experiences.

A quick note to differentiate between experience and *an* experience: while experience is an ordinary result of everyday sensory input, an experience is finite, defined, and particular (Dewey 1934). Dewey's simple test to determine whether he was discussing one or the other was to see if those involved

could look back on it and declare the event to have been an experience (ibid) – if not, the sensation was too ordinary to register as special and therefore was not *an* experience.

In discussing music therapy sessions, some therapists point to a moment where the atmosphere of the session shifts, and the patient seems – words here vary from "transported" to "lost" – by the music. This moment is finite; it doesn't begin with the session and may or may not end before the session itself is done. It is a moment that people refer to as an experience, basing it on their interpretation of sensory stimuli, and which is recognized as bearing great potential for transformation and change. In other words, by Dewey's definition, it is an aesthetic experience. While I contend that affect is an ongoing process with no clearly-defined beginning, middle or end, the way people describe their own brushes with it should be understood and respected, and may leave us with interesting ways to discuss the ways in which affect is conceived of retroactively. I believe that while affect is ongoing, the temporal language of the experience make it easier to conceptualize and discuss the results of affect, especially when aesthetic features (like music) are involved.

What is Music Therapy?

The use of sound and music for healing is probably as old as healing itself. Songs, chants, and dances are seen in medical practices throughout the world; from Hippocrates' and Plato's use of music to treat mental illnesses in Classical Greece, to the healing hymns of the Atharvan Samhitas in South Asia, and the medicine songs of the Omaha people in North America, there is a long history of attributing healing, therapeutic, or miraculous properties if not to music itself, then to its ability to reach into the spiritual or invisible world (Gioia 2006). Such is the breadth of these practices that documenting every instance of the use of sound and music in healing practices throughout history would take longer than we have here. For the sake of brevity, let's begin with the history of music therapy itself, in the country in which I conducted this research. The history of music therapy in Canada begins after the Second World

War, when doctors in military hospitals noticed that music and dance were useful to the rehabilitation of wounded and traumatised soldiers – even though mentions of music's usefulness to psychiatric patients have been found as early as 1849 (Charboneau et.al. 2014). Canadian music therapists trained in England and the United States, where there was already a burgeoning interest in mixing music and scientific medicine, established the first pilot program at Westminster Hospital in London, On. (*ibid*). The Canadian Music Therapy Association was founded in 1974, and the first music therapy training program was established at Capilano College (now Capilano University) in Vancouver in 1976. Today, six Canadian universities offer music therapy programs, and the profession is accredited and protected in certain provinces (Kirkland 2007). In Canada, a music therapist must complete at least a four-year bachelor's degree in music therapy, at least 1000 hours of clinical internship under an accredited music therapist, and then pass the Certification Board of Music Therapists exam (which is administered in the United States) in order to be officially recognized as an accredited music therapist by the Canadian Association of Music Therapists (Canadian Association of Music Therapists 2018).

Music therapy can be divided into two big categories, active and receptive (Fertier 2011). During a receptive therapy session, the client must only listen to sounds or music, while during an active therapy session the client participates in the creation of music by singing or playing an instrument. Receptive music therapy can be done in person, with a music therapist playing live music, or be done through recordings. Most music therapy practices fall under one of these broad categories. Depending on the clinical goals of the therapist and their client, it might be more effective for the client to participate in the creation of music or on the contrary, to receive music without directly participating. These categories are not mutually exclusive, since a therapist could very well be playing music for their client to listen to, all the while giving them the option of joining in on a drum if they want to, for example. Therapists can also alternate between active and receptive therapy sessions with a client if they feel it necessary to address their clinical goals (Fertier 2011).

Music therapy, defined as the skilled use of music towards non-musical therapeutic goals, has a recognized clinical efficacy in the treatment of several mental illnesses including depression (Werner et al. 2017; Fachner et al. 2013; Albornoz 2011; Erkkilä et al. 2011; Maratos et al. 2011; Brandes et al. 2010; Maratos et al. 2008), schizophrenia (Chung and Woods-Giscombe 2016; Kavak et al. 2016; Tseng et al. 2016; Bloch et al. 2010), anxiety disorders (Pavlov et al. 2017; Gutiérrez and Camarena 2015; Mejía-Rubalcava et al. 2015; Jiménez-Jiménez et al. 2013), post-traumatic stress disorder (Bensimon et al. 2008; Blake and Bishop 1994), insomnia (Street et al. 2014; Wang et al. 2014) and detoxification (Silverman 2014; Silverman 2011), as well as general mental well-being (Silverman 2016; Gold et al. 2009; Gold et al. 2004).

Music therapy is also used to alleviate the symptoms of autism (Ghasemtabar et al. 2015; Kim et al. 2008; Accordino et al. 2007; Wigram and Gold 2006; Allgood 2005; Turry and Marcus 2003; Edgerton 1994) and Asperger syndrome (Ansdell and Meehan 2010). It has been shown to be useful in treating various language impairments, including interventions following a stroke (Lim et al 2013; Jones 2012; Groβ et al. 2010).

Music therapy is used to treat pain and anxiety following medical procedures (Dóro et al. 2017; Mondanaro et al. 2017; Campbell and Ala-Ruona 2016; Tan et al. 2010). It is also considered useful in improving the quality of life of those diagnosed with serious diseases like cancer (Jasemi et al. 2016; O'Callaghan et al. 2016; Zanchi et al. 2016; Lesiuk 2015; Karagozoglu et al. 2013; Bonde 2005; Roff et al. 2005; Hilliard 2003; Burns 2001), or HIV/AIDS (Bruscia 2010; Dileo 2006; Lee C. 1992, 1991) and those living in palliative care (Gallagher et al. 2017; Clements-Cortes 2016; Warth et al. 2016; Gutgsell et al. 2013; Dileo 2006; Hilliard 2005) or long-term care facilities (Goltz 2016; Janata 2012). Music can be used to facilitate interactions between people, whether that be between client and therapist, among family members or with complete strangers (Tomaino 2008). There are many reasons for this: firstly, music can serve as a near-universal topic of conversation and can therefore allow to "break the ice" with a new

acquaintance (Edwards and MacMahon 2015); it can also serve as a tool of communication between people, particularly between clients and their families, to facilitate the expression of difficult emotions that surface in the face of illness (stress, pain, fear of death, frustration, anger, etc.) (Tomaino 2008); or still, the solidarity that can manifest when a group of people play music together can encourage not only self-esteem but also interactions between members of the group, turning strangers into friends (*ibid*); finally, since music stimulates several areas of the brain it can help people suffering from neurological impairments to engage with the world around them, which includes other people (*ibid*). Music therapy also has proven to help promote affective connections between parent and child (Krantz 2016; Edwards 2011; Jacquet 2011) et has a beneficial influence on infant's and young children's neurological development (Haslbeck 2016; Standley 2011; Standley 2002).

Music therapy's versatility is perhaps appropriate, given the broad definition of what music is and can be. Unlike many biomedical treatments, which target specific pathogens and are therefore only used to treat specific illnesses, music therapy seems to be useful when dealing with health issues as varied as mental illnesses, neurological injuries and pain management. What is interesting is that music therapy is also beneficial to health even in the absence of "pathological" conditions to treat – normal child development and social engagement are fairly mundane, and don't necessarily require any therapeutic assistance. What this suggests to me is that music therapy taps into something more fundamental and common – for lack of a better word – than most medical treatments. If the application of music is beneficial to the development of relationships for example, something that doesn't usually require therapeutic help, then it stands to reason that music is not *necessarily* therapeutic – or else that it always is. The *context* then determines whether we consider music to be a treatment, rather than the music itself. This is why the problem of affect is so interesting to me: if music can bring forward affect in any context, then is there any difference in the way it is used and felt during therapy?

Music therapists are not unaware of this apparent contradiction between music's use as both a treatment for illnesses and a facilitator for non-pathological processes. If music is always therapeutic, then how does one explain and justify the existence of music therapy as a discipline? As music therapy is still a marginal profession in the biomedical world, there seems to be a desire among music therapists to justify their work using biomedical language – quantitative studies, goal-oriented therapy, explanatory models, etc. are all common in the literature surrounding music therapy. This biomedical language is at odds with my own definition of affect as an open process of increased potentiality, and can often be at odds with the reported experiences of music therapists. The practice of music therapy itself is couched in the idea of a codified therapeutic relationship where the therapist has certain obligations and where certain rules must be followed, but these rules are not and cannot always be followed to the letter. My own experiences interacting with music therapists has uncovered a sort of divide, where on one hand some therapists are eager to quantify music therapy at every turn if only to increase the profession's respectability within biomedicine, while on the other hand others seem singularly unconcerned with quantitative data and scientific research as it pertains to their practice (while most therapists I've interacted with sit somewhere in the middle of these two extremes). There seems to be a tension in the music therapy world between viewing music as a mysterious, unpredictable force that can sometimes be harnessed towards a goal, and explaining music's health benefits through methodical explanatory models.

There is no universally agreed-upon explanation for music therapy's efficacy. This is notably because the issues that can be successfully treated with music therapy are remarkably varied, but also because results are highly individualized. However, there are numerous theories on the subject.

The earliest explanations were psychoanalytic (or psychodynamic) and were inspired by psychanalysis and Freud's work (Kim 2016). Psychodynamic music therapy focuses on the existence of unconscious desires and emotions and on the creation of therapeutic relationships between clients, therapists and the music itself (Langenberg 1997; Alvin 1978, 1976, 1975). Juliette Alvin, the founder of

"Free Improvisation Therapy", is renowned as having pioneered the use of free improvisation in her music therapy sessions in 1960. Musical improvisation was to help her clients project their unconscious feelings and desires outward, allowing them to be expressed, and therefore create a context ripe for healing (Alvin 1978, 1976, 1975). Since music is an ideal method of non-verbal communication, it allows clients to express emotions even they are not aware of. Once those emotions have been expressed, they can be addressed constructively with the help of the therapist. Music listening could also be used to trigger specific emotional or psychological reactions, in order to encourage the client to realize the underlying source of their health issues (*ibid*). These principles were retained by subsequent psychodynamic music therapists.

Like psychoanalysis, psychodynamic music therapy is first considered useful to treat mental illnesses (Gutiérrez and Camarena 2015; Fachner et al. 2013; Jochims 2003). However, is also gains recognition for its use in treating language impairments (Jones 2012) and autism (Kim et al. 2008; Alvin 1978) in children. This model relies also on neurological research – some studies suggest that verbal and musical expression of emotions are treated much the same way by the brain (asymmetrically, with priority given to the right hemisphere) (Pretti and Walsh 2004), and that psychodynamic music therapy has a certain effect on the electrical activity of the frontal lobe, which alleviates symptoms of depression and anxiety (Fachner et al. 2013).

Creative music therapy, or the Nordoff-Robbins method, is among the most well-known and most-used methods. This method is the result of a collaboration beginning in 1958 between Paul Nordoff, musician and composer, and Clive Robbins, special educator. Their work focusing on children with special needs was quickly disseminated through the United States and Europe and became very popular. The Nordoff-Robbins method has changed considerably since its inception, but it is still characterised by a methodological flexibility, a tendency to improvisation and an insistence on preserving the individuality of the client (Mahoney 2016; Nordoff and Robbins 1971). Contrarily to the free improvisation of Alvin's

method, improvisation in the Nordoff-Robbins method were meant to be structured by the therapist, who had to provide a base on top of which the client was free to improvise. This method also introduced the possibility of being done in groups, which offers therapeutic benefits to all members of the group.

The Nordoff-Robbins method is based on the notion that each individual has the potential to react to music, no matter their age, their situation or their ability: this potential is known as the "music child" (Mahoney 2016; Nordoff and Robbins 1971). Since, this method has found success not only with children with special needs (Guerrero et al. 2014; Kim et al. 2008; Aigen 1995), but also with adults (Turry and Marcus 2003) and other groups such as premature newborns (Haslbeck 2016, 2014.)

Another method, popularised by Dr. Helen Bonny in the 1970s, is "Guided Imagery and Music" (GIM), also known as the Bonny method. This method follows psychotherapy principles similar to that of psychodynamic music therapy (subconscious emotions, ego, psychological regression and therapeutic expression are all used) (Smith Goldberg 2013; Marr 2001; Bonny 1989, 1975), but uses a completely different methodology. Rather than use improvisation, the Bonny method is centered on listening to pre-recorded music that encourages the visualisation of a particular scene or emotion. This listening is meant to inspire relaxation and the expression of subconscious desires and problems. The client is generally encouraged to draw the scene that they visualize while listening to the music, and later discuss this work with the therapist. Originally the music necessarily had to be a part of the Western classical canon, but this is no longer the case. The goal of the Bonny method was to be accessible to all, and it has proven its efficacy in treating stress and anxiety (Beck et al. 2015; McKinney et al. 1997; Hammer 1996), post-traumatic stress disorder (Blake and Bishop 1994), post-operatory pain (Mondanaro et al. 2017), and in improving the quality of life of cancer patients (Zanchi et al. 2016; Karagozoglu et al. 2013; Bonde 2005; Roff et al. 2005; Burns 2001). There is also anecdotal evidence to support its success in improving the quality of life of people with HIV/AIDS (Bruscia 2010) and depression (Lin et al. 2010), and those affected by terminal illnesses (Skaggs 1997; Wylie and Blom 1986). Recently researchers have started to explore

the Bonny method's potential to trigger negative emotions and the effects of such an enterprise on the brain (Lee S. et al. 2016). The Bonny method is considered highly specialised in music therapy circles, requiring special training to use, and none of the therapists I spoke with practiced it.

Aesthetic music therapy, first theorized by Colin Lee, borrows heavily from the Nordoff-Robbins method but adds that there exists an aesthetic experience during a music therapy session, and that this aesthetic experience has as much effect on the client as the therapy itself (Lee C. 2015; Aigan 2008). The therapist's role is to help the client produce a pleasant and useful aesthetic experience based on their needs. This theory contends that music has inherent aesthetic value through its style, pitch, form, etc., and that it is those musical qualities that ultimately determine the success of the treatment (Lee C. 2015). These therapeutic properties of music are generally held to be impossible to quantify. Aesthetic music therapy is almost exclusively an active therapy, since it encourages the client to lead the flow of music through their play. Improvisation is also encouraged; improvisation and song are considered opposite points of a spectrum, where improvisation can eventually structure itself into a song, just as a song may gradually become complete improvisation (*ibid*). Perhaps more than any other theory regarding music therapy, aesthetic music therapy considers music as an art form first and foremost, with inherent spiritual, emotional and social benefits. While it has been used in many contexts, it is particularly well-known for its success in helping people suffering from HIV/AIDS (Lee C. 1992, 1991). This model has been criticized by some, who hold that music cannot be therapeutic outside of a clinical setting (Smeijsters 2008).

One of the most recent music therapy models is that of neurologic music therapy. Based on advancements in neurology and medical imagery, it developed in parallel with cognitive rehabilitation science in the 1990s. Using music, the music therapist looks to activate certain regions of the brain to encourage language, motor functions, expression, and even emotions (Thaut 2005). This model explains that because music has multiple dimensions (melody, pitch, harmony, rhythm) it is treated simultaneously by multiples regions of the brain (Altenmüller and Slaug 2015; Thaut et al. 2015; Thaut and McIntosh 2014;

Tomaino 2008). For example, musical pitch is processed in the same region as linguistic prosody (Tomaino 2008: 212). Neuroplasticity explains how the brain can develop alternative neural pathways to perform certain tasks if necessary, and neurologic music therapy considers music an effective tool to promote neuroplasticity (Altenmüller and Slaug 2015; Thaut and McIntosh 2014; Tomaino 2008; Baker and Roth 2004). Music is therefore applied in methodical ways to re-train the brain to perform certain functions (Thaut and McIntosh 2014; Grau-Sánchez et al. 2013). A man who has lost the ability to speak may have retained the ability to sing, for example, and by singing could exercise the neural pathways necessary for speech. The memory centers of the brain can be stimulated through listening to a familiar piece of music, which can help with general memory retention. Tomaino gives as an example a client who had not spoken in five years following a stroke. After receiving music therapy treatments for a few months, he had regained the ability to speak. One of the songs Tomaino had selected to sing for him was a lullaby he had himself sung to his children when they were young; not only was he more present and attentive when he heard this song, but he soon started humming the tune, then singing the words, until he was finally able to construct his own sentences (Tomaino 2008; 213). This particular method, used with clients with speech impairments, is called “speech intonation therapy” (Thaut and McInstosh 2014). Music can also be useful for those whose neurological issues result in physical impairments like a lack of balance or coordination; music with a strong rhythm can provide the necessary structure for them to gain more control over their movements (Magee et al. 2017; Raglio et al. 2017; Harrison et al. 2017; Bukowska 2016; Spina et al. 2016; Bukowska et al. 2015; Thaut and McIntosh 2014; Altenmüller and Schlaug 2013; Grau-Sánchez et al. 2013; Thaut 2010; Thaut et al. 2009; Tomaino 2008).

This model, and the methods that derive from it, are considered particularly effective for rehabilitation following brain trauma (Magee et al, 2017; Raglio et al. 2017; Thaut and McIntosh 2014; Altenmüller and Schlaug 2013; Grau-Sánchez et al. 2013; Lim et al. 2013; Thaut 2010; Thaut et al. 2009; Tomaino 2008), reducing symptoms in children with neurological disorders (Bringas 2016; Bringas et al.

2015), improving mobility among Parkinson's patients (Harrison et al. 2017; Bukowska 2016; Spina et al. 2016; Bukowska et al. 2015), and to improve symptoms of dementia (Zhang et al. 2017; Chang et al. 2015; Craig 2014; Raglio et al. 2008; Bruer et al. 2007; Koger et al. 1999). This model strives to support its efficacy mostly through systematic medical studies that use control groups (Raglio et al. 2017; Bukowska 2016; Lim et al. 2013; Thaut et al. 2009) and medical imagery showing plastic changes in the brain (Bringas 2016; Bringas et al. 2015; Grau-Sánchez et al. 2013). This model is also considered highly specialized in music therapy circles and requires special training. None of the therapists I spoke to had received the training, but some were interested in doing so. All were aware of studies showing music's various effects on the brain, however, and the fact that music may be efficient precisely because it is processed in many areas of the brain seems common knowledge among music therapists.

Most music therapy university programs seem to focus on one or two models only. However, music therapists in general seem open to the influence of other models and methods depending on their clients' needs – as previously stated, even though none of the therapists I spoke to were trained in neurologic music therapy they were all familiar with the research it derives from and some methods that derived from it. Perhaps because of this methodological flexibility, the precise theory of music therapy espoused in clinical studies is rarely specified, and results become more associated with the methods used than the model it derived from.

Interestingly, while music therapists described their methods to me, none of those I spoke to attributed their efficacy as therapists to particular models, seeming rather to syncretize various models and methods based on their own experiences of what works. We are brought again to the apparent versatility of music as a therapeutic tool, to the difficulties of instrumentalizing music therapy, and to my focus on affect: because affect is such a broad concept, it seems appropriate to use it to explore the broad uses of music as a tool for wellness – and it may present an explanation for the efficacy of music therapy

in such varied contexts. If we can retrace the efficacy of music through the affect it causes, then perhaps we can come to a greater understanding of why music is efficacious in such a variety of situations.

There is another type of musical healing developed in parallel with music therapy, usually called sound healing. Contrarily to music therapy, which is recognized as an allied health profession, sound healing is officially considered a complementary and alternative medicine (CAM). These healing techniques are inspired in part by New Age movements, notably non-western medical traditions such as Tibetan meditation or ayurvedic medicine. Certain adepts of sound healing recognize effects of sound vibrations on the human body, taking inspiration from Hans Jenny's Cymatics (Gioia 2006) and Laurel Elizabeth Keyes's Toning (*ibid*). Others adopt a more spiritual view, saying that music allows humans to connect with a universal energy (*ibid*). While some healers distance themselves from scientific inquiry, others justify their methods through scientific studies or pseudo-scientific explanations. This vein of sound medicine is less supported by the biomedical establishment due to a lack of clinical proof of its efficacy (*ibid*). In reality, the line can be very thin between what is considered music therapy and what is considered sound healing. The Canadian Music Therapy Association serves as a regulatory body for music therapists in Canada as it is responsible for their accreditation. However, in practice music therapists often use methods that are more associated with sound healing, like Tibetan singing bowls, and speak of the spiritual benefits of music. Curiosity regarding sound healing seems to be rising in the discipline, as evidenced not only by some of my discussions with music therapists, but also by the presence of a presentation on sound healing at the CMAT conference (presented by Dr. Shelley Snow). I would posit that music therapy and sound healing are not so much separate things as they are opposite ends of a spectrum, in the center of which lies a variety of permutations involving aspects of both. As such, I will not be making any hard distinctions between music therapy and sound healing in this paper.

One of the defining traits of music therapy seems to be its versatility and adaptability to different practices, methods and illnesses. It is commonly used to treat a long list of illnesses, many with very little

in common. Because of its long history and its ties to psychology, medicine, spirituality, art, etc. it is easy to find interpretations of the practice that support any number of explanations for its medical efficacy. The only thing that hardly seems to change is the constant change itself, the process of using music in order to heal – the *becoming*, so to speak, of the therapeutic context that focuses music in its purpose. Affect – the purposeful application of affect – is what binds all these disparate uses of healing music together into a cohesive, though not always coherent, whole.

On Therapy and Therapeutic Uses

I wish to clarify the way in which I use the concept of therapy and "therapeutic" in this work. In music therapy, "therapeutic" is often a relative term. Whether something is considered to be therapeutic or not depends mostly on how that thing relates to the therapeutic goals set out by the therapist and their client. These goals can also be set out by people close to the client – either a family member or caregiver – in some cases when the client is not considered able to consent to therapy (such as if they are in an advanced state of dementia, or if they are young children). The goals of music therapy are seldom curative: music therapy does not pretend to cure chronic pain, mental illness, dementia, or any other illness. Instead, the goals will often be centered around *managing* the illness and its symptoms to the client's satisfaction.

This can mean a variety of things: from making pain manageable to increasing socialization, from regaining motor skills after an accident to making peace with one's incoming death. Once these goals have been set, the therapeutic value of any intervention is determined by gaging whether it will help reach those goals. Since therapeutic goals can vary enormously from client to client, the exact definition of what is and is not therapeutic will therefore change as well based on the circumstances.

The only time when therapeutic goals can really be said to be "curative" is when dealing with neurological rehabilitation, where a client may want to regain an ability they have lost through

neurological impairment, such as speaking or walking. I would argue, however, that once again music therapy does not purport to "cure" the condition – that is, to repair the nervous system where it was damaged – but rather offers strategies to circumvent the damaged portions of the brain by re-training undamaged parts of the brain to perform the same tasks. Essentially, music therapy helps to create workarounds that allow the client to reach their goal, much in the same way it can help a client find ways to manage the symptoms of their depression. Music therapy goals seem to be more about helping the clients to improve (whatever their definition of "improve" is) within the reality of their illness, rather than being focused on curing their underlying medical conditions.

Methodology

I conducted ethnographic research for this thesis. The central part of my research was done through interviews conducted with music therapists from across Canada. I interviewed 10 music therapists in all. Some participants agreed to a follow-up interview in which we delved deeper into material already covered in the first interview. In total, I have conducted 17 interviews averaging 45 minutes each. These interviews were semi-directed, so that the content of each could vary greatly depending on the direction the conversation took; still, I find that we ended up covering very similar topics in each interview. When possible, the interviews were conducted in person, though sometimes geographical distance and timing meant that the interviews had to be done through Skype or phone call. All but two interviews were recorded (those two interviews due to technical problems) and extensive notes were taken during those that were not. These recordings and notes will be my main source for this paper.

All the people interviewed were accredited music therapists who practiced or had practiced in Canada in the past 10 years. Some had since moved on to other music-related careers, but remained aware of developments in the music therapy world.

In order to better immerse myself into the world of music therapy, I also participated in several events. The first of these was the 2017 Canadian Music Therapy Association conference held in Vancouver in May. I attended many panels and presentations, and learned a lot about the current debates in the discipline, the day-to-day reality of being a music therapist, and the field of music therapy in Canada in general - all things that had been difficult to grasp from my review of scientific literature. As my introduction into the reality of being a music therapist, it was both fascinating and disorienting. I often felt the odd one out, being, by my reckoning, the only attendee who was neither a certified music therapist or a music therapy student, but my unique circumstances didn't seem to be held against me at all – in fact, most people were very welcoming and curious, asking almost as many questions as I did. Several of the music therapists I met there would eventually agree to an interview. The conference served as a welcome introduction to the practical realities of music therapy, without which I would have been far less prepared to tackle in-depth interviews.

I have also taken a certification course in music care through Room 217, an organization dedicated to promoting music care in Canada. Music care refers to the broader use of music in care settings – it includes music therapy, but is not limited to it. Most of my fellow students during the two-day course were either professional caregivers (nurses, recreational therapists, long-term care facility administrators) looking to better their practice through an understanding of how music and sound can affect their work, or professional musicians looking to apply their musical expertise in a care setting such as a hospital, hospice or long-term care facility. The course was taught by a music therapist and consisted in a variety of learning modules related to music theory (rhythm, pitch, tempo, melody, singing, breath, etc.) and guided activities to explore how these concepts could be applied to caregiving. I was particularly thankful for the class discussions, which allowed me to learn more about the ways in which music and music therapy interact with other domains of care such as recreational therapy and nursing. The course also emphasized the ways in which music and sounds surround us constantly, and the immense impact that

even the most overlooked of sounds can have on health. I learned a lot about music and care during this course. I am currently certified by Room 217 in Music Care level 1. I have not had the opportunity to pursue that training yet to levels 2 and 3, but I was intrigued by the material and would love an opportunity to do so in the future.

Since November 2017 I have volunteered twice a month (and then once a week) at a long-term care facility, where I help one of the music therapists with a weekly program. Certain residents, under the guidance of the music therapist, form a band and meet once a week to play together. Other residents are invited to attend rehearsals and sing/play along using handheld percussion instruments like maracas or spoons. My responsibilities include helping the music therapist set up instruments, preparing the room for rehearsals, gathering interested residents and help engage them in the music by singing/playing along or helping them do so. Most of the songs performed reflect music that was popular in the resident's youth; this varies from traditional songs, to 40s ballads, to 60s rock. The program has many goals, including increasing socialization among residents, facilitating discussion and reminiscing, building self-esteem and confidence, increasing stimulation, and generally improving quality of life for the residents through music.

I did not record or tape any rehearsals; instead I have kept notes describing my personal impressions while observing things for myself that either had been described to me during interviews, or which I had come across during research. Any reference to these sessions are based on my notes. These sessions gave me a more personal perspective into the daily realities of music therapy – the set-up, the instrument maintenance, the non-musical interactions between therapist and client. They have also helped me to see firsthand several of the therapeutic techniques I'd heard about in interviews, such as the use of songs from the clients' youth and the routine of "goodbye songs" used to close out a session.

Chapter 1 - "Out of the Head, Into the Body"

My mother tells me an old joke over Christmas break, while we wait for my brother's school talent show to start. "Do you know how you torture an Acadian?" I shake my head. She says, "You play a jig and stop him from tapping his foot."

I tried to stop myself from tapping my foot later, when one performer played three jigs in a row, and I concur – the task ranges from torturous to impossible. If I refuse to move my feet, my body will commit a mutiny against me and my hand will start tapping against my leg or my head will nod to the beat.

It seems trite to say that we feel music just as much as we hear it – sound is made up of vibrations, after all, and music is nothing but specifically-ordered sound. Who hasn't felt the heaviness of a beat in their chest during a concert, or felt their footsteps fall into rhythm with the song playing on the radio?

Writ-large, vibrations are all around us, and they influence our bodies and behaviours. Henriques (2010) even theorizes that vibrations are the main way in which humans can communicate affectively. But even Henriques doesn't speak of just any vibrations – he writes of sound vibrations in the Dancehall scene, and the vibrations of bodies attracted and bound together affectively by the music playing around them. Even in Henriques's world, music – sound vibrations in a specific order – is the catalyst for affective communication. On their own vibrations may be powerful, but their mere existence doesn't entirely account for the affect that music can bring forth.

The potential for embodiment in music is a phenomenon that is well-known in music therapy. Variations on the phrase "music brings you out of your head and into your body" were spoken fairly often, and all music therapists I interviewed were at least familiar with the concept. Physical reactions to music were consistently cited as useful tools to both communicate with the client and evaluate the success of the music therapy session.

In this chapter, I wish to explore the various ways in which music engages us physically and becomes embodied, and how these processes are used to further therapeutic goals.

Music as a Shortcut

The following story was told to me by a music therapist I interviewed, Jessica[1]. She is called to a resident's room one day at the long-term care facility where she works. The resident is clearly in distress: she has exhibited violent behaviour and has been refusing her medication for two days, and is now refusing food and bathing. The nurses have tried to calm her and convince her to take her medication, but she is completely withdrawn, laying on the floor in a foetal position.

Jessica enters the room and speaks to the resident. The resident looks back to her, but does not respond. Jessica takes her guitar and sits on the floor at the same level as the resident, and begins to play a song she knows the resident will recognize. In between songs she tries to chat. Eventually the resident sits up on her bed and faces her. After about half an hour of this, the resident taps her foot in time with the music, and responds to Jessica's queries. The conversation turns to cats – the room is full of cat decorations. Jessica stays on the floor. About forty-five minutes after she's entered the room, the resident is calm and communicating casually; the nurses are able to give her medication.

"I'm not looking for her to sing with me, I'm not looking for her to dance or to shake a shaker, but it's more just to reach her because I think she gets, you know – cognitively we can't really reach her when she gets really paranoid and agitated, and she was totally recluse, like, she was in the foetal position on the floor, not communicating with anybody, so to use music as a, (…), I don't know if it transports her but it takes her to at least a comfortable place," Jessica tells me afterwards.

[1] Names have been changed.

In music therapy, music is often understood as a way to reach past the cognitive barriers of a client. These are any barriers that might impede the client from expressing their feelings, interacting with the therapist or others, or self-reflecting on their circumstances and feelings. These barriers can be symptoms of an illness, such as an inability to focus or difficulties with language, for example. However these barriers are also often described as a trauma or as personal reluctance – either due to social norms or fear of vulnerability. After all, music can be a very vulnerable experience, as can illness – and many people associate a negative connotation to the expression of so-called "negative emotions" like sadness, anger and doubt. Helena, a music therapist who works mostly in palliative care, explains to me how this property of music often manifests in her practice. "It's so interesting, because, you know, people will say 'I really want to hear this song' and you play it, or you sing it or you do whatever, and they just start crying." She goes on to explain that often, she finds that music is being used as a "scapegoat" to allow people to express their emotions in a socially-acceptable way. The term scapegoat here doesn't refer to music as a negative, but simply indicates that people project the responsibility for their emotional expression onto the music rather than on their own feelings or circumstances. Because they are allowed to project that responsibility onto an outside force, they are able to avoid, at least in their minds, most of the negative connotations of expressing vulnerability and "negative" emotions. In this view, not only does music trigger the emotional reaction, but music also acts as the "excuse" to allow the clients to express those emotions.

> *There's one lady once who used to say "I know that my loved one doesn't want me to cry, doesn't want to see me crying." But then, they would ask for music because they loved it and so I would sing some music and they would say "Well…" the person who didn't want to cry would say, "the music is just so beautiful", or "The music, whatever", and suddenly the music is the scapegoat. And they're allowed to live with these really tough emotions that have sometimes to do with music but a lot to do with the situation that they're finding themselves in. They're able to put it on that. So, music becomes a wonderful scapegoat, it becomes sort of a wonderful container, it becomes a wonderful blender to get things to shake up and to move.*

Helena also felt that "music just allows things to get shaken up, things to move around, things to get unstuck, things that sometimes don't have words to somehow be expressed." Another therapist, Alisa,

gave an example of how she worked with a technique called vocal psychotherapy to encourage these types of wordless breakthroughs:

> *The format of the session is that she sits next to me, I start playing. If she's comfortable she might start humming or singing. If she's not comfortable then I will initiate humming or singing, and she would join in in any capacity that she was comfortable. And for her, her capacity was to start moaning and crying right away. And the sounds that she was emitting sounded very newborn-like. And it was a very emotionally heavy session for her, lots of evidence of deep grief that was being expressed. And so for her – that was the first session. The second session was a little bit more grounded and she was able to express sort of a different side of her grief, and the third one, which was about a month later, she expressed more joy. And so we talked about that afterwards. And for her, the snippet that really got to me was for such an intellectual, very verbal, very well-spoken client, she said that the musical aspect of therapy allowed her to get out of her head and experiencing it in her body. By experiencing it in her body, she said "Feelings last longer than sentences". So for her, in all of her talk therapy at this point, which has provided some benefit, she was always in her head, thinking about her feelings, thinking about forming how she could describe her feelings to her counsellors and her other therapists. But she said her musical experience allowed her to bypass expressing them with words, and feel it, and process it through a musical experience. So for her it was really beneficial to get out of her head, get out of language, and express her grief without intellectualizing it.*

An important point that was reiterated to me many times is that music therapy is primarily an expressive therapy. It is of course not the only expressive therapy (drama therapy and art therapy would also be good examples, and even talk therapy seeks to promote the client's expression of their feelings and emotions through speech). What sets music therapy apart from these other therapies is the medium of music itself. According to therapists, part of the therapeutic value of music is that it allows emotional expression in a way that is both socially acceptable – that is, because it allows the expression of so-called "negative emotions" without pushing the responsibility for feeling those emotions onto the person, but rather onto the music - and allows the subject to distance themselves somewhat from the root cause of their emotions. This distance, in turn, can allow the client to come to a greater understanding of their emotions and their cause, and then to address it, as this last client did. Talk therapy, by contrast, allows very little distance between the expression of emotions and these emotions' root causes: expression must go hand-in-hand with self-reflection and cognition. Music and other artistic pursuits like visual arts allow

expression without necessarily requiring self-reflection or the conscious recognition of the feelings being expressed, which can make their expression more accessible to more people. Whether a person reacts more productively to music, visual arts, drama or a combination of several depends mostly on the individual's interests and history.

This can be particularly important when the clients are in palliative care, in a hospital, or living in a long-term care facility, as those are environments that can feel foreign or even hostile to many. As such, it can be difficult to people in these situations to allow themselves to feel vulnerable in any way. Music can act as a "scapegoat" or an "excuse" for the expression of feelings and emotions, but also as a catalyst for more embodied experiences where emotions are felt and dealt with. Mary, who does a lot of work in hospital, describes it as such:

> *(…) so in the case of someone at the hospital, it's like "I have this whole identity, but now I'm just sick in bed at the hospital and I have to kind of push away my wants and desires, I have to push away my thoughts of feeling whole, and I have to push away the part of me that is really sad that this is happening, the part of me that's angry, because I have to survive." But being in a music moment and that transcendence can make us feel connected to the parts of us, to all the parts of us. And then, so then we can simultaneously be sick in a hospital bed with lots of tubes and beeping noises and procedures and pokes and pain, and we can also feel our feelings.*

This vulnerability that often comes with music and its embodiment also leads to a form of intimacy when the music is performed or appreciated with another person. While the relationships inherent in music therapy will be discussed in greater detail in the next chapter, I think it is important to mention it here, as the presence of another person can be crucial in working out the emotions brought by the music in a constructive way.

> *I find that it's very vulnerable for both parties to be in music therapy. Like, how many times can you say that someone has come to you when you're in bed and sick, and has sung to you, or has done music with you? It already would be super intimate for someone to sing straight to you, as a healthy, able-bodied person, but to then introduce that when someone is sick is just kind of miraculous in its own way, I find. Because it's just so out of the norm of our society, that every time that it works, or I get a yes, or we involve it into the process, to me it's like a mini-miracle almost.* (Helena)

This idea of music as a bypass through cognition, while widespread, is far from a monolith in the discipline. At least one therapist I spoke to, Peter, felt that while the idea was probably true, he didn't identify with it as it failed to bring him useful, quantifiable data with which to help his clients. He did, however, consider music to be a potential shortcut to the body, giving the example of a person with Parkinson's who is able to walk to music, because the music gave him the context to "walk on through it instead of thinking about it."

The embodiment of music as it is understood by most music therapists seems to pertain to a certain mind-body dichotomy. Emotions are often seen as "living in the body" and being more inherently physical than cognitive processes. However, there is some room for nuance. For example:

> *But when the music starts happening and when you're showing up and being very present with your client or their family, it's always so difficult to think about anything else. And that presence keeps you connected with your body and your brain, because – I still feel connected with my brain when I'm present with a person, but it's – I'm not hearing that chatter that you hear sometimes when you're doing your things, you know? Oh, blablabla, you know? (…) So I find that that keeps you grounded between your mind and your body and that chatter that happens. And that analytical side of our brain kind of quiets down. Which happens too in meditation, and that's a really healthy brain state for us to be in (…).* (Helena)

Music therapy here is not described as being an either/or experience, but something that is processed through both the mind and body and allows for a greater degree of understanding between the two. As such, it somewhat breaks down the mind-body dichotomy that underlies many therapeutic endeavours and fits perfectly with our definition of affect, which attempts to break down the unproductive dualism of mind and body as separate entities. This contrasts with more "cognitive" therapies like talk therapy, which want to "translate" physical sensations into "cognitive" language expression. Music therapy embraces the body as an integral part of the therapeutic experience, not least because of music's particular ability to affect through the body.

Entrainment – or, Music as Movement

Broadly speaking, rhythmic entrainment is the synchronization of two external rhythms with one another. These rhythms must interact in some way (such as occurring in physical proximity to one another) and must be oscillating rhythms (that is, rhythms that follow a wave-like shape, such as soundwaves). The concept dates back to the invention of the pendulum clock: Christiaan Huygens noticed that placing two or more of his inventions next to one another would eventually lead to the pendulums synchronizing their swinging motion (Clayton et al. 2005). Subsequent research on this phenomenon has occurred in the realms of physics, mathematics, linguistics, biology and, of course, music. All these disciplines use entrainment to discuss such disparate phenomena as fireflies blinking in synchrony, people adjusting their speech patterns in conversation, and clocks ticking at the same time.

The particular subset of entrainment that interests us is that of biomusical entrainment. It refers to the synchronization of organisms (generally humans) to external rhythms; for example, a heartbeat with a drum, a foot with a beat, a breathing pattern with another. More recent research suggests that there exists a link between rhythmic entrainment and the induction of affect (used here in the psychological sense of "positive" and "negative" affective responses) in humans, due to the ways in which our basal ganglia interacts with rhythmic, musical patterns (Trost et al. 2017). Entrainment is as close to a truly quantitative way I have found to mobilize aesthetic characteristics to a certain affective goal – essentially tuning the body to an external rhythm which can be measured, with clear consequences recorded for its different variations. We know what a fast rhythm will do, and we can therefore choose the correct speed up to the millisecond to achieve a desired therapeutic goal. Because of this the results of entrainment can be easier to predict than with most other music therapy interventions. This lean towards the quantitative and this apparent ease of use could explain why entrainment is so commonly used in music care, the broader healthcare category to which music therapy belongs.

In the music care certification course I attended with Room 217, nearly a full day was dedicated to discussing the various uses of entrainment in music care. Perhaps the best-known use of entrainment with music is the entrainment of the human heartbeat to a musical piece. The general rule of thumb, as it is taught by Room 217, was that the average human heartbeat while resting is at 60 beats per minute (bpm). Songs with a bpm between 50 and 60 will lower this heartrate and promote relaxation and sleep; songs with a bpm between 60 and 125 are best to support everyday activities like washing dishes; and any song over 125 bpm can be used to stimulate a person into intense activity such as exercise. The specifics will vary depending on the individual, but these numbers are taught as useful averages for caregivers who wish to begin using music in their caregiving.

This rule is used to very deliberately manipulate the client's environment in music care: I was taught to make playlists by layering songs with an ever-increasing bpm in order to stimulate and motivate an individual, or to slowly lower the bpm of the songs I played to promote relaxation. I was taught that this gradual shift in bpm is crucial in order not to startle the listener, and also that entrainment is easier when done to a similar rhythm. While it might seem simpler to begin a relaxing playlist with a song at 50 bpm, it will take a normal heartrate some time to slow down to that rhythm, and even more so if the heartrate is already elevated due to anxiety, emotional upheaval or intense activity. By starting with a song whose bpm matches the listener's heartbeat, only to then gradually slow the beat, the transition from normal activity to a relaxed state will be smoother and more effective. In that logic, slowing a person's heartrate can calm anxiety, help with pain management or induce sleep; while heightening it could help promote movement, social engagement, or simply motivate the listener to perform a task.

The importance of "meeting the client where they are" was reiterated to me many times, both in interviews and during my music care training. Importance was given to a therapist's ability to assess their client and to adjust their demeanor and the music that is played to fit the client's current state. Any attempts to modify the client's state – whether it be the energy level in the room or the general mood –

should only be done after this baseline has been set. This was explained to me as a way to gently guide the client's rhythms where the therapist wanted them to go, by first matching the therapist's rhythm, tone and tempo to that of the client's to avoid startling them. This is noteworthy, since biomusical entrainment is generally regarded as being asymmetric – that is, that the human body entrains to the music but not the other way around (Trost et al. 2017). In music therapy, this one-sided entrainment process is complicated by the therapist's efforts to first entrain themselves and the music they play to the already-existing rhythms of their clients. In a way, then, live music *can*, and does, entrain itself to the rhythms of the human body – in so far as it is also played by a human -, rendering entrainment in a music therapy context much more symmetric in nature. When live music is used as part of music therapy, the client is an active participant in the music-making process regardless of whether they play an instrument or not. Entrainment, then, is not only the one-way process of adjusting a person's internal rhythms to a musical beat, but also a multi-pronged process of becoming and creation by multiple people.

The other common use of entrainment is related to breathing. While there's no quantitative equivalent to bpm for breathing patterns, the general rule holds here again: a quick rhythm will cause a person to take faster and shallower breaths, while a slow, gradual beat will encourage the same person to breathe more deeply and deliberately. Unlike heartbeats, breathing is also something that can be pretty quickly ascertained by an observer, and can therefore be adjusted and manipulated more consciously, both by therapists and clients. I was taught that, much like when it comes to heartbeats, slower or more deliberate breathing can be used to help manage pain or calm anxiety, and faster breathing can make exercise easier by providing more oxygen to the body. Breath entrainment to music can be used as part of other breathing exercises or meditation, as well as in conjunction with heartbeat entrainment to maximise its effects.

Even with breath entrainment, it is important in music care to "meet the other person where they are" by first adjusting the music and the rhythm to the person's original breathing pattern. In fact, it's

doubtful that a breathing pattern would entrain itself to a significantly faster or slower breathing pattern if there were no transition period. During the Music Care training we were asked to pair off and test breath entrainment on one another. Both partners would start off by breathing normally; then, one of us would gradually adopt a different breathing pattern, either by quickening or slowing our breaths, or by breathing in irregular bursts. The other would have to determine when this change in breathing pattern occurred, and notice any change in their own breathing. What my partner and I noticed was that when the person adopting a different breathing pattern would do so gradually, the other person would almost certainly match this new breathing pattern and be much slower to realize there had been a transition; whereas if the transition was sudden and too different from their normal breathing pattern, they noticed almost immediately and did not entrain to the new pattern. This suggests that entrainment does not happen automatically upon two rhythms existing simultaneously; if the rhythms are too different or if they fail to interact with one another, entrainment does not occur. This also suggests that consciousness can play a huge part in determining whether or not entrainment occurs: we stopped entraining almost immediately after noticing the change. The same principle could apply to therapeutic encounters: if a change in breathing or beat is too noticeable, it becomes jarring and prevents entrainment from occurring.

And of course, entrainment doesn't only refer to patterns like heartbeats and breathing. Physical entrainment is what causes your foot to tap or your head to sway to a musical beat, often without a conscious decision to do so. This type of entrainment is also mobilised therapeutically, namely in the context of people with mobility issues. Laura shared with me:

> *People with Parkinson's, (…) Parkinson's affects parts of their brain that have to do with coordination and keep a steady gate, and move their bodies, but if they are listening to preferred music at the speed that they need for walking, they can sing along with it, they can play with it, they walk with it in time to the music. Their bodies will coordinate and organize to allow them to walk with more fluidity.*

Parkinson's is often cited here, but the technique is also used with clients who have nerve damage or neurological issues. The idea is that the entire body will re-organize itself to the rhythm of the music, in

order to walk (or sometimes dance) more fluidly than they otherwise could. This is also a form of entrainment, since it involves a body's rhythms – in this case its walking rhythm – synchronizing to an outside meter *while bypassing ordinary nervous processes*. Music in these cases does not repair neurological damage or cure Parkinson's disease, but it does allow people to temporarily circumvent the limitations these things place on their bodies through rhythmic entrainment.

Even clients without specific mobility issues can benefit from movement to music. Dance, for example, can be a powerful catalyst for other clinical goals:

> *And as they progress, another activity I find that really works well is to do movement in music with them, so I may have a couple of student music therapists with me, or an intern working with me, and I would play a waltz, and then the student would actually waltz with the client, and allow them to lead as much as possible, so that again they're being active and not just being like a passive participant. And so a goal area for that, for instance, we're always thinking in terms of goals, would be social contact, making that eye contact, initiating those moves with the other person, because dancing is very social, right? And it's done to the music.* (Rebecca)

The active participation of the client, in itself, can be seen as a therapeutic goal. We will examine this in further detail later, but creation and participation can often have powerful affects on clients, and are among the key processes of music therapy.

Entrainment is not only used to refer to rhythms; the Room 217 organization, who organized my music care training, teaches the idea of mood entrainment, where a person's mood can be "synchronized" to the implied mood of a piece of music. Of course, this relies heavily on the idea that music has a universal mood, which can be understood similarly by all. Music therapists I spoke to agreed that the "mood" or "feeling" of a piece of music is highly context-dependent for the individual. This context is paramount: preferred music, or aesthetically-charged music, is considered much more likely to succeed in influencing a person's mood, or in causing entrainment in general. One therapist, Rebecca, tells me that:

> *It's what motivates us to participate. What allows you to work on non-musical goals, without the resident really focusing on the work that's involved in, say, developing fine motor skills. So, if they*

> *can scratch a drum along to the beat, it's going to be a lot less onerous and it's going to feel a lot less like work if they're doing it to their preferred music.*

This would suggest again that affect is not solely the province of the body, since it cannot be reduced to predictable, mechanical reactions to any music with a given aesthetic characteristic such as a beat. On the contrary, affect is where even the most seemingly predictable and mechanical of all embodied reactions – entrainment, the unconscious adjustment of a human rhythm to an outside beat – can create associations and potentialities.

Embodied Memory

Music therapists often use the embodied properties of music to prompt recall in their clients and bring them to a previous state of mind. This seems particularly common in caring for people with dementia. Since people affected with dementia often have better memories of their youth, playing songs they might have known or connected with as young adults is considered a good way to engage with them musically. This musical engagement can then be channeled into other clinical goals, such as social engagement, the maintenance of motor skills, or creative expression, to name a few possibilities.

> *When I'm connecting, I'm connecting with them through familiar music, and the most intact memories with dementia patients tend to be the early ones, so it's music from their past. There's different reasons for why that happens, and so a lyric might trigger a memory, a title might trigger a memory, but I think mostly it's the melodies, because they often don't remember all the words but the melody is familiar, and it connects them with the time when they were well or when it was all ahead of them at that point and possibilities were endless and there was lots of hope and you know, energy in their lives, lots of positive things, when you meet your wife or your husband, those things that happen early in your lives, generally. So it connects with a healthier time.* (Judie)

This is partly how embodiment is used in the group sessions where I volunteer. Most of the residents participating in the group music sessions live with some degree of dementia, and the songs skew older – I believe the most contemporary piece of music I've ever seen performed there was Johnny Cash's *Ring of Fire*, from 1963. This is because people who participate in the music group are more likely to recognize and respond to those songs - even if they aren't familiar with the songs themselves, they're more likely to

respond to songs that are aesthetically similar to what they remember – so the rhythms of a jazz song from the 1940s can trigger memories even if the song itself is unfamiliar.

While this use of familiar music won't cure dementia or other memory problems, it can be used to connect emotionally and even cognitively with people who may otherwise have difficulty interacting with others. These connections are crucial to combat other mental illnesses such as depression, especially for people who already struggle with isolation.

Memories can also be used to help with language acquisition and re-acquisition. Previous knowledge of a song and the embodiment it triggers can be mobilized to encourage singing and speaking for people with language difficulties.

> *To speak with him the way we're speaking, he's totally capable. But he had a stroke, so he mumbles a lot. He lost a lot of his muscular abilities so he's in a wheelchair, and he has a really hard time opening his mouth. We do music therapy and we sing to try and get him to enunciate his words better. Our visits are very different because he's all ready, he loves it, he has his little music stand, he brought a music book, he has little dividers for different types of songs; like the fast songs together, and the show tunes together. It's almost like a lesson, where I'll say: "What do you want to work on today?" and he'll go "Oh, I really want to do "Oh Susanna"". And then we'll go do that song and we'll look at making sure that his "o"s and "a"s are really big, and that he's projecting from his diaphragm.* (Jessica)

The client mentioned here is working on regaining the ability to speak as he once did. Music is used not only as a motivator – because it is pleasant for him, the task is less onerous – but also because it allows him to tap into his physical memories of singing and speaking in order to regain these abilities.

But similar techniques can also be mixed with non-song stimulus to motivate a patient to participate in a language-therapy activity. For example, Alisa described her use of a phenomenon called "lining out" to help children pronounce certain sounds.

> *Let's say they were on my lap, I'd be rubbing this [a circular rhythmic instrument called a cabasa] on their arm and singing a song. So it could be "The sheep goes up, and the sheep goes down, it says 'Ba! Ba!'" *rolls cabasa on arm rhythmically* So the song gets ingrained in their head. There's something called lining out when you want to sing a song, someone stops at "Mary had a little…". People will always line out and say "lamb!" So children, if they hear that song and it becomes a*

> *familiar one, and I go "ba!", they're then motivated by the physical contact with this instrument, the auditory response, and the sound of the cabasa that's being made on their arm, to want to say "ba!" So if I'm saying "The sheep goes up and the sheep goes down! Ba! Ba!" I'll line out, I'll wait for them to go "ba!". They want to line out, because they want the physical stimulation on their arm, and they want to complete the song. In this case we're working on their "ba", or we're working on consonant sounds, so it's working several things together at the same time.*

The client's memory of the song is mobilized here, along with a natural completion response. The implication is that if the child was not already familiar with the song, they would not feel the desire to complete it by singing the final notes. Further motivators are the sound of an instrument, and physical stimulation from contact with the instrument, two non-vocal types of vibrations.

Music and vibrations serve not only as an affective shortcut to the body as it is (current emotional states, current movement) but also to the body *as it was*. People with dementia are brought back to a time when they were younger and healthy, and "lining out" works because the body remembers previously singing the song in question. We've even discussed earlier the ability of music to allow people with neurological damage to bypass that damage to perform tasks they used to perform without music. Affect is "sticky", as we've established, and its "stickiness" is not limited to physical objects. Since affect is embodied, we can then make a case that affective memories, memories that carry increased potentiality for an individual, are also embodied memories: much like muscle memory, they do not require a person to consciously recall a particular moment in order to resurface through feelings or movements. By recreating parts of the sensory input used to create these memories in the first place (in this case, a sound), clients are able to reconnect with the other facets of these affective memories, even in cases such as dementia, when recall is difficult. For the music therapist, it then becomes possible to leverage these memories towards clinical goals, by leveraging the affect "stuck" to them. The mobilization of previous affect is not fundamentally different from the creation of new affect in a therapeutic sense: both seek to use affective responses to push the client towards specific clinical goals. However, when used to trigger affective memories, music is no longer a tool to connect the client with new feelings and create new associations. Rather, music is able to leverage the intersection of affect and the senses to allow clients to

tap into feelings, memories and movements that they *used to feel* and bring them to the forefront again. By re-creating familiar sensations, music can reach the embodied memories associated with these sensations because of the affect that already exists in relation to these memories. The affect can then lead to movement, emotions, and straightforward recall of events. Once these feelings, movements and memories have been brought forward, it becomes possible to mobilize them towards therapeutic goals – goals which can be as varied as regaining full range of movement, developing a new range of movement, connecting with others, or dealing with past trauma.

When Music Causes Harm

"So if it's good, you acknowledge that it's good and can have actually medical benefits, you have to acknowledge that there could be side-effects also," Judie tells me very seriously after I ask her if there's anything inherently healing about music. I'm surprised to hear that this is one of the first places her mind goes to – after all, she's the first to mention the potential negative side-effects of music therapy. When asked, other music therapists could readily point to cases where music – or at least certain types of musical interventions – were unsuccessful or even harmful to their clients.

Laura disagrees with the assessment that music could be harmful, pointing the finger at the wrongful application of music rather than the music itself. "I mean, even turning on [hard rock group] AC/DC or something, if there is connection and discussion of the lyrics, even the really heavy awful stuff can become a tool for therapy. As long as it's possible to open up some kind of discussion," she says. "(…) If you're working with someone that has high blood pressure, you want something that's going to lower the blood pressure. You don't want to give them hot, angry music, right? Because that will raise it. So it's, you know, what are the goals? What are the conditions the client is presenting? And then we are taught a wide variety of ways to be able to approach." According to her, music is so varied that there is no situation where any music will be inherently harmful. "Whether it's playing a tick-tock [rhythm], or

strumming a guitar with open tuning – so you don't have to put your fingers over here, just feel that vibration, strum, the calming of that. Whether it's listening, whether it's song writing, that helps to support verbal expression. Or working with the voice and (…) 'Aaaah. Aaaaaaah.' Just try that. (…) Letting go. So allowing, it's a relaxation thing, we start with that. It's a use of the voice to help to relax." The breadth of techniques that are considered to be music indicates, to her, that there will always be at least one of these techniques that can be used to further clinical goals for a client.

This raises the question: when and why does music cause harm in a therapy setting? First it is important to define what exactly constitutes harm, or negative consequences, in these cases. To the music therapists, it seems that what constitutes negative consequences or harm is dependent upon the clinical goals established at the beginning of a session. Whether a reaction is positive or negative relies mostly on whether it contributes to clinical goals or runs counter to them. There are situations, such as those that cause physical pain, that can generally be regarded as negative no matter the particularities of the situation, but most "negative" consequences of music and music therapy are seen as such entirely due to context. The same reaction – crying, for example – can be cited as both positive or negative depending on the client's and therapist's clinical goals. If, through crying, the client is able to better understand and come to terms with their trauma, which was the goal of the session, then that intervention was a positive one. However, if the clinical goal was to promote social interaction, for example, the crying was an unproductive experience and would therefore be classified as "negative".

Sometimes the reaction is considered harmful because it leads to physical pain. Judie, who first drew my attention to the potential side-effects of music therapy recalled two clients with which she avoided playing music altogether, because they complained of physical pain. She then went on to say that she had experienced something similar while sick:

> *An interesting thing happened when I was in Montreal. I got sick. I got a flu, and the sound hurt me. I couldn't practice. Like, "I'm going to be home for a couple of days with this, I'm sick, so I'm*

> *gonna play." And physically, the vibration hurt. It was the weirdest thing, everything seemed to vibrate in sync.*

It is unclear why exactly this happened; perhaps an already-taxed nervous system translated any physical stimulus into pain signals, or perhaps these medical conditions caused physical changes that made vibrations pass through the body differently (much like stuffed sinuses can change the sensation of sound traveling through the skull). This sensitivity was such that even the relatively low vibrations of sound caused physical pain. This pain, because it was unpleasant and impeded the therapist and clients' ability to address other clinical goals, was therefore considered harmful.

Other times, the reaction was seen as harmful because it caused emotional reactions that went contrary to the established clinical goals. This came in two broad sub-types: one is when the music being used has specific negative associations for the client, causing them to relive painful memories or emotions, when those emotions are not conducive to the clinical goal. This is where the above example of a client crying when the goal of the session was to promote social interaction would fit in. Another would be when the music causes emotional reactions that might be conducive to clinical goals in a certain context, but the appropriate context isn't present. This can be because the therapist doesn't have the knowledge or training to properly accompany the client on this type of emotional journey, or because there is no therapist present. One situation where therapists seem particularly wary of this is when working with clients who have mental illnesses that can be triggered by music – such as anxiety or PTSD.

A case that was related to me during my music care training was that of an elderly woman participating in an exercise activity. The therapist had decided to use music to motivate the participants, and had thought that using the rousing beat of a march would be appropriate. The woman in question had been a child in Nazi-occupied Eastern Europe. Upon hearing a march used in the political rallies of her youth while being asked to line up against a wall, she began sobbing uncontrollably. It later came out that

the woman suffered from PTSD, and that the music associated with her traumatic memories – along with the group physical activity – had triggered an episode.

> *Music has been used to manipulate, it's used to manipulate our feelings and sometimes in movies, for advertising. Hitler took popular folk songs and changed a few words, or he used them to motivate people to join him, but to twist them up, so there were German people from back then who do not want to hear certain songs that he used. So,you know, that's an individual – you know even with people who were in the occupied countries, these German songs are okay, but it really depends on the individual and what the associations are with the music*,

Laura told me later, in an unrelated conversation. While the therapist who had chosen the march did not mean to cause distress to his client, he had not taken into account the possible associations people could have to the music he selected for his activity. This was compounded by the difficulty of verifying his choices with every member of the group he would be leading, to ensure no one had negative associations with the songs. Even so, it is important not to generalize – as pointed out, not everyone will have the same associations with a particular song, even when they may have been exposed to it in the same circumstances.

This again highlights the importance of aesthetically-charged music. In these cases the term "preferred music" would be inappropriate, since the client generally does not enjoy hearing or producing it, but the aesthetic properties of the music in question are personally significant nonetheless. The major difference is that while these aesthetic properties are *meaningful* to the people involved, they are not *desirable*. Much as music therapists manipulate the aesthetic characteristics of the music they play to create embodied, affective responses that will aid their clients in reaching their clinical goals, they must be careful not to bring about affective responses that could jeopardize the achievement of these goals.

Another situation where music might cause "harmful" emotions is one where music is thought to be the catalyst for a vulnerability that either the client feels unprepared to experience, or the therapist lacks the training to redirect towards clinical goals. Judie recalled a client who refused to listen to her music, preferring to talk with her instead. "He wasn't psychologically intact enough, he felt that music

would push him over the brink or put him out of control. With that person, we talked. We talked a lot. It was interesting. So the therapeutic relationship was still there, but the music was not allowed." Mary, a music therapist, had encountered a similar situation, where she had to stop herself from singing for fear of breaking down without adequate moral and psychological support.

> *One night, I woke up in the night and was full of all this, essentially trauma, (...) and I began to sing to myself just because that's kind of what I do. And as soon as I started to sing, this was like the middle of the night, in [the emergency room], as soon as I began to make vibrations with my voice I could feel all the tears well up and I had to stop, 'cause I was like "Wow, if I keep doing this I'm going to fall apart, and there's nobody here to hold that with me, like, it's not safe to fall apart here." So that was my moment where I realized, okay, hospitals need music, hospitals need people to be with people while music does their thing.*

The therapeutic presence – whether of an actual therapist or simply an empathetic person – is framed here as the deciding factor in whether music is considered "safe". The first therapist was able to create a therapeutic relationship and help her client despite being unable to use music. To do this, she had to mobilize her non-musical therapeutic skills. The second therapist felt that experiencing her emotions alone was "not safe" because she had no other person to serve as emotional support, and relates this anecdote as the moment she decided to work in hospital, in order to be that necessary emotional support for others. These examples also use a fairly generic definition of music – the first client felt that any music could be emotionally harmful to him, while the second therapist reports that the "vibrations" of her voice were enough to be the catalyst for her emotions. This leads me to believe that the aesthetic characteristics of the music are more important in bringing about specific emotions, but that the inherent vibrational qualities of music are sufficient to create emotional vulnerability. The musical vibrations would be enough to increase the affective potentiality of emotion, while the aesthetic characteristics of the music would be the thing shaping what kind of emotions are felt. Instead of emotional vulnerability, it might be more appropriate to speak of *emotional potentiality*.

Because music is so powerful in influencing emotions, it seems only natural that some of these emotions be considered more undesirable than others. While there are no emotions in particular that

were cited to me as being *always* undesirable, causing undue distress or pain to the client was seen as a negative, and progressing towards the clinical goals was always the objective. Still, there does not seem to be any inherent difference between positive and negative consequences to interventions, outside of their relation to clinical goals. Virtually any emotion can be considered simultaneously positive and negative, beneficial and harmful. If music can heal, it stands to reason that it can also harm.

I believe that this ability to harm stems from much the same particularities that allow music to bypass cognition and become embodied. The musical vibrations, when interacting with an already over-sensitive body, are able to cause physical pain. Similarly, musical vibrations seem enough to open up an emotional vulnerability that can be beneficial when paired with the willingness to address emotional issues, clinical goals and an understanding of how to achieve them; but can just as easily lead to uncomfortable or distressing emotions when such knowledge or support is lacking. There were very few differences between the ways in which affective reactions, both "positive" or "neutral" affects of music, and these "negative" examples of emotional vulnerability, were described in interviews. The reactions to music where involuntary, physical, and deeply personal. As with other uses of music for therapy, the aesthetic properties of the music being played, while not directly responsible for the emotional vulnerability, were important in dictating what kind of affect was being felt.

The ability of music to cause harm hints at another side of the manipulation of affect: that even with skilled musicians and therapists, it is not always possible to mobilize the desired affective reaction in a client. There does seem to be a certain uncontrollable, or at least unpredictable, dimension to affect mobilization. By its very nature, this uncontrollable dimension to affect makes any systematic application of affect for therapeutic purposes imperfect, because it has the potential to divert even the most carefully planned of interventions into an undesirable, or at least unproductive, direction. Musical vibrations open us up to a level of emotional potentiality with no certain outcome, and there is no fail-proof recipe for guiding that potentiality towards clinical goals.

Ultimately, music seems able to cause harm for the same reasons it can help with wellness: because it affects us through our bodies, is able to bypass our cognitive barriers, and helps us access more vulnerable or remote states of being. By opening up an emotional potentiality through affect, it allows therapists to guide a client's emotional responses towards their clinical goals, but these attempts sometimes fail in bringing about the desired result. In order to more systematically and accurately achieve their goals, music therapists often have to go beyond simply using music, and must also leverage the relationships at play.

Chapter 2 – Tuning the Relationship

Music therapists essentially manufacture affective reactions using music, to work towards therapeutic goals. Music, because it is embodied, is an excellent medium for promoting affect and emotional potentiality. This manipulation of affect isn't done in a vacuum, however – it occurs in a very specific context reliant upon the relationships between the client, the therapist, and other therapeutic forces. On its own, music's affect is often too difficult to predict to be of any use in a therapeutic setting. In this chapter I would like to explore the various types of relationships at play, and how they contribute to the process and results of music therapy.

In psychology, attunement is the concept that describes a person's responsiveness to another person's needs and moods. The same concept is used by therapists trying to attune themselves to the needs and moods of their clients. Research shows that even the smallest gestures of both therapist and client can influence rapport, stress, and affective quality and intensity (Davis and Hadiks 1994), and that attunement, while nearly impossible to measure quantitively, is strongly correlated with the success of a treatment (*ibid*). Here I will argue that music is a powerful way to find attunement in a therapeutic context, by becoming the medium through which relationships are built, accessed and mobilised in music therapy.

While originally a musical metaphor, attunement as it is used in psychology is not particularly linked to music. However, the tuning metaphor is apt for what is happening within the therapeutic rapport in music therapy; as it is in part through music, very literal *tunes* and *tuning*, that the therapeutic relationships are worked out.

Creating a Rapport

Therapists were quick to point out the importance of the therapist-client rapport when discussing the efficacy of music therapy. Some even identified the creation of such a rapport as the most important part of the therapeutic process, above and beyond music itself:

> *In the definition of therapy is the therapeutic relationship, the skills and the connection between the therapist and the client. There have been studies that have been done, and it shows that connection is the clearest predictor of a positive outcome. It doesn't necessarily matter what techniques you use, what model you use, it doesn't matter. But if there is a good, supportive connection that happens in that therapeutic relationship, that is the biggest predictor [of success].* (Laura)

> *La musicalité c'est comme un moyen de transport. Ça facilite l'interaction entre deux personnes. Cette interaction-là est nécessaire pour s'épanouir dans la vie. L'être humain veut être en relation avec d'autres êtres humains. Donc, est ce que c'est la musicalité qui va favoriser le bien-être? Non. C'est le résultat de la musicalité qui peut favoriser le bien-être.* (Maude)

According to music therapists, it is through the therapeutic relationship that the affect of music can be shared and experienced. Without this therapeutic relationship, there can be no therapy – or if there is, as Judie put it, "it's accidental (…) it can happen, but it's not necessarily what you're going in there to try and do." While music can become embodied and cause powerful experiences, this does not provide enough of a structure to reach clinical goals save by complete accident. In order to consistently work towards specific clinical goals, therapists must therefore work within the framework of a personal relationship, where music is the medium through which therapist and client communicate rather than a force for wellness in and of itself. Through these relationships, therapists are able to channel and control affect to a degree great enough to manipulate it towards their goals.

Because therapists' jobs involve working towards clinical goals with their clients, and this rapport is considered critical in being able to work with the client, many of them have developed techniques to quickly or effectively develop a rapport in circumstances that may be less than ideal: for example, limited time with a client or meeting that client in a moment of distress. Some of these techniques pertain to the initial approach of the client, how the therapist presents themselves and initiates the session. Therapists who work in hospitals or long-term care facilities, where clients are not always the ones requesting music therapy, reported being conscious of how they present themselves when first approaching a client. The goal of the initial approach seems to be to make the client (or rather, potential client in many of these cases) comfortable with the therapist's presence, and willing to continue interacting musically with the

therapist. For this purpose, therapists often must explain what they do, what services they can offer, and how this could benefit the client, all in a way that is clear but also not intimidating or alienating to the client. In other words, they must attune themselves to the client as quickly as possible. This can be complicated by certain medical conditions such as dementia, which is common in people living in long-term care facilities, and which can affect the client's memory and awareness of their own abilities. The therapists I interviewed who work with clients who have dementia all mentioned having to (at least occasionally) disguise their sessions as social visits in order to approach the client without alienating them.

> *One of the main symptoms of people with dementia and Alzheimer's is that [according to them] they don't have dementia. So I don't really get referrals. I'll often get an email from my supervisor being like "Hey, we've got this new client, they have a background in music, can you go visit them, see how they receive what you do?" I have to be kind of sneaky and I'll go have a visit with them. I have so many just, absurd little catchphrases like "Oh my gosh! There's a guitar! Right in this closet! What do you think of that?" But that's what I have to do, because if they know what I am, I don't want them to suddenly have their back up and "Oh, I don't need therapy, what are you talking about, there's nothing wrong!" So I usually just have a very laid-back social visit with them to see if they're interested in music. Depending on how that goes, we do some singing, it's kind of like a sing-along, and I talk about what I do (…). I don't usually say that I'm a therapist but I usually say like "I'm on staff here, these are the kind of visits that I provide, is that something that you'd like to do again?" and they'll either say yes or no. From there I can go on to properly assess what their music abilities are, how social they are, what their quality of speaking is, how mobile they are, what their motor skills are like, all that. So it's a very long, drawn-out assessment, because it can take a few visits.* (Jessica)

Working with patients who have memory problems caused by dementia can also be a challenge if the clinical goals pursued by the therapist and the client's family require several sessions.

> *People who are experiencing dementia, they won't remember my name. I always have my nametag right here in the front (…) and then I have my hospital tag below it, but it's quite a big nametag, so people can read it at a distance to find out who I am. But my name is less important than the music, so I'll often have my guitar on my back, or I'll walk into a room with my mandolin in front of me so they'll also get that cue and they'll go "Hm, I don't remember what happened last time she was here but I think it was good." Right? So they're able to build memories on how you made them feel. We use that to build rapport. Hopefully it will be a positive encounter, and if things are starting to shift in a session I try to redirect carefully. And if that's all they can take today as far as social engagement then I will be quick to say, "Goodbye and see you next time!"* (Judie)

The initial meeting between a therapist and a client is crucial even in situations where the client does not have dementia. Many therapists discussed more general techniques they'd developed when first meeting clients, in order to create a welcoming and safe environment. These techniques rely heavily on a quick assessment of the client and their needs. This assessment can be done by gathering information about the client from a third party such as a medical chart or family member, or by conversing with the client about their needs, wants and abilities. Another method of assessment that was described was through non-verbal cues such as objects found in the client's room (if the encounter is taking place in a hospital or long-term care facility), the client's demeanour, the presence or absence of other people and the client's response to them, etc. Through these quick assessments, therapists are able to attune their own demeanour, means of communication and musical input to what they think would suit the client best. For example, a client with mobility issues might be more comfortable playing an instrument that doesn't require fine motor skills, like a drum; a client who appears nervous might want to wait for the second session before playing music themselves.

> *But I do think therapists need to be very aware of who they are, how they communicate and how they come across, because we need to shift that based on who our client is. Working with a diverse population of kids, palliative care, seniors, infants, I really have to shift my energy based on my client's energy. I think rapport can be established – or, rapport can be more quickly established or more deeply established by being aware of how you're communicating. It's also part of the assessment. Because if I've developed this physical rapport, and expressive and communicative rapport with my client, but then musically I'm choosing the wrong interventions, stretching them to do things like vocal psychotherapy which is way out of their comfort zone, or I'm sticking to only improv and they really would like to delve deeper with either song writing or vocal psychotherapy, then that might disconnect our rapport. So I think that part of the assessment as well is being able to figure out the musical experience that is needed in this therapy.* (Alisa)

However, all therapists I spoke with agreed that a rapport between a therapist and client cannot be reduced simply to a series of well-executed techniques and accurate assessments. They pointed out the importance of "fit" – whether a client and therapist are able to develop a pleasant, beneficial rapport regardless of their efforts to do so. Once again, there is an unpredictable and uncontrollable aspect to affect that must be considered when trying to mobilize it for therapy.

> *One of the things that therapists are trained to do is, they're trained in assessment. And that's – yeah - our ability to assess a client – what can I say about this? Yeah, our assessment ability is part of creating a good relationship with the client and sort of reading what they want, knowing what approach to take, and – but in some cases it's just, it's not a fit and that's fine. Like, it's that way with any therapist. We're always taught, go out there and search until you find a therapist that you click with.* (Mary)

There seems to be an unexplained element to the creation of a therapeutic rapport, based on the personalities, interests and dispositions of the people involved. It's not clear what makes a client and therapist "click" together, or what specifically goes into finding a good fit. It could best be described, perhaps, as personal chemistry between the therapist and client – something that is difficult to manufacture purposefully if there is not the basis for it. This means that it is not always possible for a therapist to develop a good working rapport with each client. In these cases, several therapists told me that the best thing to do was for the client to look for another therapist altogether rather than continue trying to establish a rapport with their current one. It seems that the therapeutic rapport – this type of affect created by the interactions of therapists with their clients, musical or otherwise – while it can be encouraged through careful assessment and adjustments on the part of the therapist, cannot be forced. The reality is that it is not always possible for two individuals to become attuned to one another.

Shared Experiences

The previous chapter explored the various ways in which music can become embodied, and how this embodiment is lived and used in music therapy. However, these musical experiences are not necessarily limited to a single person, especially in cases where music is being performed live. In fact, music is often used to promote feelings of togetherness or to create an impression of shared experience among groups; it is literally used to *tune* people together through their vibrations, *attune* them to one another's mood – a form of group entrainment. This is the case with concerts, political rallies, religious celebrations, parties, and numerous other types of gatherings where music is played.

This same principle – that music is a means of creating group affect – applies to most music therapy sessions. However, because of the specific nature of the therapeutic relationship, these shared experiences are not entirely comparable to experiences between peers. Therapists told me that while they promoted a meditative or "transportive" state for their clients, they themselves had to remain mindful of their surroundings at all times. This was both because they had to remain concentrated on the task of creating the best possible musical environment for their clients, but also because they felt it was their responsibility to intervene if the situation called for it. Mary described it as such:

> *We need to keep one foot on the shore – and like, go into the pond, but don't go swimming. We need to stay half on the solid ground and half in the water. So absolutely, the music is totally transportive, I think there would be a problem if it wasn't. We're all people, (…) It doesn't matter if I'm a therapist or a client, this stuff works because there's a personal and human connection at the center of it.*

Rebecca shared an anecdote where her music therapy group was so engrossed in the music and transported by the experience that they failed to notice a fire alarm go off in the building (this was a scheduled drill of which the therapist was aware in advance, so in this case she did not end the session. However, she noted that had this not been a drill, it would have been her responsibility to notify her clients and end the session.)

> *I had a situation where I was doing a group improv with a women's group, (…) And there was an alarm going off in the building, but we were in a group improv and nobody noticed except myself. They were so totally immersed in the music, and then afterwards I asked "Did anybody hear that? Did anybody notice that?" and they were like "No, we were so focused on this beauty that we were creating, this music that we were creating", they kind of laughed at themselves. "Gosh, we didn't even notice that!" So that for me is a big indication of someone being fully immersed in the experience.*

It could be argued, then, that in order to be best attuned to a client's *needs*, a therapist cannot be fully attuned to the client's *mood*. Because it is the therapist's responsibility to remain mindful of possible hazards in the environment and to consciously direct the session towards clinical goals, they cannot allow themselves to become fully attuned to their clients' state of mind and become transported with their client.

Even though the experiences in question are focused on the clients, they remain a shared experience with the therapist, who keeps a close eye on the proceedings and makes adjustments for the sake of attunement if necessary. These adjustments can be as minor as mirroring what a client is playing (playing the same notes or rhythms back to them, to support their musical expression), or as major as introducing new musical elements that fundamentally change the tone of the session. However, just because the therapist reports being more grounded than the client during the session does not mean that they are not affected by these shared experiences. Many therapists told me they often felt satisfaction or joy while connecting with their clients through music, but that they tried to limit their own expression of these emotions in favour of allowing the client the space he or she needs to have their own experience.

> *Doing music therapy, it's important for me to benefit from it and get something out of it but the focus is the client. It has to be on the client to have a transportive experience, to feel deeply changed, and it's very satisfying and joyous to have a connective experience with a client. But it's not for my end solely, it needs to be for the client's end.* (Mary)

These experiences can also be emotionally difficult for the therapist, who carries a burden of care for their clients. As most of my research centered around speaking with therapists, their perspective is the one that was naturally brought up the most; and one thing that came up several times when discussing therapist-client rapport was the often difficult or exhausting care work put in on the part of the therapists. Especially in palliative care, or when working with client populations where mortality is high (such as the elderly), the relationships formed between client and therapist mean that therapists can struggle with grief as part of their work.

The therapist I am quoting here, Jessica, works in a long-term care facility, mostly with elderly clients with dementia. In cases where clients have certain illnesses that affect their memory and perception like dementia, the therapeutic relationship can vary from the typical professional distance expected of them.

> *I'm working with people till the end of their life. So I lose a lot of clients. And it's hard, because you build relationships with them and I think in most healthcare areas they teach you that you're not really supposed to be their friend, but when it comes down to end-of-life, that's what you are ultimately. I think the client-therapist sort of relationship that we were taught in textbooks, doesn't really work quite the same because a lot of the time the client would never be able to consent to the therapy that they're receiving. It's this very grey sort of thing. So I think to some, I see them as a client but I'm sure they see me as their pal with the guitar that happens to be in the hallway sometimes.*

Judie, yet another therapist who works mostly with an elderly population notes client deaths as being a particularly emotionally difficult part of her work, notably the actual experience of staying at the client's bedside.

> *Some days it's really sad to do this work. I do palliative music therapy, so people are dying because they're at the end of their life. And part of what my work is, is finding ways to be able to have a bedside experience that's meaningful for families, to interact with their loved one through music. A lot of that palliative stuff can be transformative. And it isn't always transformative, but it is in those times when someone who hasn't responded to anything, (…) and the family is gathered around the bedside, and they say "Yes, come in, because I know you know him." And so, I bring my guitar, we sing a familiar song, and the person that's lying there in their last hours, responds – squeezes the hand, or makes eye contact, or has a smile. (…) And sometimes I'm not playing, I'm holding a hand and I'm singing. And when those sessions are really challenging it takes it out of me.*

Conversely, the instances when clients respond positively to the therapist's presence or to the music are often cited as a powerful counterpoint to the more difficult emotional experiences of dealing with client deaths or experiencing a client's trauma or grief during a session.

As mentioned above, most therapists were clear that they needed to remain grounded during music therapy sessions, and avoid fully experiencing the music alongside their clients, in order to be able to provide the client with the support and structure necessary for them to have the best possible musical experience. This need to remain grounded can prevent the therapists from openly expressing their own feelings during the therapy session, as doing so might interfere with the client's expression. This remains true when the musical experience being shared deals with "negative" emotions such as grief, sadness or trauma. Therapists can become highly affected by the emotions and expressions of their clients but must not allow themselves to fully express this affect for fear of interfering with the needs of the client.

However, for the therapist to display no emotion whatsoever is not desirable either, as in order to develop a rapport with their clients they must be approachable and friendly. There seems to be an unofficial limit to just how much a therapist can express during a music therapy session – and a few therapists mentioned needing to take some time outside of their sessions to express the emotions they didn't feel appropriate the express with their clients.

> *Yesterday I was actually talking with someone about where the limit is, and I said "Let's say everyone in the room is crying from the music, and that's great, and I think there's a lot of value to get for a therapist being teary, but maybe not falling apart." Some equivalent of getting teary or getting that catch in your voice, when you're showing that you're – and you're genuinely expressing emotion but you're not at the point where you're having the deep catharsis. Like – and that can happen but maybe sometimes it happens after. I've had sessions where I've left to go somewhere and just weep. But that needs to happen after the fact.* (Mary)

This means that the therapeutic rapport is inherently unequal. It relies on one party – the therapist – to unconditionally support the expression of another party – the client – to the detriment of their own ability to express themselves within the relationship. This could be argued to limit the true potentiality of affect by constraining the relationships through which affect is generated into a strict therapeutic framework, attempting to codify these encounters into a mechanistic process. However, the therapists I spoke to did not seem to think this codification made their relationships with their clients any less fulfilling or genuine. In fact, when asked what their favourite part of the job was, most pointed to the experience of shared catharsis with a client. The fact that this catharsis was, by their own reckoning, neither as deep or as transformative as it was for their client did not seem to lessen the impact of the experience.

> *It's very subtle visual cues that I get from their face, and just knowing how to read people at various stages of consciousness. Sometimes it's also if they start talking about their experience after, you can tell that they went somewhere. Or they'll say how much it touched them or moved them. It's a combination of eyes closed, touched and moved them, that I know that they were probably taken somewhere else outside of the four walls of their room. (…) It grounds me, and it reminds me of why I do what I do. So it's very meaningful and useful for me as a professional also. I think it just reminds me of the beauty and the aestheticism of the work that I do. It grounds me into my humanness.* (Helena)

While the therapeutic relationship in music therapy relies on shared experiences between therapist and client, therapists feel that these experiences are not felt identically by both participants. Because the therapeutic encounter is attuned to the needs and the expression of the client, the therapists must ground their experiences and temper their emotional expression during the session itself. The affective process of *becoming* is therefore asymmetric, as one party attempts to consciously change themselves to suit the other, but not the other way around. However, these shared experiences and the rapport through which they take place still carry meaning and importance for the music therapists. The question still remains of how, exactly, the therapists and clients go about creating these shared affective experiences through music.

Musical Conversations

The term that came up the most in my interviews to describe the interactions between a therapist and client during a music therapy session was that of "conversation." These conversations can be verbal or non-verbal, musical or not. Even when the client is not playing music, the therapist is reacting to their presence and their actions and modifying their own music in response to those factors.

> *I would probably say at this point in my practice, there are three conversations that are happening simultaneously. The musical conversation, the client-therapist relationship conversation, and the conversation inside my own head. The conversation happening between me and my client can be verbal or non-verbal, and that can be the signals that I'm seeing in their body language, or in their eye contact, or in what they're saying. Then there's the other conversation happening, the musical piece, whether we're improvising, or songwriting, or doing vocal psychotherapy. There's that second conversation. I'm paying attention to what they're playing, or what they're singing, or how they're responding to what I'm singing or what I'm playing. And then the third conversation is the conversation happening inside my own head to make sure that, as a professional, I'm aware of what's going on and I'm doing my best to achieve the goals that my client would like to see achieved.* (Alisa)

The musical environment – and indeed, the therapeutic environment as a whole – is created through the interactions between the therapist and the client. Through these conversations, people are able to "become" something different from themselves, an amalgamation of which they would not be

capable on their own. The stated therapeutic goal of this amalgamation, this conversation, is to create an environment where the client feels comfortable enough in reconnecting with their bodies and expressing themselves to be open to the changes outlined in the clinical goals. The crux of the therapy is that in order for the client to reach that point and "become" the person they want to be by pursuing the therapy – a person with less anxiety, or better coping mechanisms, or better mobility - client and therapist must first "become" together through their conversations, musical or otherwise. This is an example of the kind of "becoming" process that Deleuze and Guattari describe in their work on affect: namely, it is an interaction where the therapist, the client, and the music they create are all fundamentally affecting one another to become a hybrid being, a kind of client-music-therapist, which does not completely disappear once the session is over.

The therapist is usually the one to initiate and structure the musical conversation, since they are generally the more musically experienced party. This is perhaps clearest during bouts of musical improvisation, where both therapist and client are playing music without a pre-established arrangement. As with the other aspects of establishing a rapport, it's important for the therapist to keep in mind the client's comfort level and needs, and to try not to alienate the client. However, unlike the initial assessment of the client, the therapist should attempt to push the client outside their comfort zone a little in order to reach the point where change is possible. This can be a delicate balance to strike.

> *I'll start really gentle, super neutral. (…) Just a really grounding rhythm at first, just to see what it's like, to see what music is like in the space. (…) Ideally, I just respond in the music by doing a combination of just plain music that might, maybe, go into some of those uncomfortable emotional places, but also doing that combination of going to those places and then grounding, going to those dark places and then grounding. And I'll only do that also if that's what the tone of the initial interview felt like. If it was like "Yeah, clearly there's stuff sitting right below the surface, like deep existential stuff" – which frankly most people in hospital have, all of us have, but in hospital it kind of brings it out, (…) That's the main content of what happens in the music and how we have that therapeutic conversation. And then at the end, we'll probably talk about it. Sometimes a patient doesn't want to talk, they're like "Yeah, *sigh*" and it's like something changed, just happened. Maybe it's small, maybe it's big, maybe it gave them something to get through the rest of their week, or the rest of their morning, who knows.* (Mary)

Much like the building of the rapport itself, there are general techniques that music therapists will use to promote the creation of a suitable musical environment. One that was mentioned to me several times was mirroring (repeating what a client has played to make them feel supported in their expression); another was grounding, bringing the music back to something familiar and regular to help the client stay comfortable. However, these techniques are not sufficient to explain the synergy that can occur between participants in a music therapy session. Helena described the way she could connect with her clients through music as "the mysterious part" of music therapy, and Laura struggled to explain how she and her clients could reach a point where their various musical styles would combine into a cohesive sound:

> *Last spring I had a group of women. I was introducing them to the concept of the rhythm instruments as a way to tap into and express themselves. We'd play together. In the middle of it there are times when the rhythms would really get going and it really becomes a unified sound piece. And it's all improvisational, so these people are tuned into each other, connected. Part of our job is to find ways of connecting, trying to get the other person out of just their own feelings. We find ways that they can connect [with something else] as part of the art.*

Both related the experience to the connections formed through the music. Once again, the emphasis was put not on the music but on the relationships and connections being formed between therapist and clients through the music. I posit that this "mysterious part" of music therapy is nothing more than a shared affect, and attunement constructed together by music therapist and client in ways that can be difficult to express in words.

These musical conversations were described to me as almost always being complemented by non-musical conversations either before or after the music, to ensure that the therapist and client are both aware of the progress that is being made and the "success" of the session relative to the clinical goals established. The non-verbal affect is not considered enough to maintain the sort of long-term rapport necessary for attaining long-term clinical goals. Even in the case of short-term goals, the "becoming together" of non-verbal affect can carry ambiguities with it, that are more easily dispelled through verbal

communication. Client self-reporting after the fact was consistently one of the main ways in which therapists said they evaluated the success of their therapy.

Like any conversation, the musical conversation involves the bringing together of two or more individuals with their own personalities and modes of expression. The majority of therapists are very aware of the musical sensibilities that they bring into the session. Mary even notes that she will often default to "[her] Sarah McLaughlin power ballad chords" when pressed for time with a client, because "stuff is cheesy because it's good. Like, there's a reason why stuff gets used a lot." By using a musical shortcut that she is familiar with and that is culturally intelligible to the client (one would be hard-pressed to find someone in the Western world not familiar with power ballads in some form), it is believed that she is able to quickly create a fairly neutral and effective musical structure on which to build a more complex conversation.

Using such musical shortcuts is also a way for therapists to react quickly to changes in the room when playing music with or for a client, without having to think too deeply about what they are playing. These shortcuts are familiar for the therapist and fit with their own musical sensibilities – not only are they therefore more instinctual and easy to access, but they also allow the therapists to inject part of their own personality and sensibility into the conversation. This means that, far from being a neutral therapeutic presence, the therapist is an active creator of affect – and that, rather than being a general affect of non-specific potentiality, the affect that is manufactured during music therapy sessions is specific to the therapist, their training, their sensibilities and the circumstances they find themselves in.

> *Like with anything, you practice technique. But when you're actually doing it, you can't think about it too hard. When I'm in the moment in a session, I'll kind of read the room and feel when non-verbal shifts happen. So that's a bit of a practice I think that I've developed: just based on the whole picture, the conversation we've had, the whole picture of the client, where does the music make sense to go? I'm not always going to get it right, I don't even know if there is a right or wrong. Therapy is a conversation, therapy is a relationship. It's fallible, because humans are fallible. (…) it's intuitive but it's a trained intuition.* (Mary)

This “trained intuition” seems to be the best way to explain the mixture of indescribable affect and careful thought that therapists must exhibit in their conversations, especially their musical conversations, with their clients in order to properly attune themselves to their clients needs. Because I am missing the client perspective I cannot say whether a similar intuition – though likely an untrained one – can be felt on the part of the client during these musical conversations, but it seems likely. However, because this trained intuition is by definition unique to each therapist’s experiences, this means that one of the music therapist’s most effective therapeutic tools – their ability to adapt their music to the needs of their clients – is also a display of the therapist’s creativity and musical agency within the therapeutic relationship. The therapist, far from being an impersonal, neutral therapeutic presence there only to further the client’s clinical goals, is in reality a creator and feeler of affect within the relationship they share with their clients.

Networks in Music

And of course, the relationships that are important in music therapy are not limited to the one between the therapist and client. The family and friends of the clients can also be important contributors to the goals of music therapy, and to the relationships developed through its music. Some music therapy projects depend on the participation of the client’s social circle, while others are made especially for the client to share with their friends and family. One example of such a project that was described to me:

> *One of my clients had Parkinson’s. Her facial affect as well with her personality seemed to relay to the staff that she was usually grumpy or irritable, or more particular and picky than she actually was. And (…) her reputation didn’t actually coincide with who she was. We did some songwriting as part of this recorded project that the facility was doing, and part of it was spoken word. She came up with three areas where she would speak about people; two were staff members and one was a friend from the facility. It was all beautiful and positive and how she looked forward to seeing them and how a smile came across her face, and then she would also sing. (…) But the thing that I really loved was when I played the recording with her in the room for the staff members, and you could see the joy that it brought to them. I think that was really long-lasting, because they were able to hear how much she actually positively viewed them. That really helped their relationship moving forward at the facility. They were able to appreciate her more deeply and also understand that when she might look like she’s having a negative feeling, that was just her Parkinson’s, that’s not how she’s actually feeling.* (Alisa)

In this case, not only did music therapy help the client express her feelings, it also led to changes in her social support network. Through music, she was able to express and share emotions that were difficult to make understood to others because of her illness. This particular music therapy project therefore did not only affect the client and therapist that had participated in it, but a wider circle of people around the client who were then able to see and appreciate this person differently. Through music, and music therapy, the client was able to deeply change her interactions with the people in her social network.

Friends and family of the clients can also be invited to participate in the musical conversations during the sessions themselves. This is only done if the friend or family member in question is either already present in the room, or if the client expresses the desire to involve them in the process. By participating in the session, the friend or family member can also receive the benefits of the music therapy, though they are not the primary focus of the session.

> *If there's someone in the room, I'll offer for the patient if they can play an instrument, because ideally it's great for us to interact, there always has to be an interaction, and the most easiest way, the most obvious way to do that is when I client is playing an instrument too. (…) I'll give that, I'll give that to clients if they consent to it, or maybe their caregiver, often the loved one, the spouse, the daughter, the husband, the mother, whoever, is there – is usually feeling pretty high-stress and pretty helpless, because there's not a whole lot you can do when you're there. And so I'm like "Why don't we play this? We'll make so-and-so feel better!" But really I'm just trying to care for the caregiver *laughs* And we'll start playing music.* (Mary)

In cases where the client is in hospital or in another context where they are being cared for by a friend or family member, this participation in the music-making is considered to be beneficial to the caregiver as well, as it gives them a sense of purpose in helping the client. It also allows them to participate in the same expression and embodiment that the music provides to the client, and experience a similar catharsis. Not only that, but as illustrated above, it can also result in the permanent modification of the relationships between the caregivers and the client. Some music therapists even mentioned that their rapport with family members of their client was a good indicator of the success of their rapport with the client themselves:

> *Sometimes too they'll meet me in the hallways, or I'll notice that in the hallways family members will smile and wave at me. Then I know that we've created a therapeutic rapport where they feel secure enough to address me in public. So that's also a cue that something happened in the session that they associate with good, or meaning.* (Helena)

Community music therapy is a facet of the discipline that also involves quite a bit of network-building. In these cases the therapy involves a rapport and conversations not only between the therapist and one client, but between several clients participating in the same session as well. A few therapists told me they greatly enjoyed community music therapy for its ability to bring peers together in pursuit of a common goal – especially in long-term care facilities, where community-building is considered important and isolation is a constant concern:

> *Once you give advice or seek advice from someone who's a peer, I think that helps achieve a sense of their individuality again, because their individuality is constantly being lost, either because of their poor memory or because they're in a facility, but to have those points of connection throughout their day or throughout their week really highlights their capacity and their sense of self.* (Alisa)

The help of peers and the connections with people outside the therapeutic relationship are seen here as beneficial for the client. Because peers are not bound by the limitations of an unequal therapeutic relationship, they are able to provide a different kind of support than what a therapist can. Peers are able to share their emotions openly, and provide support in contexts where it might be considered inappropriate for a therapist to do so. Unlike a therapist, they are also able to attune themselves to the needs *and* mood of the other person. Music, and music therapy, is used here as a tool to help people connect with their peers and build social support networks outside of the therapy space that can help them achieve their clinical goals.

Another use of musical networking occurs in palliative care, with the creation of legacy projects. These types of projects draw just as much from the musical memories of the client as from those of the client's family, friends and loved ones. Examples of legacy projects that I was given were recordings of the client singing a favourite song or lullaby, writing and composing a song addressed to the client's family

and friends, or making a playlist of songs that reminds the client of important times in their lives. All these projects had the ultimate goal of being shared with family and friends. Through music, the clients are able to extend their relationships with members of their social circle even after their death. This is important for the clients, who can use music to communicate memories and ideas to their loved ones that they may not have the words or inclination to share otherwise; but it can also be very important for the family members and friends who receive the final music project to have these kinds of musical mementos to aid in the grieving process.

Far from only encouraging the creation of relationships between therapist and client, music and music therapy can be used to foster wider social networks outside of the simple therapeutic relationship. These relationships, though not "therapeutic relationships" as defined by the presence of a therapist, can be therapeutic in nature for the client and for their greater support network. This is because music therapy - and the affect it can create - allows the communication of ideas and feelings through music, the emotional catharsis of caregivers, the creation of new supportive relationships, and the extension of existing relationships past death. All these things can be and are important factors in attaining a variety of clinical goals for the client, including fighting social isolation, communicating with loved ones, and dealing with grief.

Aesthetic Relationships

I would be remiss to discuss relationships in music therapy without mentioning the relationships that can form between people and the music itself. This can come in two forms: what I call relationships with songs, and relationships with sounds. Relationships with songs refer to the ways in which particular songs can become objects of affect and meaning. Relationships with sounds, on the other hand, has more to do with the ways in which people form relationships to instruments, timbres, rhythms and genres.

Much like people form complex support networks of friends, families and caregivers, they also form complex networks of musical relationships based on memories, experiences, and affective potential.

One thing that was repeated to me several times by many different therapists is the distinction they draw between aesthetics as simply beauty, and aesthetics as a need. One therapist, Antoine, said that in his experience, banging on a drum could be as aesthetic for his clients as more traditionally beautiful music, because the banging of the drum could let them express pent-up energy; it is aesthetically pleasing because it is what the client needs in that moment, regardless of the aesthetic value an outside observer would place on it. This distinction between what is aesthetically beautiful and what is aesthetically needed extends to the therapists' musical offerings as well. While many therapists highlighted the importance of having musical skills in their practice, most then went on to specify that their skills were not most important because they allowed them to produce beautiful music, but because they allowed them to identify and play music that would be aesthetically charged for their clients.

> *Don't get me wrong, I think it's very important for anyone who's a music therapist to be a good singer and a good player, and be very well practiced in that skill. It's a fine art. But I don't think it's really about beautiful sound, I think it's more about finding that connection with the resident. If you can sound nice and your residents are going "Wow you have a beautiful voice", that's icing on the cake. Because it's really about finding a song that their childhood friend used to sing around the house when they were 6 years old, and it's amazing when they remember that and they get all excited and they tell you. So I think that's the importance of aesthetics in the music, rather than the beauty of the actual song.* (Jessica)

Similarly, all therapists I spoke to emphasised that the music they play with their clients may not always be considered beautiful by an outside observer, but that this was not their goal. After all, most clients who pursue music therapy are not professional musicians, and some have no musical background at all. Even for the music therapists, who have the kind of musical background that would allow them to pursue a socially-dictated aesthetic perfection, the goal was to perform in a way that allowed their client to connect with themselves, the therapist, and the music itself. This does imply a certain level of musical skill, but the

importance is on whether those skills are sufficient to engage with the client, not whether they are technically perfect.

> *In music therapy, the offering is valued. It doesn't matter what the offering is, there has to be a value there. And, as far as my aesthetics when I play, that's something that I'm constantly working on. For example, my voice: is it aesthetically pleasing, does it have beauty? Enough beauty? I'm not trying to be Adele, I'm trying to be me, right? I'm trying to be honest when I'm singing. (…) So, the aesthetic aspect is that it needs to be pleasing enough. And that kind of goes to the Winncox theory of the "good-enough mother". I have to be a "good-enough music therapist". I don't have to be the best, I have to be good enough. I need to make sure that the aesthetic of my performance isn't going to impede us in having a relationship.* (Judie)

Most clients enter the therapeutic space with an existing relationship with music, and particularly certain types of music. They may already play an instrument, or have a favourite song, or react strongly to a musical genre they associate with their childhood, for example. Music therapists are trained to mobilize these pre-existing relationships with music towards therapeutic goals. We've already discussed the use of familiar music to connect with the body as it was, and the importance of aesthetically-charged music in prompting emotional reactions. But these relationships with music can also be used to promote another therapeutic relationship: a relationship with a therapist, which can provide the framework to turn these musical relationships towards specific clinical goals. Here is an example of a music therapist using a client's interest in playing guitar to promote not only the clinical goals they had set, but also the therapeutic relationship through which they could work towards these goals:

> *I had a client in a practicum in a youth detention center. This can be scary. (…) He had very little trust. (…) And I was green, this was my third semester. There were electric guitars in the prison and he was interested. So my music therapy guitar teacher showed me power chords and taught me the first 12 bars of Stairway to Heaven, which this kid was interested in. Even though it was difficult, he started to trust that I knew stuff. I also had this other group at the detention center, and there was one kid who was our lead guitar player. He was the one who actually had music experience before coming to the prison, so he could play guitar, and he had a reputation in the joint for being a good musician. When he spoke well of me, then the other guy could open maybe a little bit of trust. In that case we weren't improvising music. I was teaching him to play. I had to ask myself – what was the music he valued, and what were the easiest inroads in helping him develop any sort of skill with it? Because he had very low self-esteem, he had low self-worth, and very basic attachment problems. (…) It's not the music itself that's the goal, it's the "Can I help him*

> *to feel attachment in any way? To open up just a crack of trust?" That's the music therapy goal.* (Laura)

Here it is only through the client's pre-existing relationship with music – both to an instrument, guitar, and to a particular song, Led Zeppelin's *Stairway to Heaven* - that the therapist was able to create a therapeutic relationship with her client. She also used that relationship with music as a way to pursue clinical goals in a way that was motivating and personally fulfilling to her client. It could be argued that in this case, without mobilizing the pre-existing affective relationship between her client and music, the therapist would not have been able to carry on with the therapy at all.

Not all clients come into a music therapy session with positive affective relationships with music, however. Music can carry profoundly uncomfortable affect, as it engages not only with desirable thoughts and emotions but also with undesirable ones. While music can allow us to express difficult emotions in a way that is more socially acceptable, the very act of playing music can also be fraught with insecurities. The emotional potentiality, or vulnerability, that musical affect brings can be difficult precisely because it is by nature a very personal process – of process of change, or *becoming oneself*. Many people who may like music also have very little or no experience playing an instrument, and may feel self-conscious about their musical talent. Some music therapists described their strategies to approach clients who may not already know how they interact with playing music. One does it through her collection of instruments:

> *So I have my instruments. And the first thing I do is, sit down and spread them out on the floor. Even with an adult, sit down on the floor, spread them out on the floor. I just want to introduce you to my tools. There's no wrong way to play it, you can invent new ways of playing it, I don't know them all. It's just music, that's all. And just explore the instruments first, and then find an instrument that feels like you connect with, that expresses something that's going on inside you. I'll go from there. And feel free to change instruments, because feelings can change, something else can come in. We just play with those feelings and those instruments.* (Laura)

The therapist's role in this encounter is to first help the client find an instrument with which they can develop a relationship. The choice of instrument is important, as a movement that is natural for one person may feel stilted for another – someone may feel playing the guitar is much more natural to them

than hitting a drum. The timbre of the instrument is also important; if the ultimate goal is expression, then the client needs to feel that the sound of the instrument is capable of properly expressing what they want or need to express. In this respect as well, a drum is very different from a shaker, and a shaker from the human voice. The vibrations emitted by each instrument are distinct, and empower different forms of aesthetic expression. As stated earlier, what one client needs might be to create a strong rhythm on a drum, while another is soothed by the open vibrations of a guitar placed on their lap. People can have relationships with music even if they do not perform music themselves – they might enjoy listening to certain genres in particular, have a favourite song, or perform other activities to music. Relationships to instruments are only a focusing of those musical relationships into a way not only of enjoying music, but of creating it. In the case of music therapy, the clients must find the instrument that is best attuned to their needs when it comes to creating music, not just listening.

But the insecurities around playing music can go deeper than simply being unsure of how to approach an instrument. Music may be a more socially-acceptable way of expression certain emotions, but that does not mean that society places no value on how music *should* sound like and how people *should* play it. The discrepancies between the perceived musical ideal and a client's own perceived musical competence can be destabilizing for a client trying music therapy:

> *A lot of people have trauma around – or just deep-seated insecurities around their ability to express themselves through music. A lot of folks have been told from an early age that they're not musical, and they just carry that with them. So if you just give someone like that an instrument and saying "Hey, play your feelings", it can be like taking someone who's terrified of dancing and saying "Okay, now dance how you feel". It's actually more humiliating than anything. So I think that it's quite important that we make sure that the client actually, truly find their voice on an instrument. And often I don't think they can. I think often a client might not quite be comfortable playing the drum yet and being able to express themselves, whereas meanwhile the therapist can play the guitar, play the piano, and then there may just be some insecurity that emerges because of that and it doesn't feel good. So I'm making sure that the client can actually, truly be using their voice, whatever that means; it doesn't have to be their physical voice, but finding an instrument where they can express themselves without being tripped up by insecurities is important.* (Mary)

Here the choice of instrument is paramount as well, because it is what allows the client to overcome their doubts regarding the prescriptive ways in which society tells them they *should* enjoy music, and be able to express themselves musically. By "finding their voice" – by finding the instrument which best fits their aesthetic needs and aligns itself best with their expression – music therapists report that the client is able to push themselves towards the clinical goals at hand.

This exploration of aesthetically-charged music and sound is ultimately a part of the creation of therapeutic rapport as well, since it encourages and frames interactions between the therapist and client. While a therapist and client may develop a relationship based on one's already established interest in learning the guitar, yet another might develop this relationship by exploring the various sounds at their disposal together.

Music therapy essentially attempts to create an environment full of attunements – attunement to the needs of the client, attunement within the wider social circle, attunement with the music itself – in order to allow affect to flow between the participants. These attunements are essentially ways for therapists to direct the affect created by music towards their clinical goals. Therapists do this by listening to their client's needs and deliberately *tuning* themselves, their instruments and sometimes the larger environment to suit those needs. Eventually, it is through this constant tuning of relationships that harmonies can be found – and therapeutic change can occur. Without these relationships, there is no structure to the affect, or way to mobilize it effectively and systematically towards a goal. Music therapy is not just a process of *becoming* for the people involved, but very much a *becoming-with*.

Chapter 3 – The Creative and the Healing

In the process of determining how I wanted to approach this thesis, I spoke with several music therapists to learn more about the discipline, and whether there would be interest in the kind of research I wanted to do. During one of those conversations, I had the opportunity to improvise some music with one of the therapists (who later agreed to be interviewed for this project). She let me try out a variety of percussion instruments, while she played the guitar – I picked up some sort of shaker made out of nuts first, then some wooden spoons. Despite these instruments being interesting to me (and having played the spoons since the age of three), I couldn't get them to sound how I wanted in the space. There was some trial and error while we tried to play together – the process was a bit frustrating for me, mostly due to my insecurity at playing with a stranger, and my inability to output the kind of sounds I wanted. Eventually I settled on a drum. For some reason, the sound felt right. I started tapping a beat, and we were off.

We sang and hummed, wordlessly working around each other's voices. At some point, she also grabbed a drum. I remember singing in a sort of looping pattern – four repeating notes, one, three, six, three, though the key changed throughout, while the therapist worked harmonies and a melody into the mix. Sometimes she would change the beat, sometimes I would. Eventually it became difficult to tell exactly who was initiating any given transition. The sounds became almost tactile; I kept picturing our voices forming a shape like a starlings' murmuration, weaving back and forth through the air, thickening and loosening in places depending on who was loudest.

I can't remember how long it lasted, but it ended without much fanfare: we just stopped, sensing that the song was over. I remember laughing. The vibrations in my fingers and legs took several minutes to dissipate. It was the closest thing to complete musical improvisation I've ever done with another person, and it felt absolutely freeing.

Some therapists have told me that music, without the framework of a therapeutic relationship or the expertise of a music therapist, cannot be considered therapeutic. At best, music without this framework can have *accidental* therapeutic benefits. Others, however, have admitted that music has a power that is not wholly contained by the therapeutic model – though the therapeutic context is needed to deliberately apply this power to therapeutic goals. After all, there was nothing explicitly therapeutic about my improvisation session with this music therapist: there were no goals, save to help me learn more about music therapy, and our relationship only consisted of about an hour of conversation around that very topic. Yet it would be impossible for me to say that the experience did not leave me with a sense of joy and release, similar – though profoundly different – from that I get from belting out some favourite showtunes in the shower. I felt that I had a better understanding of the space, of the person I had made music with, and of my own place in our interactions.

Was that sensation therapeutic? By music therapy's definition, probably not. My goal in this chapters is not to debate whether music outside of a therapeutic context is *therapeutic* per say, but rather whether music can become a way of interacting with our environments – and whether those interactions can affect our relationship with our surroundings and with ourselves. We've seen that musical vibrations can open spaces of emotional potentiality and affect, that music can be a way to *become-with* others and form relationships, and that music therapist are able to mobilize this affect created by music towards specific goals. It stands to reason, then, that ordinary people would also be able to mobilize and manipulate musical affect for their own benefits. A lack of music therapy training might make this more difficult, but not impossible. My interest lies in how – and perhaps even why – music can be such a great force for change even when used outside a systematic medical system.

Music, as any other form of art, is intrinsically linked in the public consciousness with creativity. It is that act of creativity, more so than specifically music, that is of interest to me in this chapter. Because

music is fundamentally an act of creation, of bringing something into the world that did not exist without you, then it seems dishonest to ignore that element of music when discussing its uses in therapy.

I theorize creativity as not only a form of embodied expression or a way to create and work through relationships, but as a *way of becoming* – a fundamental way to interact with the world around us. A way to exhort control in a chaotic array of lines and knots, and rearrange the world around us in ways that are not necessarily immediately productive, but do allow us to *become* and *become-with* the world. After all, if bodies and their environments are never completely discrete from one another (Blackman and Venn 2010), constantly in a state of relatedness (Blackman and Venn 2010; Haraway 2004), and using these relationships to un-make and re-make themselves, could creativity not be a way to accelerate that process of un-making and re-making? If, as Ingold theorizes, the world is made of connecting lines – movements, writings, speech, ideas (*Lines,* Ingold 2007) – then creativity could be a way to grasp even the most abstract of those lines and consciously bend them around us, in the process changing the lines that intersect to form our own selves. Alfred Gell identifies many ways in which humans can derive social agency from art-like objects, which he calls "indexes": when people invest feelings into objects which they connect to and admire, they begin to see these objects (or indexes) as *parts of themselves* through a process which he calls abduction (Gell 1998). While Gell was explicitly only concerned with material objects, it would not be out of place to apply the same logic to art-like sounds (music) as well. When the aesthetic characteristics of a musical piece connect with us, do we integrate this piece of music as a part of ourselves? Do we derive social agency from its existence, in the same way that a child might use her favourite doll to project her own agency into the world? (*ibid.*)

Ingold's world of lines and Gell's process of abduction have in common that they seek to understand the ways in which various entities connect and relate to one another, changing one another in a process very much like affect. Since affect is a process of *becoming* between related entities, I would

like to theorize that creativity is a way to mobilize affect for our own purposes, and to *become-with* our environments and surroundings.

Thinking Creatively

It is important to define here what I mean by creativity. I want to be careful not to conflate creativity with innovation – the subversion of established social and artistic conventions. In vernacular speech, it is not uncommon for creativity and innovation to be treated as one and the same (something is creative because it is new or uncommon). This has led to some in the Western world to view innovation as the only guarantor of authenticity in art, while reproductions are viewed as impersonal and lacking in creativity and skill (Gell 1992). By this logic, a cover of a song would not be much of a creative act, as it does no more than reproduce the original melody and lyrics – and so most musical expression would be rendered un-creative. After all, most people who sing or play an instrument do not write original music every time they want to play – and even when they do, they may rely on already well-known musical tropes (such as the music therapist who admitted to often relying on power-ballad chords when improvising in a pinch). If something must be deemed innovative in order to be considered creative, I feel that we limit our reach in discussing creativity. I would therefore like to propose a definition of creativity that relies more on the process of creation itself than on the innovation of the end result.

Ingold and Hallam make an important distinction between improvisation and innovation when it comes to creativity; where innovation defines creativity by its results, improvisation does so by its processes. In order for something to be considered innovative, its end result must be known, and it must be determined to break with established conventions. In contrast, improvisation is less concerned with the conventionality of the end result than it is with the minute and constant adjustments made in response to a world that is constantly being made and re-made by those that inhabit it (Ingold and Hallam

2007). It is those adjustments, that *process* of creativity, that I feel is the most important when discussing the kind of creativity that is encouraged by music therapy.

Creativity in those lines is not an artistic process exclusively, as much as it is a way of being in the world. The world is made up of designs that take time to emerge and make themselves known, be they an architect's plans or the genetic code of a foetus, and these designs will come to fruition in an environment completely different than the one in which they were envisioned. The very nature of creation implies not only time but the contributions of other actors, people, animals, materials, weather, etc. and these other actors affect the final manifestation of the design. A conversation is just as much an act of creativity as a symphony, a stroll through the park just as much as a dance. In effect, creation is the process of actors coming together to make something new; of strings coming together to form knots (Ingold and Hallam 2007).

Perhaps one of Ingold's more well-known ideas is that outlined in his book *Lines: A Brief History* (2007). In it, he argues that human activities take the shape of lines – whether literal, when walking for example, or metaphorical, when telling stories. These lines (along with lines formed by other beings and forces) are in a constant state of flux, intersecting, knotting, following parallel paths to one another, and together they form the world in which we live. In this view, humans become active participants in the creation of their environments alongside other beings such as animals, plants, and objects.

Using this model, any deliberate act is imbued with creativity, whether or not it is innovative, because it is by definition unique. He uses the example of the *kampi kolam*, traditional patterns drawn by Tamil women to protect their homes and temples, to explain that even with pre-determined patterns (in this case, the *kampi kolam* follow specific traditional shapes), the execution and the process of creation is in itself innovative and creative. The painting does not exist before the artist begins to paint, and the *kampi kolam*, though its shape has been conceived before, does not exist pre-conceived in the mind of

the artist before it is drawn (*Introduction,* Ingold 2007) and in fact, the final *kampi* may be wholly different from what was originally envisioned (Mall 2007). This is the same with music: a song, which may very well have been composed years or decades ago, is still being remade every time it is performed, because it will never be performed exactly the same way, in exactly the same circumstances, by the same people. For Ingold, the work of art "embodies the process of thinking rather than the detached thought, a consciousness rather than a conception, life itself rather than a way of living" (Ingold 1986: 182). Creativity is indistinguishable from the very act of living itself.

Even listening to a piece of music is not devoid of creativity, because, as explored earlier, the experience involves the embodiment of sound waves and the binding and maintaining of relationships. Even though not acts of creation in the classical sense, as nothing tangible is created, these are still examples of improvisation and therefore the same kind of creativity that comes into play in even the smallest of interactions. Even if the only creation is in the realm of the intangible – an unnoticed muscle contraction, a connection with another being – it is still creation.

Creation then becomes not only an exercise in *being*, but also an exercise in *becoming*: a constant interaction between beings, people, environments, animals, plants, objects; pulling and tugging at the lines that form the world to form new knots and tangles. This constant "becoming" is a hallmark of affect and affective relationships: Ingold's world of lines can easily be read as a model for the transmission of affect itself. Conscious creation, then, becomes a deliberate vessel for affect. It does not manufacture the constant "becoming" process of affect but it does heighten it considerably.

So how does one distinguish between the ordinary affect of everyday creative improvisation, and the more dramatic affect of, say, musical creation? Why is it that musical creation and the affect it creates can be regularly called upon as a therapeutic practice, while everyday affect is rarely credited with any therapeutic benefits? I believe the answer lies in the aesthetic value placed on the creative activity. As

mentioned in previous chapters, the aesthetic value placed on a piece of music or on a particular sound can make that piece of music or that sound more effective in prompting emotional reactions from music therapy clients – similarly, people build relationships with certain aesthetic values such as sounds, songs and musical genres, and music therapists are able to use those aesthetic relationships to create a therapeutic relationship within which they can address therapeutic goals. Much like aesthetically-preferred music is much more effective in bringing out emotions, a preferred medium of creation will heighten the affective potential of the creation. This is what separates, for example, the process of making a microwave dinner for no other reason than because you're hungry, with the process of setting aside time to cook your favourite meal and savour it. In one instance, the aesthetic value of the process is minimal; the process is not aesthetically charged. In the other, the aesthetic characteristics of the process make it aesthetically charged, and therefore a more effective vessel for affect.

Mary describes the ways in which making aesthetically charged music can add to the process of emotional expression:

> *When I can actually play my sadness out, not only can I feel that sadness, but it's okay, it's part of my story because I'm creating something out of it. I feel same satisfaction that can come from hearing a piece of music, hearing a song, and thinking "Oh my God, that sounds exactly like how I feel!" Suddenly the feeling that we have that we don't understand how to integrate into our lives can have a place again. And when we're making music together, that also has the benefits of creative satisfaction.*

Making music is not just a way to express feelings and emotions or to share them, but also to "*integrate (them) into our lives*". Mary places importance on the affect brought on by the song, the feeling of "*Oh my God that sounds exactly like I feel*" – when the aesthetic characteristics of a song align with the emotions that are already present, it allows for a way to contextualize those emotions and knowingly integrate them into our perception of the world. Aesthetics are therefore crucial in delineating the powerfully affective creation from the ordinary improvisation.

That these creative moments capable of contextualizing emotions can be ephemeral does nothing to distract from their impact: even if no other person is aware of the new tangle of lines you have tugged into being it does not change that the tangle exists, or has existed for a time, and that those involved are changed by its existence. The emotions were contextualized and integrated, and whether they remain so does not change that fact. Creativity and creation, and by extension music, are ways to interact with the world and be a part of it – to affect the world as we are affected by it. The best aesthetic medium for the task depends wholly on the individual - whether this interaction is best done through sound vibrations, through colours on a canvas, or through carving a tree to make a table. In effect, creation and creativity are the *vessels* of affect.

Musical Environments

Sounds are powerful shapers of our environments. One only has to look at the study of soundscapes to find proof that the sound vibrations all around us play a key role in how we respond to the space that surrounds us. Schaeffer describes soundscapes as the "middle ground between social science, society, and the arts" (Schaeffer 1994: 4); they are, essentially, the purely sound-based environments in which we progress every day. While some have attempted to "capture" soundscapes through the recording and mixing of everyday sounds (Feld and Brenneis 2004), others, like Ingold, criticize the concept as too narrowly focused on only one type of sensory input (*Against Soundscapes,* Ingold 2007). I tend to agree with Ingold, in that a too narrow focus on sound only runs the risk of obscuring the vast number of factors that come into play when observing and manipulating our environments. However, I do believe that sound is an important and often neglected facet of our constant interactions and "becoming" with the world around us.

Most of the music therapists I spoke to, as well as the instructor of the music care course I attended, seemed very aware of sound's potential to transform a space (I stumbled upon this topic mid-way through my fieldwork, and so it did not come up in all interviews). The *Room 214* music care course

included a section on the creation and maintaining of musical environments conducive to health and well-being. We were taught to pay special attention to the sounds, not only of daily life but specifically of care spaces (hospitals, long-term care facilities, hospices) and to understand how these sounds could affect these spaces and the well-being of care receivers. Things as simple as machines beeping or squeaking cart wheels could be distracting or detrimental to a care receiver's well-being. Volume is also something important to keep in mind, as noises which exceed 85 decibels are considered dangerous in the workplace by the World Health Organization (Papkalla and Collison 2017) and even noises at a lower volume can cause some damage. An environment that is too loud, or loud for too long, can lead to unnecessary stress, hearing loss, and a decrease in overall wellness.

It's also important to consider the associations we make with certain sounds. Beeping machines may be simply annoying when taken in a vacuum, but we as a society have a fairly strong association between that very sound and hospitals – which in turn are associated with illness, isolation and a host of other experiences generally considered unpleasant. Another example of the (in)appropriateness of certain sounds based on context: laughter may be fine on its own, but jarring and unwelcome near someone who is grieving.

As such, our sound environments are capable of greatly affecting our moods and even our health outcomes. In cases where people are in situations where they have little control over their environment, such as a hospital, these sounds can affect people with little to no agency over the sounds themselves. Making music can then become a way to regain a bit of control over the sound environment – and the environment in general – through something that is both deliberate and often aesthetically charged. By controlling the music we make, the choose to create a space of potentiality and change, and we allow ourselves to manipulate the world around us through this musical affect. Mary mentions this in regard to her work in hospitals:

> *When I started doing music therapy, people - patients, but mostly staff, they were just losing their minds. "This is amazing!" I would just go into a waiting room when I had no patients to see and just play a little bit of piano – people were like "Oh my God!" There was just this deep, sore need for something that was just profoundly human and simple.*

While music therapists have extensive training that allows them to use music in a therapeutic capacity, it should be noted that music therapist training is not needed to play music in a hospital. Professional and volunteer musicians are regularly brought in to care spaces like hospitals and long-term care facilities to provide music, without necessarily looking to further therapeutic goals. It follows, then, that there is something valuable *in the music itself*, whether that value can be considered therapeutic or not.

Even in spaces that do not specifically imply a lack of control, music can be used to transform the environment and people's relationship with it. One person I interviewed, Maude, who worked as a music therapist before transitioning to early childhood education, describes the place of music in her own life as such:

> *La place de la musique dans ma vie ben c'est pas mal tout le temps, dans le sens qu'on soit avec des enfants justement ça nous apporte beaucoup à réciter des comptines, chanter des chansons, des berceuses pour les coucher. Pendant mon congé de maternité, mon premier bébé, j'étais très anxieuse, puis je mettais toujours de la musique le matin. Puis ça me calmait et donc ça avait certainement l'effet de le calmer lui aussi, parce que les jours où je le mettais pas j'avais l'impression que c'était le bordel dans la maison, ça allais plus. Puis ouais, avec le recul, je vois ce que la musique m'a donné lorsque j'étais en période d'insécurité, de transition, puis moi c'est le médium que je vais aller chercher pour me calmer pis me grounder.*

For her, music was something that was able to ground her in times of stress, and whose effects spread to her child and her entire house. Once again, musical interactions are used to transform a space and the people in it by radically affecting the aesthetic characteristics of that space. What is interesting here is the deliberateness of her use of music – she was responsible for playing music and causing the changes in her sound environment. Musical creation may be able to transform a space, but it also allows people to *deliberately* transform their own space to something that better suits their wants and needs. While there is an unpredictable element to affect, there are many ways in which it can be predicted and manipulated,

even if this manipulation is as simple as playing preferred music to change the energy of a space. This is only one way through which creation can be used to control one's environment and manipulate one's surroundings.

Interestingly, much like music can be used to connect with the body *as it was,* music can also be used to connect spaces and people through time. This is a particular type of environmental manipulation that relies once again on the aesthetic characteristics of the music, their associations to the people making the music, and the embodiment of those characteristics.

> *I remember one time I was in a liturgical choir. I was brought up Catholic. I joined a choir, and we were singing the most exquisite motets. As an adult I had never sung anything like this. It was a six-part motet. And I remember turning to the alto beside me and I said "You know, if I died tomorrow I would be content because I've had this experience". Music transports me, and I don't know where it takes me but it's like a connection with the people who might have sung it 1200 years ago. Gregorian chant. Those kinds of music that have such a long lineage, I feel connected to that.* (Judie)

Because of the aesthetic properties of the music – in this case Gregorian chant – Judie felt a connection to others who may have sung the same piece of music centuries ago, though in a different space and in different circumstances. The ability of music to bring people into a meditative or "transportive" state that radically affects their perception of their surroundings can also bring about the perception that the space around them is closer to a space that no longer exists (a modern choir rehearsal to a monastery 1200 years ago). She then went on to say:

> *But I also like Leonard Cohen. I went to see him twice, and those concerts were really, really amazing. To have that shared experience with – you know, I don't know, what there were, 14 thousand, 18 thousand people in the stadium, and you could hear a pin drop, and that was the only time I've been in that place where people weren't even breathing audibly, they were just so focused on Leonard Cohen, he was so amazing… Yeah, that kind of stuff, I am transported by music.*

Shared experiences like these are also potent ways to affect spaces and the people within them. Even concert-goers become active participants in the music creation, and collectively create the space conducive to their own interactions with the music. These almost religious experiences of social

communion are an example of the shared affect we discussed in the second chapter – where the process of *becoming-with* others through music brings forth a shared meditative state. Unlike during music therapy sessions, these moments of shared affect are not asymmetric in nature, as there is no need for one participant to prioritize the others' experiences over their own, like in the case of music therapists. This is yet another situation in which the space is transformed through music, though through the contributions of several people rather than only one.

All these applications of music are theoretically possible with other forms of creation, like dance or visual arts. However, music's particularity is in its vibrations that are able to travel through spaces and bodies, perhaps more quickly and viscerally than other creative mediums. As such they enable people to deliberately, if only in part, *create their own surroundings*, becoming-with the space that surrounds them in a way that requires little time or resources but those of the human body (voice, limbs). If our sound environments matter to our health outcomes and to our perception of the world around us, then consciously manipulating that sound environment becomes as much an exercise in becoming-with others as it is an exercise in *becoming ourselves*.

The Art of Creation

Interestingly, creativity in itself was never cited to me as a goal of music therapy – *creation,* however, was. It seems acknowledged by music therapists that the very act of creating music – playing an instrument, singing, writing or composing a song, performing in front of others – can improve a person's self-esteem and confidence. While this can be linked to either embodiment or the relationships created with others, it cannot be explained solely by those factors.

While "beauty" remained a subjective term for all the music therapists I interviewed, dependent on the specific aesthetic needs of their clients, there was a certain acknowledgement of beauty as something that is needed and beneficial in itself, even though the specific details of what is beautiful were

left undefined. “Beauty” in these cases was not a remote factor but something that one was an active participant in, whether through creation or close appreciation.

> *It’s foundational. Because people need beauty, people need to be an active participant in something that’s beautiful. Because it’s meaningful. Because it’s purposeful. Because it makes you feel alive, it’s joy, it’s what life is all about, basically, is my approach. And so my job as the music therapist is to create and facilitate – I won’t even use the word create, I would say “allow for”. To facilitate, to foster, to nurture situations in which clients are a part, are active participants in creating beauty.* (Rebecca)

There is the feeling that creation (not necessarily musical creation) is needed in order to find some meaning in life, and perhaps even in order to be fully healthy. Rebecca then goes on to add:

> *We certainly in music therapy are taught the medical model. So we are taught to have specific goals. I think it has value, of course, and it’s beneficial. But all the while the other goal, while we’re working on these non-musical goals, is to have an aesthetic experience in which the clients are participating in something that is meaningful and concrete to them. Which I think is what makes it effective, frankly. In my experience, they’re not going to remember that they learned song lyrics. They’re not going to remember that they improved their cognitive skills through learning song lyrics. They’re going to remember that they made beautiful music, and that they did it themselves. So that’s the takeaway, in my experience that’s what impacts people.*

This same sentiment was echoed by other therapists as well, including Mary:

> *I do believe in the therapeutic benefit of creative engagement, period. And so much of the way we approach therapy is still through the medical model. We approach it by looking at what’s wrong with a person and giving them the tools to get better. And that’s all very power-heavy on the side of the therapist, whereas I think when we’re creating, when we’re engaged in creativity, we are by nature, implicitly, empowering the client and supporting them to feel whole... and then often they can figure their own shit out, after that. This is called a strength-based approach.*

Despite the many therapeutic techniques and psychological concepts that are used in music therapy, there seems to be an awareness, at least among some music therapists, that music creation on its own has therapeutic value to their clients. This value cannot be contained within the medical model, which prescribes narrow goals to reach and empowers the therapist to guide the client towards those goals – rather, this value is about empowering the client *outside* of the therapeutic space as well. It is about participating in the creation of “beauty” – whatever that means to that particular client – in order to create value and meaning, and to “feel whole”. This beauty, of course, reflects the aesthetic

preferences and needs of the client. This last therapist even reports that clients are often able to deal with their issues on their own after participating in music creation (in the context of music therapy), suggesting that these acts of creation facilitate and allow for a greater capacity for improvisation and creativity in all aspects of life.

This is not a new idea in the medical world. Researchers have found that creativity among men was a consistent predictor of longer life expectancy (Turiano et al. 2012) and that engagement with any of the creative arts improved general well-being among healthcare receivers (Stuckey and Nobel 2010). And, of course, there is a large body of work showing quantitatively that various forms of music therapy, in particular, are beneficial to overall health outcomes. Turiano et al. suggest that this link between creativity and longevity may be due to creative individuals being more open to try new forms of medical treatment, and that they may experience slower cognitive aging by engaging many different areas of the brain at once in creative activities. However, I don't believe that creation and its benefits can be reduced to neurological arguments. Affect, as we've established, has an uncontrollable and unpredictable dimension that fits poorly with a neurological understanding of its effects. While neurological explanations might be necessary to fold the benefits of creation and creativity into a format that is understandable by science and biomedicine, they are not the only way to describe or understand this phenomenon.

No therapist has explained to me the benefits of music creation in neurological terms, or by relating it to further medical treatments. The music therapists I interviewed were much more focused on a client's self-esteem improvement, on their social network building, and on the spiritual benefits of their client's interactions with music.

> *There are concerns in some parts of the world that the science model, the neurological model, is taking over too much, and that the aesthetic and cultural value of music therapy may be lost. It's in the aesthetics and the culture that we have the social adhesion that provides the social benefits of music. It's there that we have the spiritual dimension that comes through in the beauty that is*

> *created, and is expressed through beauty, and whatever that beauty means to a person. We don't want to lose that, because it's a vital part of why music therapy works. (…) There are types of music that can bring us into ecstatic experiences, and help us connect spiritually with our divine centre, God, whatever you want to call it.* (Laura)

Some therapists even reported doing their best to ensure that their clients would feel like their creations were their own, rather than a by-product of interacting with a trained musician. They prefer instead to step back whenever possible, and to allow the client's peers to contribute as much as possible to the final product in group settings:

> *In groups I find either song writing or adapted lyric writing [replacing certain lyrics in an already-existing song] quite useful, because it works great to facilitate a group discussion, and it really forges a group dynamic where the members of the group feel connected to one another. That's what I really want. I want them to feel connected to one another, to feel like they've accomplished something with as minimal input as I can give. I want them to feel like it's their own.* (Alisa)

If anything there appears to be something deeply satisfying, and perhaps even therapeutic, about creation – whether it be singing a song, writing a story, or even building a treehouse; about the ability to impact the world around us in a way that is so intensely personal. This ability seems central to a person's conception of self; the importance of creation was especially stressed to me when discussing situations in which a person has, to a certain extent, lost control over their circumstances – whether they be in hospital, in a long-term care facility, or struggling with personal issues over which they have little power.

> *And she and I wrote a song about a story that she had written in her mind, it was an incredible story, a beautiful story, and I put it to music. We wrote the lyrics together, and then she and I performed it in a concert. And because she had a history of performing in a music group and performing in a drama troupe, she was a drama teacher, with all of these things I knew that it would be a positive experience for her. (…) It was such a big deal for her, and it was like "You know, I'm in this home, and I have this disease, but look at what I can create, look at this beauty that I can create." And people coming up to her and saying "That song touched me so deeply, thank you, thank you for sharing that with us", it was so empowering for her to be able to still use those skills that she had as an artist.* (Rebecca)

> *And it's the tears, sometimes after their solo, people start to cry, they're just so touched by what they accomplished, when they're in this nursing home and they don't get to experience that beauty, to be honest. They really don't. And they don't get to create, like that in itself is a whole other level of empowerment.* (Rebecca)

The idea of using creation as a way to *become ourselves* through interaction with our environment seems to cut to the core of what it means to become human. At least, creation seems to give us an outlet to allow for our own re-invention and re-creation, and does seem to be an important part of how many people interact with the world. Now, I am in no way trying to suggest that every human being on the planet needs aesthetic creation in order to live a meaningful and fulfilled life, or that aesthetic creation is some kind of universal constant of humanity – or even that aesthetic creation is necessarily unique to humans. I would never suggest that creativity on its own is a cure for disease or illness without further proof to that effect. What I can say, however, is this: that in some situations, creation and creativity has been known to alleviate stress, improve self-confidence and facilitate problem-solving. That creation is often linked to feelings of personal empowerment. That in music therapy, this act of creation is almost always funnelled through musical sound waves. That, at least according to many therapists, this very act of musical creation has been known to be beneficial to their clients' wellbeing and general health outcomes. And that these benefits can almost certainly, if perhaps accidentally, be therapeutic even outside of a therapeutic context.

Music of the Spheres

The fact is that music's place in society is not defined or limited by therapy. While one music therapist I interviewed did not report having a strong relationship with music outside of his music therapy work, all the others reported listening to music, playing music, and sometimes writing music as a form of deep personal expression outside of work. Music was reported as being an important part of their lives, even outside of their work as music therapists – their interest in music always pre-dated their interest in music therapy as a career.

In fact, music was cited to me several times as being a key aspect of a therapist's self-care. This included playing music, listening to music, composing music, and participating in other music-related

projects such as being part of a band or choir. These non-professional interactions with music were seen as important not simply because they allowed the music therapist to hone their skills, learn new songs to use in therapy sessions, or otherwise better perform in their jobs – they seemed rather to be important because they allowed music therapists to *be* musical. Musicality in itself was seen as an "outlet" for expression and stress, and as a way for music therapists to keep themselves "balanced".

> *And I think it's important that music therapists are taking care of themselves musically, because we can't use our clients for that outlet. (…) I feel really good about myself as a singer-songwriter right now, in that I've produced my own album and I feel supported. So that is a big source of creative output for me. I think, for me, self-expression is so important, so having musical outlets that help me tell my story is important. And listening to music, too. It's something I try and consciously make the time to do, to let myself be really moved by music.* (Mary)
>
> *And sometimes I get surprised, I just get this urge to compose, to write a song, and I don't know what's going to come out. And then I pick up my pen and I start working, and emotions that are really in me, stuck in the unconscious come out! And it just helps to liberate that whole area.* (Laura)
>
> *Making my own music, when I was writing my master's thesis, I found out was integral to my well-being as a music therapist and as a person. So I very much commit myself to making music for myself and others in a more performance setting, because I just love it. And I want to do it.* (Helena)

Here music creation is discussed as a necessary part of a healthy, emotionally-balanced lifestyle for these therapists, even outside of their work. Musical creation *for themselves* is not an activity separate from the rest of their lives, but an integral part of it. Music allows them to express themselves and improve their well-being by being a tool of re-conception and re-creation of the environment and the self.

Even the sheer enjoyment of playing music was cited a few times as being a profoundly beneficial activity for therapists – not because playing allowed the expression of specific feelings, but simply because playing brought joy.

> *And I really love playing, I love playing in a band, I love playing with other people, and I missed that a lot. I just didn't have space for it. I didn't have space to build my business, to work with clients and to raise a young family, so that left my table for a while. And recently I've been able to jam with a few musicians, both classically and pop, which has been interesting *laughs* and it's been life-giving.* (Alisa)

> *And I play, I play for myself. I'll probably play the piano today, just to read through some books and noodle around. That's not transformative, but it's therapeutic for me to play these things and just enjoy myself doing it. It's not for anybody to listen to – the dog listens *laughs* but it's not for the listener, it's for me.* (Judie)

Playing music, interacting with music, becomes not just a tool that can be wielded towards therapeutic goals, but a goal in itself that has a positive effect on overall well-being. The people I interviewed mostly chose music as their creative medium, but their comments reminded me sharply of conversations I'd had with other writers and artists. "The opposite of writing for me is depression," a fellow writer told me once. While the feelings might be exacerbated for some people – perhaps some are pre-disposed to seek creative activities, or perhaps proximity to creative activities encourages some people to use them as mediums – the fact is that creativity as I've defined it is an intrinsic part of human life and interactions. And, it seems, some humans not only deal with this creativity as a necessity, but actively seek it out as a way to create and re-create themselves and their surroundings.

And the fact is that music is used in therapeutic ways, deliberately or not, by people who are not in therapy. This application of music's importance may not be systematic enough to be considered *therapy* per say, or it may be closer to *accidental therapy*, but it is a way to cope with the conditions of existence that is used by therapists and non-therapists alike. Creativity opens up new ways of being, because it opens up new ways of interacting and becoming with the many lines that surround us and that we are a part of. More to the point, it is a way to exercise our agency by integrating these interactions and these lines *into ourselves* and into *who we are* and *who we are trying to be*.

Sound is a part of the environment that surrounds us. Sound waves, in many ways, are how we interact with the environment that surrounds us. And music, as open as its definition may be – as organized sounds waves, as deliberate creation of sound - is a very potent way to participate in the shaping of the world we all live in. The experience is deeply spiritual for some people:

> *So I believe that God created us to have beautiful experiences and to connect with others, which is a form of joy and beauty. Music definitely, was given to us by God in order to facilitate those experiences. So I would say absolutely, because for me personally my faith – I don't compartmentalize, like, it's in everything that I do and my relationships.* (Rebecca)

> *And then when I was in my early twenties music came back into my life, and it was almost like I couldn't control it. It was so intense to welcome it back into my life, and to deal with the fact that it had been gone for so long. That process was deeply therapeutic for me, and painful, and then once music was back in my life it was really clear: I can't not do this. I think, I know, that music means something different to me now. This isn't just something I do to get attention, and people applaud, and I feel good about myself – which is lovely, and I'm not complaining. But there's something deeper here. Music, for me, is about some deep healing of the world.* (Mary)

While others describe musicality not in terms of spirituality, but rather as something instinctual but no less foundational:

> *L'esthétisme de la musique, la beauté de la musique, l'appréciation de la musique, ce que les gens en font, ça rejoint beaucoup le fait que la musicalité soit instinctive. C'est quelque chose qui est en nous qu'on a le potentiel de développer. Tout le monde nait avec le potentiel d'être musical, contrairement à d'autres talents. Je ne pense pas que tout le monde nait avec le potentiel de faire de l'équitation, *rire* C'est démontré par la recherche que la musicalité est instinctive, c'est pour assurer la survie de l'espèce. Quand la mère s'adresse en disant *in motherese* « Oh, le beau bébé! » et elle change l'intonation de sa voix, c'est pour avoir l'attention de son enfant, créer une interaction avec lui, pour qu'il puisse s'attacher à elle. C'est fort quand même! C'est un comportement instinctif. Ça date de la préhistoire, l'homme allait chasser le mammouth, la mère protégeait la famille. Ce sont des comportements importants pour l'évolution de l'espèce. C'est inné. Donc si on offre un moyen d'intervention qui utilise un médium qui est inné, on a plus de chances d'arriver à un résultat qu'en offrant un moyen d'intervention sur une pratique qui devrait être acquise, avec le temps, avec la pratique, avec l'expérience. Nécessairement on y arrive, mais ça prend plus de temps et c'est moins naturel chez certains enfants qui ont déjà des difficultés d'apprentissage.* (Maude)

While my research has necessarily focused on music as the medium of creation of choice, most of these observations could be extrapolated to apply to creation as a whole. Music therapy may be one way to effectively harness music towards therapeutic purposes, but it is not the only way, nor necessarily the most effective. People, including those that practice music therapy for others, are able to harness the unpredictable, uncontrollable dimensions of affect towards their own wellbeing outside of therapy, using music and performance as their medium. Music is specific, and it is possible that sound waves possess a quality that renders them better conducive to these affective interactions than other creative mediums;

whether that is the case is not something I feel qualified to weight upon. However, based on these interviews it seems clear to me that it is not the music in itself that holds power, but the *creation* of music. It is partly through that creation and that embodiment of music that therapists engage with the world around them. Is music, without people, even music at all?

Conclusion

If there was one thing I did not expect when I started this research, it was the ways in which this project would force me to re-evaluate so much of my own day-to-day experiences. Though music and art are an important part of my life, I never conceptualized them as complex therapeutic tools before this. Music therapy seemed an entirely different beast from the kind of music I listened to while studying, and completely unrelated to the affect of sketching or writing or knitting. And yet the more I learned about the various ways in which music can contribute to a person's wellbeing, the more I began to recognize my own behaviours in the therapeutic uses of music.

Who would have thought that my uncontrollable urge to tap my foot to any and all drum beat would be a manifestation of the embodiment of music? Who would have thought that my urge to cry when listening to the soundtrack of *Toy Story 2* could be used to therapeutic effect? Being a therapist requires years of training, but what makes music so efficient as therapy is very simple: it reaches us in a place beyond cognition, where emotion and movement come to the forefront. You don't need to be a therapist to feel that salsa music doesn't make you want to dance because it makes you stop and think, but rather because it moves you to… well, move. The neurological reasons for this continue to elude me (and science), but that seems to belie the point, doesn't it? For the most part, music is not a place of cognition, but of affect. It seems to resist any attempt to scientifically break it down to understand it.

Even my social circle has been affected through music. I've made some lasting friendships based on common musical tastes and karaoke nights. I've learned new things about family members by playing old country songs together. There are songs that I share a special relationship with, either because they're old French tunes my grandmother sang to me, or because they're the jigs I've been tap-dancing to since the age of seven, or even because my friends and I sang it in the car during a memorable road trip. I can't

even begin to imagine how powerful music could be if I had applied it deliberately and consistently, as it is in music therapy, to create and change my relationships with others.

But perhaps the point that most surprised me, and which still fascinates me the most, is that I've also begun to re-examine the ways in which I mobilize affect for my own benefits. I deliberately choose the music I play when friends come over to project a version of myself that has consistent taste in music, for example, which – I hope – helps me make friends and develop my social life. We go to karaoke together and I make them laugh with my silly renditions of Bohemian Rhapsody. Then there are all the other creative endeavours I share with others – to move them, I think, or to show them a different side of me. The paintings I hang on my walls. The knitted sheep I make with scraps of wool, which have now found homes all over the country. The fanfiction (gasp) that I've published online. These are all things that I've created myself, for the purpose of sharing with others, and of providing others with a template through which to relate to me. Through my creations, through the affect I try to elicit through them, I shape my own relationships.

But more so than the examples of times when I project affect to my social benefit, I also project affect with no social goals in mind at all. I affect myself and the world around me, sometimes deliberately and sometimes not, even when no person is around to see it. I sing in the shower when I'm home alone; I keep most of my drawings in a sketchbook out of sight; I've written entire short stories only to delete them once they're completed. The question seems so simple, but I had never really pondered it before: why?

The truth is that I feel better, more grounded after banging out a complicated set of arpeggios on the piano, or singing along to a favourite song. I feel more *myself* when I take the time to sit down and sketch a scene from a beloved book. Even knitting something as simple as a hat gives me the satisfaction of a job completed, of a problem solved, of a world different because I am a part of it. Many of my friends

and acquaintances are what might be known as “creative types”: artists, musicians, writers, poets. All of them have expressed similar feelings to me – creating (or writing or painting or singing or playing or dancing) is life. It is how we cope, it is how we carve our own place in a world that does not always see us, that does not always seem clear, or fair, or straightforward. We are affected by the world every day, and sometimes we turn around and say: “Enough. You be affected now. *You* deal with *us.*”

Writing this thesis - doing this research - has taught me things about music, about therapy, about the myriad ways in which we interact with one another every day, and also about myself. Even while writing this, I’ve noticed that times when my creative output was low – when I was too busy to sit down and sketch, or too tired to hum while doing the dishes – were also the times when I struggled the most to keep working. Sometimes sitting down for the evening to outline a story was all it took to bring the creative juices flowing and end a week of procrastination. Sometimes taking the time to belt out a song was all that kept the stress from overwhelming me. In a weird way, those were the only ways I had to tell this thesis: “That’s enough. You deal with *me* now.” And, perhaps even weirder, it worked.

I think that is the crux of my argument here: that in a world in which we so often feel dispossessed, controlled, or helpless, creating something can allow us to metaphorically fight back and exert some control over our environment. Ingold tells us that we make our own environments; music allows us an accessible and measurable way to do this. But music also allows us to make ourselves – our bodies, our emotions, our relationships are all made, un-made and changed by music. We can allow others to affect us, and we can choose to affect others by playing with the aesthetics of soundwaves. Music therapy is a way to codify this affect, to give it a goal and a purpose, and to empower its clients to search for that affect themselves.

Ultimately, music therapy is valuable because it taps into a much wider, more fundamental urge to create – and it finds ways to direct that urge towards concrete therapeutic goals and health practices.

At least in a western, Canadian context, without the structures of music therapy, the benefits of musical creation would probably remain unreliable, if not unattainable, to many people – and probably to the people who, due to illness, might need it the most. Rather than creating a remedy for many ills, music therapy seems to have perfected it through research and technique, and given it a platform through which to reach as many people as possible.

I don't know if this thesis has deciphered anything novel about music therapy. I know it certainly hasn't "cracked the code" of how or why it works – many people much more knowledgeable on the topic have tried and failed to do that before me. But I hope that it might help shed some light on why it can be valuable. Affect, whether ordinary or extraordinary, whether contrived or unforced, is fundamentally just the process of *becoming* yourself within a larger world. Music therapy, one of the many arts of mobilizing affect, can give us the tools to become who we would like to be. And perhaps that is the most therapeutic things of all.

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