Composing Care: The Aesthetics and Politics of Music Therapy in the Clinic

Meredith Evans

A Dissertation submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements for the Degree of
Doctor of Philosophy

Graduate Program in Social Anthropology
York University
Toronto, Ontario

December 2021

©Meredith Evans, 2021

Abstract

This dissertation examines the care work of music therapists in North American hospitals. Based on sixteen months of fieldwork conducted between 2019 and 2020 in Canada and the United States, this ethnography investigates the clinical aesthetics of music therapy, or how music therapy is sensed and made sense of in the clinic. I show how, through its foundation in Western art music traditions, the profession of music therapy is depoliticized—grounded in the values of universality, rationality, and objectivity—and aligned with biomedicine. It is through an association with biomedical knowledge systems that, I argue, music therapy is made into a health profession. I found that music therapists struggle to have their work taken seriously as they care for patients on the margins of hospital systems. Music therapists are in pursuit of what I call *clinical recognition*—being seen and valued from a biomedical perspective. As they strive to be recognized as indispensable to biomedical care, I show how music therapists attempt to ameliorate biomedical care structures from within. They cultivate sensitivities to sensory experience, especially to sound, that inform their movement through hospitals and guide their interactions with patients and staff. By intervening in what I describe as the *clinical sensorium*—the dominant structuring of sensory modes of attention that shape what is sensible in the clinic—music therapists disrupt the stultifying *an*aesthetic, or numbing, qualities of the clinic by reconfiguring clinical attunements, composing atmospheres of care, and structuring feelings in their extra/ordinary care practices. These care practices, I argue, are grounded in reciprocity; through musical gift exchange, music therapists foster affective connections and attachments for hospital patients that reimagine care in ways that remain partially tethered to yet exceed biomedical logics. Mobilized for and against biopolitical care regimes that attempt to delineate, capture, and govern life and death, I argue the care practices of music therapists reimagine the sensory-affective possibilities of living and dying in the clinic.

Acknowledgements

I am forever grateful to the music therapists who supported and enabled the research for this dissertation. They welcomed me enthusiastically into their professional spaces and generously shared their stories, insights, and daily lives with me. I am deeply appreciative of the patients and their families who allowed me the privilege to be present for music therapy sessions. I would also like to thank the hospital staff who took time out of their workdays for interviews.

Natasha Myers, Ken Little, and Maggie MacDonald have been phenomenal advisors. From guiding me through preparations for my comprehensive examinations to closely reading this dissertation, my supervisor Natasha always pushed me to deepen my theoretical and methodological attunements. Ken introduced me to the world of affect theory and inspired me to approach thinking and writing more creatively and imaginatively. Maggie's rigorous engagements with my work and incisive feedback have shaped this project for the better. I am so grateful for their mentorship and support. I would like to thank examiners Todd Meyers, nancy viva davis halifax, and Sandra Widmer for their generous and thoughtful engagements. Thank you to the anthropology faculty at York University, including Othon Alexandrakis, Shubhra Gururani, and Albert Schrauwers, York graduate students, especially Jessica Caporusso, Jillian Fulton-Melanson, and Heather Tasker, and administrators Colleen Robinson, Diana Baldassi, Roshan Singh, Natalie Vacianna, and Nadia D'Angelo. At York, I appreciate having been part of the Medical Anthropology Occasional Paper Series and am thankful to the group for their feedback. I am grateful to Keith O'Regan for the support offered through his Graduate Writing Café. I would like to thank faculty in the department of music at the University of Pennsylvania and in the department of anthropology at St. Francis Xavier University for their support during research trips, specifically Jairo Moreno, Jim Sykes, and Carol Muller at UPenn, and Susan

Vincent and Christina Holmes at St. FX. This work benefited from the engagements of Stacey Langwick, Emily Yates-Doerr, and Lisa Stevenson. I would also like to thank my past advisors, particularly Hadley Z. Renkin at Central European University and Peter Allen, Jennifer Bain, Steven Baur, and Jacqueline Warwick at Dalhousie University, for setting me on this path.

I am thankful for the many incredible friends across time and place who have sustained me over the years. Special thanks to Zethu Matebeni and Fiona Guerra for initially pointing me in the direction of this project, and to Diana Escobedo Lastiri, Lee Veeraraghavan, Adam Kuhn, Nompumelelo Zungu, Sarah Vickery, Will Horne, Patryk Wozniczka, Sabelo Mcinziba, Laura Harris, Maureen Batt, Dayna Lutes, Katie Hunter, and Erin Moir. I have benefitted immensely from writing and workshopping this dissertation with Andrés Romero, Janita Van Dyk, Juliana Friend, and Melissa Lefkowitz in our writing group. I am lucky to be a member of this amazing cohort. Maria Murphy and Craig Jennex have been a formative presence in my life since our music school days. I am grateful to work and laugh with them every day. I am thankful for Jake Danson Faraday, who saw me through each step of the research and writing of this dissertation with companionship and care. I am so grateful to Jake, Craig, Maria, Janita, and Andrés for carrying me through this degree; they have read every chapter and offered immeasurable support. Finally, thank you to my wonderful family. I am fortunate to have such a close and supportive extended family network. I am especially grateful to have been able to lean on my relatives in and around Toronto during this degree, namely Cheryl and John Hendriks, Susan Brown and Barry Deathe, and Barb Evans and Chris Barnett. Special thanks also to my family at home in the Maritimes, Alec Evans, Cameron Evans, and James and Kristan Weir, for their support. My parents, Judith Brown and Chris Evans, instilled in me a deep appreciation for music and learning from an early age. I am grateful for their unwavering support and encouragement.

The research for this dissertation was supported by scholarships from the Social Sciences and Humanities Research Council of Canada (SSHRC), the Ontario Graduate Scholarship program, the International Council for Canadian Studies, and York University.

Table of Contents

List of Tables

List of Figures

List of Abbreviations

AAMT	American Association for Music Therapy
AMTA	American Music Therapists Association
BAMT	British Association for Music Therapy
BLM	Black Lives Matter
BMTN	Black Music Therapy Network
CAMT	Canadian Music Therapists Association
CBMT	Certification Board for Music Therapists
CJMT	Canadian Journal of Music Therapy
COPD	Chronic obstructive pulmonary disease
EMT	Environmental Music Therapy
EAC	Equity Advisory Council
JMT	Journal of Music Therapy
GIM	Guided Imagery and Music
MT-BC	Music Therapist-Board Certified
MTA	Certified Music Therapist
MTP	Music Therapy Perspectives
NAMT	National Association for Music Therapy
NICU	Neonatal intensive care unit
PPE	Personal protective equipment
RCM	Royal Conservatory of Music
RCT	Randomized controlled trial
VA	Veterans Affairs
WFMT	World Federation of Music Therapy

Chapter 1. Introduction: Music Therapy and the Aesthetics of Care

My Way

Buddy lay in his hospital bed, staring at the ceiling. He grimaced as a nurse gave him an injection into his right arm. Dressed in a hospital gown, his left arm lay at his side. His hand was wrapped in layers of bandages. Sophie and I hung back at the periphery of Buddy's section, waiting. A room dividing curtain hugged only the left side of his hospital bed, offering minimal privacy in the hospital room shared with three other men on the geriatric unit. Fluorescent overhead lighting illuminated the space; a neglected dinner tray perched on the overbed table, wheeled up against the wall. As the nurse hurried out of the room, Sophie walked across the threshold into Buddy's corner. Positioning herself in his line of sight, she spoke loudly and clearly through her mask and face shield.

"Hi Buddy," Sophie said. "It's Sophie, the music therapist. I'm wondering, would you like to do some music with me today?"

"That would be wonderful!" Buddy said. He spoke emphatically, smiling as he slowly reached his right hand toward Sophie's. Tenderly, she took his hand in hers.

"Is it okay if my friend Meredith joins us today? She's researching music therapy and what we do here at the hospital."

"Oh, yes!" Buddy nodded, noticing my presence at the foot of his bed, standing two meters behind Sophie. Releasing Sophie's hand, Buddy reached toward the side table. Seeing his eyeglasses' case perched beside a tissue box, Sophie picked up the case.

"May I?" She asked. Buddy nodded and Sophie retrieved the glasses from their case. Gingerly positioning the plastic arms of the glasses over his ears, Sophie rested the frames on the bridge of Buddy's nose. "How's that?" she asked.

"Perfect."

I handed Sophie her portable swivel stool off her portable cart. She placed it on the right-hand side of Buddy's bed, close enough so she could be in his line of sight. iPad and Bose portable speaker in hand, she said, "Last time I was here we listened to Frank Sinatra together. I know he's one of your favourite singers. Should we start with some Frank Sinatra today?"

"Oh, yes!" Buddy exclaimed.

Sophie began to play a 1969 recording of Frank Sinatra singing the popular song "My Way." Buddy closed his eyes as we listened to Sinatra croon over a subdued rhythm section:

And now the end is near
And so I face that final curtain
My friend I'll say it clear
I'll state my case, of which I'm certain
I've lived a life that's full
I travelled each and every highway
And more, much more than this
I did it my way

Opening his eyes, Buddy sang along to the last line gently, holding the final two notes of the melody for four beats each with Sinatra. As strings began to swell into the second verse, Sophie added her voice in support of Buddy's baritone. Together, they sang:

Regrets, I've had a few
But then again, too few to mention
I did what I had to do
I saw it through, without exemption

Sophie stayed with Buddy as he sang the lyrics a half-second behind Sinatra, catching up on the held downbeats:

I planned each charted course
Each careful step, along the byway
More, much more than this

Buddy's singing became more forceful at the final line of the second verse, which took the place of a refrain.

I did it my way

The orchestration thickened with the addition of horns as the vocal melody ascended in pitch and dynamics, accented by tambourines. Buddy and Sophie sang the intensified third verse:

Yes, there were times I'm sure you knew
When I bit off more than I could chew
But through it all when there was doubt
I ate it up and spit it out
I faced it all and I stood tall
And did it my way

As the orchestration and dynamics diminished, Buddy's singing quieted as he listened to Sinatra sing the nostalgic lyrics:

I've loved, I've laughed and cried
I've had my fill, my share of loosing
And now, as tears subside
I find it all so amusing
To think I did all that
And may I say, not in a shy way
Oh, no, oh, no, not me
I did it my way

As the recording moved into the final climactic verse, Buddy raised his right arm into the air, conducting Sinatra and Sophie as they sang. He gazed upward dreamily as he waved his hand back and forth rhythmically:

For what is a man, what has he got?
If not himself then he has naught
To say the things he truly feels
And not the words of one who kneels
Let the record show I took the blows
And did it my way

The recording faded. After a brief silence, Sophie asked Buddy, "How does that song make you feel?"

Buddy looked over at Sophie. “It touches my heart,” he said, his voice breaking. “I don’t get that feeling very often.” He paused as a tear rolled down his cheek. Looking up at the ceiling again, he continued to speak slowly, as Sophie leaned in, listening intently.

“I sang that song at a party. Thirty years ago. Everyone was there. It was wonderful.”

Sophie affirmed his words. “You sang it at a party, and everyone was there. That’s a wonderful memory.”

Buddy nodded.

“Are there any words that stand out to you?” Sophie asked.

Buddy averted his gaze.

Sophie spoke the refrain slowly. “*I did it my way.*” She paused, letting the words linger. “Is that important for you, the message of living life on your own terms?”

Buddy did not answer the question. Slowly, he turned back toward Sophie and said decisively,

“It’s a special song.”

“A very special song,” Sophie reiterated, abandoning her question about the meaning of the lyrics. “What do you think, how about we sing it together once more? I’ll play guitar this time.” Buddy nodded.

Setting the speaker aside, Sophie reached for her guitar. Strumming D major, she began to sing. As they sang together, I noticed Buddy sang more of the lyrics than he had previously when singing along with Sinatra’s recording. Sophie had slowed the tempo of the song and made subtle adjustments to the rhythm of the vocal line to accommodate Buddy’s pace. She projected her voice clearly in a straight tone style, adding vibrato at the end of held notes. Buddy conducted them:

And now the end is near
And so I face that final curtain
My friend I'll say it clear
I'll state my case, of which I'm certain
I've lived a life that's full
I travelled each and every highway
And more, much more than this
I did it my way

Regrets, I've had a few
But then again, too few to mention
I did what I had to do
I saw it through, without exemption
I planned each charted course
Each careful step, along the byway
More, much more than this
I did it my way

After the final refrain of "*I did it my way*," a lingering silence filled the room.

"Beautiful. Beautiful," Buddy smiled.

"That was beautiful," Sophie affirmed. "You have a lovely voice."

Buddy closed his eyes.

"Have you had enough music today?" Sophie asked.

Opening his eyes and looking at Sophie, Buddy nodded.

"Thank you for singing with me today, Buddy," Sophie said. Touching Buddy's arm gently, she asked, "Is there anything I can do for you before we go?"

Buddy smiled, "I don't need anything else. *My Way* is everything."

An Ethnography of Music Therapists

Since the mid-twentieth century, the field of music therapy has undergone increasing professionalization in the United States, Canada, and globally through the proliferation of professional associations, certification processes, educational programs, research, and academic

scholarship.[1] Music therapists care for people by offering music as a creative realm, a mode of expression, a medium for psychosocial and emotional support, and a means for developing cognitive and physical capacities through methods such as playing or listening to music, improvisational music making, and song writing.

Music therapists like Sophie work in hospitals across North America, facilitating "special" moments that offer "everything" to people like Buddy. Yet, unlike other clinical professionals—such as doctors, nurses, social workers, and occupational therapists—music therapists are not found in every hospital. They are not, as music therapist Rachel explained to me, a "standard of care." Their work is considered complementary or supplementary. As a non-curative therapeutic modality, music therapy is deemed "nice" but non-essential. Consequently, hospital music therapists operate on the margins of biomedicine, struggling to have their programs funded and to have their work be taken seriously as they straddle the borders of the medical model and alternative care practice. Rachel explained this friction to me; she said:

> I'm not a physician. I don't offer curative care. With music therapy, people can't always measure the effects very easily. So, people are hesitant to take it seriously.
>
> I do try to be seen as medical. And yet, there are moments that I think, "I can't explain this, and I don't want to." Because it just happened, and it was beautiful, or complicated, or powerful. These unexplainable moments are worth something.
>
> At the same time, I really hate when music therapists talk about the magic of music therapy and just can't explain it! Because we do have evidence and we know what we're doing. We're skilled—we're attending to and attuning to our patients. We're making clinical decisions every moment to adapt to them. That's important too.

[1] Music therapy is a formalized profession in many countries. The World Federation of Music Therapy (WFMT), a non-profit incorporated in the United States with an aim "to promote music therapy throughout the world," has twenty nine member countries: Argentina, Australia, Austria, Canada, Chile, Croatia, Cyprus, Czech Republic, Finland, France, Germany, Greece, Hong Kong, Italy, Japan, Luxembourg, Malaysia, Mexico, Netherlands, Nigeria, Poland, South Korea, Spain, Singapore, South Africa, Taiwan, United Kingdom, United States, and Uruguay (WFMT 2020).

> So, I feel this tension between embracing the ambiguous, the mysterious, and trying to be seen as medical. There's some middle ground of acknowledging that there's a lot we don't know. There's a lot that's mysterious and complicated—but it's not magic!

In medical settings, therapeutic interventions are required to be legible, with measurable effects. Over the decades, evidence-based research on the clinical efficacy of music therapy has accumulated, including in the form of randomized controlled trials.[2] Nevertheless, as Rachel indicated, hospital music therapists grapple with a "tension" between the pressure of making moments in music therapy clinically legible and embracing the complex opacity of what unfolds in music therapy sessions.

My Way with Sophie and Buddy is illustrative of ambiguous moments in music therapy. In line with popular interpretations of Sinatra's "My Way" as an American anthem that represents the values of individualism and self-determination (Tyler-Ameen 2019), Sophie asked Buddy if living life on his own terms was important to him. This was a subtle effort to initiate verbal processing—a clinically legible therapeutic process—about what the song represented to Buddy. But Buddy did not respond to Sophie's question about what singing the song "My Way" meant to him. Instead, overcome with "special feelings" and reverie, he told us

[2] Clinical research has demonstrated the psychological and physiological effects of music therapy; for example, that music therapy interventions can reduce pain, stress, and anxiety for adults and children with various conditions including as part of palliative care (Cepeda et al. 2006; Cole and LoBiondo-Wood 2014; Colwell et al. 2013; Guétin et al. 2005; Gutgsell et al. 2013; Hsu, Chen, and Hsiep 2016; Li et al. 2011; McConnell, Scott, and Porter 2016; Ulrica Nilsson 2008; Tse, Chan, and Benzie 2005; Warth et al. 2014; 2015); reduce anxiety and depression anxiety (Atiwannapat et al. 2016; Boothby and Robbins 2011; Canga et al. 2015; Chan, Wong, and Thayala 2011; Colwell et al. 2013; D. Evans 2002; Hsu, Chen, and Hsiep 2016; Maratos et al. 2008; Tamplin et al. 2013; Zhou et al. 2015); improve outcomes for patients with severe mental illness (C. Carr et al. 2012; Gold et al. 2009; Ulrich, Houtmans, and Gold 2007); improve outcomes for people with dementia (Cooke et al. 2010; McDermott et al. 2013; Ridder et al. 2013; Ueda et al. 2013; Y. Zhang et al. 2017); improve outcomes for children with autism spectrum disorder (Geretsegger et al. 2014); improve psychological outcomes for adult cancer patients (Huang, Good, and Zauszniewski 2010; Li et al. 2011; Bradley Palmer et al. 2015; Zhou et al. 2015; J.-M. Zhang et al. 2012); increase coping-related behaviours for children with cancer (Robb et al. 2008); improves maternal and child outcomes (Chang, Chen, and Huang 2008; Lai et al. 2006; J. Loewy et al. 2013; Joanne Loewy 2015); reduce stress for postoperative cardiac surgery patients (U. Nilsson, Unosson, and Rawal 2005; Ulrica Nilsson 2009); improve blood pressure of individuals with hypertension (do Amaral et al. 2016; Kunikullaya et al. 2015); improve motor capacities among people with Parkinson's (Stegemöller et al. 2017) and quadriplegia (Tamplin et al. 2013); improve gait outcomes for people with acquired brain injury (Bradt et al. 2010); improve spontaneous speech for stroke patients (Raglio et al. 2016); and is an effective addition to general physical rehabilitation (Weller and Baker 2011).

that it's a "special song," stating "I don't need anything else. *My Way* is everything." Through Buddy's statement that "*My Way* is everything," we can understand music therapy to have fulfilled his needs in that specific moment, however ambiguous those needs may be. In clinical contexts, music therapists attend to patient needs like Buddy's—needs that can be difficult to quantify or qualify.

Based on sixteen months of fieldwork conducted between 2019 and 2020, this ethnography examines the work of music therapists in Canada and the United States, paying attention to the ways in which they navigate the margins of biomedicine to care for people in hospitals and affiliated long-term care institutions. I argue that music therapy is made into a health profession through an affiliation with the clinic and biomedicine as the standard of clinical care. I show how music therapists make their care practices legible within the clinic and, simultaneously, exceed clinical normative logics and models of clinical care in their work.

What is Music Therapy?

"The problem with music therapy, especially in North America, is music therapists' identity." Matthew told me this in his straightforward tone. "It's such a big thing, I'm tired of it. There are so many approaches to music therapy. Even for us, music therapists, it's not well defined. So, imagine for the people who are not music therapists. What is music therapy? Everybody has their own way of explaining it. It's not a clear profession." The music therapy literature reflects Matthew's assessment, affirming that the field is difficult to define and that the debates over defining the field relate to the frictions surrounding music therapists' professional identity.

Eminent music therapy scholar Kenneth Bruscia devoted an entire text to *Defining Music Therapy* ([1989] 2014), wherein he reviews over one hundred different definitions of music therapy published since the late 1970s. He claims that definitions of music therapy

constitute “the very foundation of professional discourse on [music therapists’] identity” (xix). While acknowledging the challenges of defining the field and recognizing that “music therapy is different things to different people” (8), Bruscia provides an explanation for why the field is difficult to define:

> As a body of knowledge and practice, it is a hybrid of two subject areas, music and therapy, which relate to many different disciplines; as a transdisciplinary field, it is at once an art, science, and humanity; as a fusion of music and therapy, both of which have unclear boundaries, it is very difficult to define; as a treatment modality, it is incredibly diverse in application, goal, method, and theoretical orientation; as a worldwide endeavor, it is influenced by differences in culture; as a discipline and profession, it has a dual identity; and as a relatively young field, it is still developing. (Bruscia [1989] 2014, 8)

For Bruscia, music therapy is a difficult field to define because of its heterogenous nature. Nevertheless, Bruscia provides the following general definition:

> Music therapy is a systematic process of intervention wherein the therapist helps the client to promote health, using music experiences and the relationships that develop through them as dynamic forces of change. (Bruscia [1989] 2014, xxii)

The Canadian and American national professional associations of music therapists also provide general definitions of music therapy. For the Canadian Association of Music Therapists (CAMT):

> Music therapy is a discipline in which Certified Music Therapists (MTAs) use music purposefully within therapeutic relationships to support development, health, and well-being. Music therapists use music safely and ethically to address human needs within cognitive, communicative, emotional, musical, physical, social, and spiritual domains. (CAMT 2020a)

According to the American Music Therapy Association (AMTA):

> Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music therapy interventions can address a variety of healthcare and educational goals: Promote Wellness; Manage Stress; Alleviate Pain; Express Feelings; Enhance Memory; Improve Communication; Promote Physical Rehabilitation; and more. (AMTA 2005)

Finally, the World Federation of Music Therapy (WFMT) provides the following definition:

> Music therapy is the professional use of music and its elements as an intervention in medical, educational, and everyday environments with individuals, groups, families, or communities who seek to optimize their quality of life and improve their physical, social, communicative, emotional, intellectual, and spiritual health and wellbeing. Research, practice, education, and clinical training in music therapy are based on professional standards according to cultural, social, and political contexts. (AFMT 2011)

These definitions vary, with "music therapy" defined by Bruscia as a systematic process of intervention, by the CAMT as a discipline, by the AMTA as the clinical and evidence-based use of music interventions, and by the WFMT as the professional use of music and its elements as an intervention. Despite variations in these general definitions, music therapy is consistently defined in terms of two essential components: first, that there is a music therapist present, and second, that music is used by a music therapist in or as a therapeutic modality.

The CAMT and the AMTA highlight that music therapists are certified or credentialed professionals; similarly, the WFMT refers to "the professional use of music" and Bruscia states that "a music therapist has to be recognized as a 'trained professional' through some official mechanism or authority (e.g., certification or registration by a professional association or state licensing board)" ([1989] 2014, 38). Although the use of music for health and wellbeing in a variety of contexts is recognized by music therapists as potentially therapeutic (Aigen 2014; AMTA 2021e; Bruscia [1989] 2014), it is the presence of a trained and certified music therapist that makes a musical experience music therapy for patients and clients.[3] As Canadian music therapist Barbara explained to me:

> Yes, music can be therapeutic and healing when used by other people. But people don't know what music therapy is. Anything musical is called music therapy. People will put

[3] While "patient" is used consistently by medical staff, allied health professionals like music therapists, psychologists, social workers, and physiotherapists often use the term "client." Music therapists working in hospitals use the standard medical term "patient" interchangeably with the term "client." In long-term care, other terms like "resident" are used. Since my research centres on the work of hospital music therapists, I typically use the terminology "patient" throughout this dissertation in accordance with hospital terminology.

> on a CD [compact disc] and say, "We have music therapy." Or a volunteer that plays music, "we have a music therapist." That's not music therapy and unless the volunteer is a certified MTA, they're not a music therapist.
>
> So, a lot of us do advocacy. We're trying to get the word across that it's certified music therapist, MTA in brackets, so that people recognize that the MTA is the professional credential that signifies you have a trained and qualified music therapist. Like MD, everybody knows that stands for medical doctor. It's a credential recognition. And a professional recognition that this is someone who's been trained, qualified, and is approved by their profession.

As Barbara highlighted, the profession of music therapy is not well understood by broader publics. While the activities of volunteers who talk to people or assist people with physical activities are not referred to as psychotherapy or physical therapy, and the volunteers themselves are not referred to as psychotherapists or physical therapists, music therapy is regularly used to refer to any musical activity that could be therapeutic—Barbara gave the example of playing a CD—and volunteer musicians are often referred to as music therapists. Music therapists like Barbara advocate for their profession by increasing awareness that music therapy is a professional field with certification processes that reflect a music therapist's training and qualifications. The distinction that, as I was often told, "it is only music therapy when a music therapist is doing it" delineates the boundaries of the profession and, simultaneously, points to the skills that music therapists have carefully cultivated through training and practice.

In Canada there are over one thousand Certified Music Therapists (MTAs) and in the United States there are over eight thousand Board-Certified Music Therapists (MT-BC) (AMTA 2020a; CAMT 2020b).[4] Becoming a MTA in Canada or a MT-BC in the United States follows a

[4] Board-Certification for music therapists was established in the United States in the 1980s by the NAMT; since 2017, CAMT has required music therapists in Canada to pass the CBMT examination in order to apply for MTA certification. Previously, the certification process consisted of a portfolio review (CAMT 2016a; 2017). In 2021, there are 9378 Board-Certified music therapists residing in thirty six countries: 8836 in the United States, 348 in

similar process. First, it requires university-level training at the undergraduate or graduate level with a supervised clinical internship of one thousand hours in Canada and a minimum of nine hundred hours in the United States (CAMT 2020a; AMTA 2017c), followed by successfully passing a board certification exam administered by the Certification Board for Music Therapists (CBMT 2021; CAMT 2021c; AMTA 2021f).[5] Certification processes are overseen by the CAMT in Canada and the AMTA in the United States; these national professional associations establish training standards, approve training programs and internships, maintain a standard of practice and code of ethics for professional practice. Certified music therapists work in hospitals, long-term care facilities, hospices, schools, prisons, substance abuse and addiction treatment centres, community or non-profit programs, private practice, and other settings across North America.

Music therapists use music to promote health or accomplish health-related goals through various methods and theoretical frameworks. Bruscia ([1989] 2014) organizes music therapy interventions into four methods: (1) improvisational, the spontaneous and unplanned creation of music; (2) re-creation, the reproduction of precomposed music; (3) compositional, the planned creation of music; and (4) receptive, the act of listening to live or recorded music. The intervention techniques listed by the CAMT and AMTA on their websites can be understood in terms of these four umbrella categories.[6]

Canada, 59 in Japan, 26 in Taiwan, 20 in South Korea, 14 in China, 11 in Singapore, and less than 10 in each of the following countries: Argentina, Australia, Austria, Bermuda, Cyprus, France, Germany, Hong Kong, India, Indonesia, Ireland, Israel, Italy, Kenya, Macau, Malaysia, Netherlands, New Zealand, Norway, Philippines, Portugal, Puerto Rico, Qatar, Spain, Sweden, Switzerland, Thailand, Trinidad and Tobago, and the United Kingdom (personal correspondence with CBMT, September 2021).

[5] The total clinical training requirement in the United States is twelve hundred hours, with a minimum of nine hundred consisting of internship hours; the remaining three hundred hours can be completed through clinical practicums during coursework or through additional internship hours (AMTA 2017c).

[6] The AMTA lists intervention techniques as: "music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, music performance, and learning through music" (AMTA 2021a). The CAMT lists

Music therapists often turn to psychoanalytic, behavioural, and neurological scientific discourses to explain how they use music and its beneficial effects. Psychoanalytic approaches to music therapy, such as music psychotherapy, claim that music can stimulate the unconscious mind (Austin 2009; Backer and Sutton 2014; Bruscia 1998; Hadley 2003; Priestley 1994; 2012), while behavioural and neurological approaches understand music as a stimulus that can affect brain functioning and behaviour, offering psychological and physiological benefits (Baker, Tamplin, and Kennelly 2006; Hanser, Suzanne B. 2015; Madsen 1981; Silverman 2015; Thaut 2013; Thaut and Hoemberg 2014). Such approaches conceptualize music as a tool, object, or medium that can transform minds and bodies emotionally, behaviourally, or physically to achieve medically legible "clinical goals," such as reducing pain, depression, and anxiety; improving speech and motor skills; and developing cognitive, communicative, social, emotional, and behavioural skills.

Other approaches to music therapy that music therapy scholar Kenneth Aigen (2014) characterizes as "music-centered"—such as Nordoff-Robbins music therapy (Aigen 1998; 2005; Nordoff and Robbins 1971; 1985; Verney and Ansdell 2010), creative music therapy (Ansdell 1995; C. Lee [1996] 2016; Nordoff, Robbins, and Marcus 2007; Robbins 2005), aesthetic music therapy (C. Lee 2003), resource-oriented music therapy (Rolvsjord 2010), culture-centred music therapy (Stige 2002), and community music therapy (Ansdell and DeNora 2016; Pavlicevic and Ansdell 2004)—understand music not as a tool but rather as an experiential activity, social practice, and participatory event that is transformative. For music-centered approaches to music therapy, "musical goals are clinical goals" (Aigen 2014, 69) since music participation is understood as inherently enriching to human life. Music therapy scholars characterize such

intervention techniques as: singing, playing instruments, rhythmic based activities; improvising; composing/song writing; imagery-based experiences; and listening (CAMT 2020a).

transformative effects of music therapy in different ways. For Gary Ansdell (1995, 68), this musical realm—what he calls the "musical between"—enables "a different feeling of both yourself and how you relate to other people." Carolyn Kenny (2006; 1982) calls this musical realm the field of play, while Rachel Verney and Ansdell (2010, 48) describe this experience in terms of "being-in-the-world musically." Similarly, for Colin Lee (2003; [1996] 2016), musical experience enables an altered reality that transcended the boundaries of life and death.

These philosophical differences in understanding how music therapy works shape music therapists' professional identities; Aigen (2014) claims that music therapists who take a psychoanalytic, behavioural, or neurological approach to music therapy identify as "clinicians first" and music therapists who take a "music-centered" approach identify as "musicians first." Despite theoretical contestations about how music therapy works—either as a tool that has a physiological impact on the body, a medium for psychological transformation of the mind, or a phenomenological social and cultural experience that envelops the mind-body holistically—these various approaches to music therapy are predicated on the idea that music is a unique and inherently good object or activity with healing properties.

The idea that music is an intrinsically good object or activity is a widespread conviction not restricted to music therapists. For music scholars Amy Cimini and Jairo Moreno (2016), the belief that music has inherent and inexhaustible value for the social good is a "fiduciary notion." Whether conceptualized as either an autonomous object or a performative event, they argue that music retains "immanent conditions of singularity and exceptionality" and is imagined as "something that cannot betray those for whom it is entrusted to care" (Cimini and Moreno 2016, 17–18). However, Cimini and Moreno argue that this fiduciary configuration of music obfuscates the political. They assert the value of music is not intrinsic—it must be historicized

and contextualized in its material specificity. Their work is in line with other contemporary music scholars who have demonstrated the ways in which music is constituted through material practices and implicated in complex economic, social, cultural, and political relations (Abbate 2004; Born 2005; 2010; Eidsheim 2015; 2019; Ochoa Gautier 2014; Piekut 2014; T. D. Taylor 2016; Sterne 2003; Stoever 2016). Despite these theoretical interventions, as well as scholarship on the ways in which music is mobilized for torture and warfare (Cusick 2008; 2020; Friedson 2019; Cloonan and Johnson 2002; Pieslak 2009; Daughtry 2015; Goodman 2010), a belief that music has inherent and inexhaustible value for the social good remains common sense.

Music therapists situate themselves as uniquely positioned to tap into the supposed inherent and inexhaustible value of music for the social good. As Rachel articulated:

> In the right hands, in a *music therapist's* hands, music is such an effective way of supporting somebody's whole being. Because human beings are inherently musical. Music intersects with our lives from birth until death.

In music therapy, music is mobilized "in the right hands"—by professionally trained and certified music therapists—in the pursuit of health and wellbeing. This dissertation is concerned with questions of professionalization and practice. In this ethnography, I argue that music therapists position themselves as having the "right hands" to use music as music therapy and make musical experiences into music therapy through their relationship with the clinic.

A Clinical Practice

Music therapy is a clinical practice. While historical accounts of music therapy often trace the lineage of the field to practices of musical healing in ancient Greece as well as to traditional healing practices of Indigenous peoples around the world (W. Davis and Hadley 2015; Horden 2000; Gouk 2000), music therapy is understood to have been firmly established as a "modern" profession in the mid-twentieth century, informed by scientific methods and rooted in Western

biomedicine (W. Davis and Hadley 2015). This "modern" profession developed through nineteenth and early twentieth century European and American physicians' use of music in institutional settings, including hospitals, asylums, and sanitoriums (Korenjak 2018; W. B. Davis 1987; W. Davis 1997; W. Davis and Hadley 2015).

The early formalization of music therapy as a professional field in North America emphasized the clinical use of music. The first longstanding professional association for music therapy in the United States was established as the National Association for Music Therapy (NAMT) in 1950 (Green 1950).[7] The stated objective and purpose of the NAMT was "the progressive development of the use of music in medicine" and a commitment "to the advancement and development of educational and professional standards in music therapy" (Green 1950). In 1950, NAMT had formed only one committee—one devoted to research. This suggests that research played a central role in early efforts to "develop" the profession of music therapy. The NAMT, known today as the AMTA, is the oldest professional association for music therapists, having been one of the first organizations to establish training requirements and certification processes for the professional category of music therapist.[8] Ten years after the formation of the NAMT, a survey on the use of music in Canadian hospitals was presented at a NAMT conference by Norma Sharpe, a Canadian music therapist trained and registered in the United States (Sharpe 1960), which subsequently led to the creation of a Canadian association for music therapy in 1974—known today as the CAMT (CAMT 2021a). In 1977, the CAMT

[7] In the United States, early efforts to form national music therapy societies or associations include the National Society of Musical Therapeutics founded in 1903 by classical musician Eva Augusta Vescelius, the National Association for Music in Hospitals founded in 1926 by Isa Maud Ilsen, a nurse, and the National Foundation of Music Therapy, founded in 1941 by music teacher Harriet Ayer Seymour (W. Davis and Hadley 2015).

[8] In 1998, the NAMT merged with the American Association for Music Therapy (AAMT) to become the AMTA (AMTA 2021b). The AAMT was established in 1971 (initially as the Urban Federation of Music Therapy) as a separate national organization in the United States with a humanistic and music-centred philosophic orientation, maintaining separate training and certification standards (Hesser 1992).

incorporated with similar goals as the NAMT—"to promote the use and development of music therapy in treatment, education, training, and rehabilitation" with a commitment to the development of educational and professional standards as well as to furthering research (CAMT 2021a).[9] In both the United States and Canada, the "development" of music therapy for clinical applications—in medicine or treatment—was foundational to the profession.

According to music therapy scholar Barbara Wheeler (2015, 10) the professional formalization of music therapy with the NAMT in the United States was "in response to the need to help hospitalized soldiers from World War II." During World War II, organizations like the National Federation of Music Clubs, the Music Teachers National Association, and the American Red Cross organized volunteer musicians to work with returning veterans in the United States. In the late 1940s, the National Music Council's Hospital Music Committee—a precursor organization to the NAMT—began to document the paid employment of what they referred to as "full-time music specialists" in their *Hospital Music Newsletter;* this publication was later renamed the *NAMT Bulletin*. The first issue of the *Hospital Music Newsletter*, published in 1948, lists one hundred and seventeen American hospitals employing full-time music specialists, with many being Veterans Administration (VA) hospitals (Green 1948).[10] Ray Green, military composer-conductor and Chief of Music in the VA Recreation Service, chaired the Hospital Music Committee in the late 1940s and became the first president of the

[9] In 1997, the CAMT stated the following objectives: "to promote the use and development of music therapy in the treatment, education, training, and rehabilitation of children and adults suffering from emotional, physical, or mental handicaps, by: establishing, maintaining, and improving standards of treatment and service in music therapy; establishing, maintaining, and improving standards for education and training for music therapists; encouraging, developing, and promoting research in music therapy; encouraging, developing, and promoting a body of literature in and related to music therapy; furthering the practice of music therapy in scope and quality, in clinical, educational, and community settings throughout Canada" (CAMT 2021a).

[10] For more on the history of music therapy with American veterans and its relationship to the military in the United States, see Rebecca Vaudreuil's edited collection *Music Therapy with Military and Veteran Populations* (2021). On music therapy with military populations more broadly, see "Music Therapy with Military Populations: A Scoping Review" by Lori F. Gooding and Diane G. Langston (2019).

NAMT in 1950 (Green 1950). While there was a broad interest in the therapeutic use of music in institutions during the early-to-mid twentieth century—for example, surveys documented the use of music in American hospitals, mental institutions, institutions for disabled adults and children, and prisons in the 1930s and 1940s (van de Wall 1944; 1948; Hamilton and van de Wall 1944)—hospitals, especially VA hospitals, were important sites for the development of the profession. As Esther Goetz Gilliland, the second President of the NAMT (succeeding Green), stated in 1951:

> The phenomenal growth of hospital music during the past five years offers proof of the need for recognition of a new profession, fully accepted by the medical profession. Ever increasing numbers of social-minded musicians are being attracted into the ranks of paid hospital workers. […] Hospitals paying the best salaries are asking for music therapists with degrees. (Gilliland 1952, xiii)

As Gilliland suggests, hospitals shaped the early establishment of music therapy as a paid profession in the United States as well as a site for establishing the "recognition" of music therapy as a profession "fully accepted by the medical profession."

Hospitals were essential sites for the clinical training of early music therapists. In tracing the historical development of the music therapy curriculum in the United States, music therapy scholar Shannon de l'Etoile (2000) details how in 1919 Columbia University began offering the first university courses in "musicotherapy" in New York City and in 1944, led by Music Department Chair Roy Underwood, Michigan State University began the first bachelor's degree program in music therapy, followed by other programs established in 1948 at the Music Department of the University of Kansas, the Music Department of Alverno College in Wisconsin, and the Chicago Musical College. De l'Etoile highlights that many of the university music degree programs were associated with hospitals and, during the 1940s, that some

hospitals even established their own training programs for musicians, such as the VA Hospital of Lyons New Jersey and Iowa state hospitals.

Early music therapy training consisted of a university music degree in conjunction with a hospital internship (Anderson, Gaston, and Underwood 1953; Gilliland 1951). As I discuss further in chapter two, a foundation in Western art music training through university degree programs continues to shape the professional field alongside clinical training. Hospitals were understood as important sites for learning how to "coordinate and integrate" with other health professionals—namely, "internes, nurses, laboratory technicians, social service workers, chaplains, psychologists, occupational therapists, recreational therapists, physical therapists, speech therapists, dieticians, and attendants" (Gilliland 1952, xi). In 1951, Gilliland argued:

> The best place to learn to do this effectively is in the hospital. Any course of study which does not include hospital internship should be avoided. On the other hand, to go into a hospital with nothing more than musicianship and a desire to use it places a severe handicap on the would-be therapist as well as on the patients and staff. This desire to do good without adequate knowledge of how to go about it is one of the causes for skepticism on the part of the medical profession. With the great amount of knowledge already tried and true there is no reason to start from scratch.
>
> Many hospitals realizing the value of music and greatly in need of volunteers have set up orientation programs to train these musicians to present programs and to do individual teaching. While this is a noble attempt to fill existing voids, music therapy must include more specialized training under adequate leadership as well as internship in order to achieve professional status.
>
> There have been some, fortunately a minority, who have maintained that all that is necessary for a hospital program is a musician, plus a physician to direct activities. […] A physician's services in a hospital are in such great demand that he has little time to attend to details of music procedures or activities. Situations constantly arise where the therapist must use his own judgment. Just as an efficient secretary must know almost as much about her employer's business as he does, so must the music therapist understand basic healing processes in order to carry out a doctor's orders scientifically and successfully. (Gilliland 1952, xi)

According to Gilliland, advancing toward "professional status" as music therapists would be best facilitated through clinical training, under the supervision of physicians and in collaboration with other health professionals.

Today, the clinic remains an important site of training, research, and practice; however, music therapists are no longer restricted to hospitals as sites of clinical training. Music therapy students can complete their clinical training through coursework practicums and internships in any setting so long as it is supervised and approved by the AMTA or CAMT (AMTA 2017c; CAMT 2018). Music therapists have also broadened conceptualization of their work beyond the notion of music in medicine.[11] However, despite "diversity in clinical practice" (Bruscia [1989] 2014, 12), with music therapists working across various settings, music therapy remains a clinical profession—in other words, involving the assessment and treatment of patients.

In this ethnography, I approach the clinic as not only a major site of training and practice for music therapists but also a crucial site for the making of music therapists into health professionals and music therapy into a health profession. Philosophers Georges Canguilhem ([1943] 1998) and Michel Foucault ([1963] 2012) situate the clinic as a space where biomedical norms, truths, and experts are in the making. According to Canguilhem, it is in the clinic that norms—characterized as what is desired and valued as well as what is considered average or standard—of health and disease are produced. The clinic for Canguilhem is the space of medical therapeutics that hinges on the interpersonal relation between patient and practitioner. In *The Normal and the Pathological* ([1943] 1998), he critiques the purported objectivity of medical

[11] There continues to be clinical interest in what is referred to as "music medicine." While music therapy is contingent on a therapeutic relationship with a music therapist, music medicine is the therapeutic use of music by non-music therapist clinical professionals, such as physicians and nurses. Research and practice of music medicine ascribes to a "dose-response" model, with the assumption that the application of music (with music presumed to be an isolatable object) can produce desirable cognitive, behavioural, or physiological effects.

empiricism, arguing that the pathology of disease depends on the subjective relation between the patient and the physician in the context of the clinic. Canguilhem writes:

> Every empirical concept of disease preserves a relation to the axiological concept of disease. Consequently it is not an objective method which qualifies a considered biological phenomenon as pathological. It is always the relation to the individual patient through the intermediacy of clinical practice which justifies the qualification of pathological. (Canguilhem [1943] 1998, 229)

While Canguilhem acknowledges other spaces, such as the scientific laboratory, as sites that construct norms, he understands such norms to be perpetually transformed in the clinic through relationships with patients. Following Canguilhem, Foucault traces a nineteenth century epistemic shift in medicine towards normativity that unfolds in the clinic. With the emergence of the clinical gaze of the expert physician in the academic teaching hospital, Foucault ([1963] 2012, 59) claims attention turned to "the disease itself, in the body that is appropriate to it, which is not that of the patient, but that of its truth." The truth of disease became produced through the clinic as a space of observation, testing, and treatment; Foucault (2006, 336) writes, "its distinctive nature, its essential characteristics, and its specific development would finally be able to become reality through the effect of hospitalization." The norms of health, disease, treatment, and care continue to be shaped in the clinic through clinical practice. While, as Rachel explained, music therapists do not offer "curative care" like physicians, they nevertheless strive to offer care that is "taken seriously" or, in other words, believed to be something that "works" as a mode of healthcare. Rachel and other music therapists hope that music therapy might, someday, be considered a "standard of healthcare"; in other words, a clinical norm, a mode of care that is both desirable and typical. As I discuss further in chapter three through the analytic of clinical recognition, the clinic is an everyday site for making music

therapists into health professionals and clinicians, and for making music therapy a mode of clinical care.

This ethnography focuses on the clinical practices of hospital music therapists. My focus on hospital music therapists is commensurate with medical anthropologists who understand hospitals to be clinical institutions at the heart of biomedicine. Medical anthropologist Byron Good (1994, 82–85) characterizes the hospital as an "extra-ordinary 'totalizing' institutional setting" that is "not only the site of the construction and treatment of the medicalized body, but the site of moral drama." Hospitals are therefore important ethnographic sites for investigating the making of biomedicine and its objects (Good 1994; Livingston 2012; Mol 2002) and for unpacking social, cultural, political, and moral questions of life, death, health, illness, and care (Long, Hunter, and van der Geest 2008; van der Geest and Finkler 2004). Medical anthropologists Sjaak van der Geest and Kaja Finkler (2004, 1998) suggest that hospital ethnographies offer "a window to the society and culture in which the hospital is situated." Further, they suggest that through hospital ethnographies medical anthropologists illustrate how, although a universalizing project, biomedicine is not practiced homogenously. This is evidenced by recent hospital ethnographies; for example, in her ethnography of a cancer ward in Botswana, medical anthropologist Julie Livingston (2012, 6) argues that biomedical practice is improvised, particularly in low resource settings, and "a highly contextualized pursuit." Medical anthropologists have also demonstrated that the hospital is not merely a site of clinical practice; Annemarie Mol (2002), for instance, demonstrates how atherosclerosis is enacted in multiple sites of a Dutch hospital (including the clinic and the pathology laboratory) and assembled through coordination. Similarly, in her ethnography of Madang public hospital in Papua New

Guinea, Alice Street (2014, 30) illustrates that hospitals are sites where biomedicine's epistemological hold can be rendered "unstable." According to Street:

> It is hospitals' paradoxical capacity to be at once sites of "total" biopolitical management *and* places where alternative and transgressive social orders emerge and are contested that makes them crucial ethnographic sites for exploring relationships between science, society, and power. (Street 2014, 12)

The public hospital, for Street, is "an important site of political theatre as well as health infrastructure" (181); she demonstrates how Madang public hospital is made into a site where biomedicine, modernity and technoscience are rendered unstable through hospital management's partnerships with government and non-government organizations. Hospitals are sites of "sociomaterial complexity" (Street 2014, 15); as institutions, hospitals are places shaped by various actors including management, boards of directors, public policy makers, private industry such as for-profit insurance providers and pharmaceutical companies, professional associations and regulatory colleges, and broader publics.

While my ethnographic research follows music therapists employed by hospitals and explores the relationship between biomedicine and music therapy as a clinical practice, this is not a hospital ethnography. The many hospitals I learned about through interviews and participant observation with music therapists had their own specific histories, contexts, and cultures. However, my focus on the clinic as an ethnographic site rather than the hospital reflects an attention not on hospitals as institutional places but rather as spaces of clinical practice, where biomedical norms, truths, and expertise are in the making. I approach the clinic as a site that is found within hospitals yet is not all-encompassing of hospitals. I also approach the clinic as a site not limited to the inpatient units of hospitals; I follow hospital music therapists through inpatient units, outpatient clinics, long-term care facilities, and outreach programs. I am interested in how music therapy in the clinic produces effects that, following

medical anthropologist Todd Meyers (2013, 12), are "registered elsewhere." This "elsewhere" that Meyers charts as he follows adolescents within and outside of a residential drug rehabilitation treatment centre in the United States is elusive, as the boundaries between the clinic and the outside world are tenuous. Meyers traces how "the clinic was carried into other places—a kind of intra-corporality between body and place—even if these other places were, in a sense, nowhere" (22). By focusing on the nebulous space of the clinic as not an enclosed location but rather a field of relations, this clinical ethnography charts the contentious relationship music therapists navigate with biomedicine and considers the implications of their negotiation of music therapy as clinical care both within and beyond hospital settings.

The Aesthetics of Healing

As a medical anthropologist trained in music with a background in public health, I was drawn to studying music therapy from an ethnographic perspective. As I began this project, I was surprised to find little ethnographic research on music therapy as a symbolic and cultural healing practice. This was striking to me because music therapy has proliferated globally, with widespread application across various contexts. While music therapists themselves have produced a substantial body of literature on their practice, including scholarship that draws on ethnographic methods, the work of music therapists has been overlooked by ethnomusicologists and anthropologists.[12] By shifting the ethnographic lens to music therapy and the practices of music therapists, this dissertation redistributes anthropological attention to the healing arts.

[12] In recent years, music therapy scholars have applied ethnographic methods to music therapy research (Hjørnevik and Waage 2019; Low, Kuek Ser, and Kalsi 2020; J. Mondanaro 2020; Procter 2011; 2013; Ruud 2020; Stige 2001; 2005), including through collaboration with non-music therapy scholars; for example, music therapy scholar Gary Ansdell's ethnographic research on community music therapy with music sociologist Tia DeNora (Ansdell and DeNora 2016; DeNora and Ansdell 2014; 2017). Music therapy scholar Brynjulf Stige (2001) encourages music therapists to approach writing clinical research as writing ethnographically. Indeed, music therapy scholars often write accounts of their clinical encounters with "thick description" (Geertz [1973] 2000). Examples that come to mind include Colin Lee's evocative description of his musical relationship with his client Francis in *Music at the*

Anthropologists have theorized the aesthetics of healing through ethnographic attention to the performative elements of traditional healing practices with a focus on ritual. Ritual, for anthropologists, has been approached as "a 'laboratory' of the aesthetic" (Kapferer 1983, 8). Song, music, and dance are understood as aesthetic forms that play an important role in Indigenous healing practices by inciting visceral and tacit bodily sensations in rituals that effect healing (Briggs 2016; Desjarlais 1992; Friedson 1996; Kapferer 1983; Stoller 2016; Roseman 1991; Schieffelin [1976] 2005; 2016; Stoller 2016). For example, Edward Schieffelin ([1976] 2005; 2016) describes how successful Kaluli healing practices in Papua New Guinea are predicated on musical performance. Healers must negotiate a relationship with the audience, sensing the audience's mood and energy, engaging their interest, and interacting with them in a way that is sensitive to timing and synchronicity to gain the authority necessary to engage with spirits. Song composition and construction, the quality of singing, a capacity to distinguish vocalizations of spirits, and an ability to move an audience to tears, is essential to the efficacy of Kaluli healing practices. Steven Feld (1982) expands on Schieffelin's reading through a closer attention to emotion, symbolism, and metaphor, arguing that Kaluli performative aesthetics embody and communicate shared sentiments of sorrow and loss while reaffirming cultural myths through sound as "aesthetically coded sentiment" (223). Similarly, Marina Roseman (1991) attends to the performative processes of Temiar healing practices in Malaysia, demonstrating how it is through the emergent and transformative performance of song—where sounds evoke sentiments of longing—that Temiar cosmology is enacted. Human and nonhuman realms are joined, and spirits are enticed to transform illness in health. Again, the aesthetics of such performances—as symbolic codes that "convey meaning in terms of the values of a

Edge ([1996] 2016), as well as SarahRose Black's depiction of her experience offering music therapy to her patient John as he received medical assistance in dying in "That's how the light gets in" (2020).

believing community" (9)—shape processes of healing. Paul Stoller and Robert Desjarlais also describe such processes in their work. Stoller (2016) illustrates how the sounds and rhythms of musical instruments of Songhay healing ceremonies in Niger facilitate the creation of a space in which spirits and patients can communicate about illness and healing through music and dance, while Desjarlais (1992, 208) draws attention to the ways in which a performance of Yolmo healing practices in Nepal "must change how a person feels" through "a change in sensibility—a change, that is, in the lasting mood or disposition that constitutes the sensory grounds of a person's bodily experience." Through performances of song, music, and dance, bodily senses are engaged, human and nonhuman realms are joined, boundaries between bodies and selves are delineated and exceeded, bodies are reconfigured and shaped, and illness is diagnosed and treated.

While anthropologists and ethnomusicologists have focused on the role of music in the aesthetics of non-Western traditional healing practices, in recent years music scholars have considered the role of listening in medical diagnostics (for example, through the use of a stethoscope) and the way in which hospital soundscapes shape patients' clinical experiences (Moreno 2019; Rice 2008; 2003; 2010; Steingo 2019; Sterne 2003). However, the role of music or music therapy in clinical care practices has received little attention from anthropologists and ethnomusicologists. The newer sub-field of medical ethnomusicology has continued to focus on traditional healing practices. In *The Oxford Handbook of Medical Ethnomusicology,* editors Benjamin Koen, Gregory Barz, and Kenneth Brummel-Smith (2008, 7) suggest that the concepts of "music as therapy" and "music medicine" are interesting to medical ethnomusicology but not music therapy as a practice itself. They claim that:

> Music therapy has historically taken a "Western" biomedical stance in conceptualizing the nature of a human being as it relates to health and disease, that is, as a physical entity

> or mechanism. Hence by understanding the modes of action that constitute the proper functioning of the physical body, one can achieve therapeutic effects. In contrast, traditional and long-standing practices the world over, which are among the foci of medical ethnomusicology, include, along with the physical body, the neural, psychological, emotional, and cognitive processes, sociocultural dynamics, spirituality, belief, and the metaphysical as central concerns and modes of action that play critical roles in achieving and maintaining health and, more important, can engage all aspects of a human to move beyond therapy to create healing or cure. (Koen, Barz, and Brummel-Smith 2008, 7)

Koen, Barz, and Brummel-Smith advance a reductive framing of music therapy as a purely biomedical practice, concerned only with the materiality of the physical body, while suggesting that traditional, alternative, or community healing practices that engage music are more interesting to medical ethnomusicology because, unlike music therapy, they approach bodies holistically.

The failure of medical ethnomusicologists to take music therapy seriously is symptomatic of colonial logics and imaginaries of what constitutes a legitimate cultural practice for anthropological and ethnomusicological inquiry. By situating traditional and Indigenous musical healing practices as the proper object of ethnographic attention, anthropologists, ethnomusicologists, and medical ethnomusicologists perpetuate an extractive colonial gaze by assuming there are underlying natural or pre-cultural healing effects of music, fixed in time and space, that are lost in the desensitized West and found in the exoticized Other.

This ongoing Othering of traditional healing practices reinforces the fictitious construct that anthropologist Michel-Rolph Trouillot (2003, 1) has deemed the "Savage slot"—"a space for the inherently Other." Trouillot argues that the production and reproduction of the "Savage slot" through anthropology's ethnographic gaze helps to construct "the West" (the First World, the Developed World, the Global North) as a geographic imaginary—since it can only exist in relation to "the Rest" (the Third World, the Developing World, the Global South)—and its

metanarrative of universalism. Though an ethnographic fixation on the exoticized Other, anthropology and ethnomusicology reifies the West, along with its values, beliefs, and systems (such as development, progress, modernity, and democracy), as the universal default, the hegemonic unmarked Subject against the marked Other. Universalisms, Trouillot writes, are "prescriptive inasmuch as they always suggest, even if implicitly, a correct state of affairs: what is good, what is just, what is sublime or desirable—not only what is, but what should be" (35). Trouillot (2003) calls for ethnographies that unsettle the myth of the West/Rest and expose the processes that produce these fictions. Hidden behind rationality, Western metanarratives of universalism help to maintain colonial dominance and control. Philosopher Frantz Fanon (2007) reminds us that the imposition of Western thought and forced assimilation of the colonized through systems like medical science was not only part of the violence of colonialism but also a justification for imperialism and empire. Anthropological attention to the aesthetics of healing, and ethnomusicological attention to the role of music in healing practices, must attend to the specificities of biomedical practices in order to destabilize biomedicine as an unmarked Western universal and trouble colonial imaginaries. By turning attention to the aesthetics of the clinic, this dissertation contends that the care practices of music therapists, through entanglements with Western art music and biomedicine, perpetuate the metanarratives of the West through while simultaneously work to unsettle and expose these fictions.

In this dissertation, I follow philosopher Jacques Rancière's (2006; 2009) reconceptualization of aesthetics as the distribution of the sensible through the relation between sense (in terms of what is sensed, felt, and perceived) and sense-making (as understanding, or making sense of what is sensed). Aesthetics is typically theorized, following the Enlightenment philosopher Immanuel Kant ([1790] 2007), in terms of the perception and judgement of a form,

or what Rancière gleans as a process of doubling sense (making sense of a sense given) where representation is privileged and a truthful reality can only be discerned through a perception that is "pure," seemingly devoid of bodily sensations and feelings. In a Kantian configuration of aesthetics, knowledge (sense-making) is privileged over sensation (sense). Anthropological and ethnomusicological approaches to the aesthetics of healing can be understood as having ascribed to Kantian aesthetics, describing how traditional practices mobilize art forms (song, music, dance, and drama) to incite bodily sensations (sense) which are perceived (make sense) as healing within a particular sensible world (culture), with the (dis)interested anthropologist pursuing the underlying truthful reality. Rancière identifies a problem in the aesthetic belief that knowledge and sensation can be divided; instead, he argues we must pay attention to the ways in which their entangled relations are distributed. It is through what Rancière calls a dissensus, the staging of an excess that exposes a "conflict of sensory worlds" (2009, 11), that offers radical political potential for disrupting dominant aesthetic distributions and opening up possibilities for redistributing the sensible. While music therapy scholars have considered aesthetics in terms of artistic form, structure, and qualities like beauty in music therapy (Aigen 2007; C. Lee 2003; Stige 1998; 2008), my ethnography approaches aesthetics as the distribution of the sensible and asks, how do different clinical actors sense and make sense of music therapy? By attuning to the ways in which music therapy is sensed, felt, perceived, and made sense of, I argue that music therapists strive to assimilate within the dominant aesthetic configuration of the clinic while also staging moments of dissensus with the clinic. Music therapy, as I demonstrate in this dissertation, is both commensurable and incommensurable with the sensory world of the clinic.

The Aesthetics of Care

In this dissertation I approach the aesthetics of music therapy in terms of the aesthetics of care. To care, as technoscience scholar Maria Puig de la Bellacasa (2011, 90) argues, denotes "an affective state, a material vital doing, and an ethico-political obligation." I use care instead of healing for various reasons. While healing has many meanings, in the clinic the notion of being healed resonates with curing disease, while care is conceptualized more broadly (Mol 2008). In hospitals, what is often referred to as patient care involves: treatment or therapeutics that seeks to cure, manage, or palliate disease, carried out by medical staff like physicians and nurses; supportive care provided by allied health staff, including social workers, occupational therapists, and music therapists; and support for activities of daily living (such as assistance with eating, drinking, and toileting) provided by assistive staff including personal support workers or nursing aids. During my fieldwork music therapists did not describe themselves as healers or music therapy as a healing practice; rather, they understood their work as contributing to patient care. Some actively distanced themselves from the healing paradigm, saying that the concept of healing was loaded or even frustrating for them. This is because phrases like "musical healing" or "the healing power of music" are frequently used by broader publics to describe music therapy, as well as to describe what music therapists would refer to as the therapeutic use of music by non-music therapists. This conflation caused frustration for music therapists, who want their work to be distinguished from "just music" (as a mode of recreation or entertainment) and distanced from alternative healing practices that are not "evidenced-based" and, therefore, considered pseudoscientific or untrustworthy (such as sound therapy or vibroacoustic therapy, for example). At the same time, music therapists also acknowledged the role of music in traditional healing practices—music therapy is situated as a "modern" mode of

professionalized care, as indexed by the use of music in healing practices "in many indigenous cultures around the world" (W. Davis and Hadley 2015, 3).

In chapter two I demonstrate how the aesthetics of music therapy are influenced by Western art music traditions. While the classical aesthetics of Western art music are marked by performance technique, virtuosity, perfectionism, and discipline, music therapists cultivate techniques of improvisation and flexibility. Nevertheless, what is sensible as "music" and "music therapy" is often conflated in the clinic. While music-centered music therapists understand the musical experiences inside and outside of music therapy to operate on a continuum (Aigen 2005; 2014; Ansdell 1995; Rolvsjord 2010; Stige 2002), in my fieldwork I found that music therapists were regularly required to negotiate this distinction and demonstrate that their work holds therapeutic value as clinical care.

Insights from philosopher Walter Benjamin ([1935] 2007) on art are helpful in thinking through the broader context for why is difficult for music therapists to distinguish the aesthetic form of music therapy from other aesthetic forms of music-making in the clinic (for example, music-making by volunteer musicians or music activities organized by recreation therapists). Benjamin claims that the emergence of mechanical reproduction through the industrial revolution alienated copies from originals and representations from sensual worlds, destroying what he calls the aura of art—a temporal and spatial aesthetic presence that is sensed and felt. The aura encompasses the social value of art, as exemplified in ritual and tradition. Building on Karl Marx's ([1867] 2019) theory of commodity fetishism, Benjamin argues that the social value of art is compromised by the commodification and mass consumption of art under industrial capitalism that spurred the emergence of a political-economic "exhibition value" (224) or entertainment value of art, marked by spectacle and artifice. This was complimented by

the bourgeoisie "pure" ideology of art as *"l'art pour l'art"* (224), which claimed that art has an intrinsic value. Both art-as-entertainment and art-for-art's sake failed to recognize the social value of art and its capacity for world-making. The work of music therapists is often dismissed as "nice" for the sake of entertainment or for the sake of art, and not recognized as having transformative capacities. In chapter three I document how music therapists struggle to assert the world-making capacities of music in music therapy as they pursue recognition in the clinic.

In response to the failure to recognize the social value of art, Benjamin advocates for "politicizing art" (242)—claiming art as social, an aesthetic object caught up in the sensual world. Philosopher Susan Buck-Morss (1992) interprets the stakes of politicizing art as restoring a sensitive perception to the world. However, the solution of politicizing art in terms of its social value and restoring a sensitive perception requires a consensus that the social value of art is preferable to its entertainment value and that a sensitive perception is preferable to a desensitized perception. This is what Rancière (2009, 9) calls the "simple consensual game of domination and rebellion" that needs to be supplemented by the aesthetic staging of a dissensus. Instead of offering a return to sensuous experience, a dissensus stages an excess that neutralizes the hierarchical relation of ethical rule and exposes a distribution of the sensible and the aesthetic beliefs that enable such hierarchical relations. In chapter four I claim that music therapists stage extra/ordinary encounters in music therapy that exceed the dominant aesthetic regime of the clinic and reconfigure attunements to what I call the clinical sensorium—the aesthetic distribution of what is sensed and makes sense in the clinic.

Buck-Morss critiques Kantian aesthetics for valuing human subjects who are not open to the aesthetic field but who are desensitized as influencing reality, as exemplified through the (masculine, white, autonomous, contained) figures of the statesman and the general who

demonstrate rational control over the passions as bodily affects. She argues that the masculine myths and values of autogenesis, creative imagination, and artistic production are reified in Kant's aesthetics because he holds the statesman and the general in higher moral and ethical regard than the artist, who is understood to shape representations of reality rather than reality itself. In the clinic, recognition of music therapy is often understood in terms of expression and representation. Ethnomusicologist Jim Sykes (2018) argues that the relegation of music and the arts as modes of representation and expression overlooks the world-making capacities of music through relations of gift exchange. Informed by Sykes' theorization of the musical gift, chapter five of this dissertation argues that music therapists' care practices are characterized by musical gift exchange; through reciprocity, music therapists compose connections with patients in the clinic.

In thinking about music therapy and the aesthetics of care, my work follows a recent turn in medical anthropology toward an attention to care practices (Buch 2014; 2015; 2018; Fassin 2008; Garcia 2010; Kaufman 2015; Kleinman 2013; Kleinman and Geest 2009; MacDonald 2018; Mattingly 2017; McKay 2018; Meyers 2013; Mol 2008; Mol, Moser, and Pols 2015; Stevenson 2014; J. S. Taylor 2008; 2017). This work is in line with feminist scholarship, notably political theorist Joan Tronto's (1993, 104) conceptualization of care as "both a practice and a disposition," as well as attention to the gendered dimensions of care work, particularly through the feminization of reproductive, domestic, and emotional labour (Coltrane 2000; Hochschild [1983] 2012; Hochschild and Machung 2012; Kittay 2013; Okin 1989). Feminist scholarship has highlighted the affective dimensions of care work, or what political philosopher Michael Hardt (1999) calls affective labour—the intangible production and manipulation of affects. Music therapy can be understood as a feminized practice and much of

the labour of music therapy, as I illustrate throughout this ethnography, entails affective labour; for instance, by attuning to the feelings of patients.

In medical anthropology, Annemarie Mol (2008) has influenced ethnographic approaches to care as enacted through material practices. She challenges the biomedical logic of choice that insists a more egalitarian patient-provider clinical relationship can be achieved by increasing individual patient choice. In attending ethnographically to relationality, Mol disrupts assumptions that individuals can make independent choices within therapeutic encounters, demonstrating how patients do not engage as isolated individuals but as members of broader collectives. She advocates for a clinical logic of care that is attuned to relationships with care givers, medications, food, family, and so on, that inform patient decision-making in therapeutic encounters. For Mol, "good care" is characterized by "a calm, persistent but forgiving effort to improve the situation of a patient, or to keep this from deteriorating" (2008, 20). In other words, "You do what you can, you try and try again" (78). This has also been described by Mol and colleagues as "persistent tinkering" (Mol, Moser, and Pols 2015, 14). Mol's theorization of care is commensurable with the dominant structuring of clinical aesthetics, or what I call the dominant structuring of the clinical sensorium, that inform what is sensed and what makes sense as clinical care.

Chapters two and three of this dissertation examine how music therapy is made sensible as a mode of clinical care. In chapter two, I argue that a foundation in Western art music makes music therapy sensible as a care practice that is neutral, objective, and universal in application—a practice that can be made sense of as clinical care. In the clinic, practices that seek to improve or make better the situation of a patient ascribe to biomedical metanarratives of progress and correspond with the dominant aesthetic regime of the clinic—they are sensible as

clinical care. In chapter three, I explore how music therapists struggle to have their work be sensible as clinical care as they strive to have their work valued from a medical perspective, pursuing what I refer to as clinical recognition. Nevertheless, as I demonstrate throughout this dissertation, their work often fails to ascribe to the dominant aesthetic regime of the clinic and is not always sensible as clinical care. In chapter four I argue that the care practices of music therapists intervene in the dominant structuring of the clinical sensorium by reconfiguring clinical attunements and opening-up sensory-affective possibilities through alleviating perceptions of noise, composing atmospheres of care, and structuring feelings.

My thinking on care follows the work of anthropologists like Janelle Taylor (2008) and Lisa Stevenson (2014) who have demonstrated that care is not always about improving a situation and that recognition is at stake in practices of care. In her ethnography of the contemporary suicide epidemic among Inuit youth in the Canadian Artic, Stevenson (2014) theorizes song as a mode of care that is not predicated on tinkering; rather, through song, we "call each other into being" (174). On song as a mode of care, Stevenson writes:

> Seeing a human before you (instead of seeing someone as human) means recognizing *potential* as company, recognizing them as loveable kinds of beings, capable of showing up regardless of any subject positions they may have been asked to occupy. (2014, 163)

Similarly, through auto-ethnographic reflections on her mutual caring relationship with her mother living with Alzheimer's, Taylor (2008) conceptualizes care through practices of mutual exchange, where "the exchange itself is the point," as "a way of being together" (327). For Taylor, recognition is at stake in practices of caring. Too often limited in terms of cognition, Taylor demonstrates how recognition can unfold otherwise, through practices of care that are not unilateral, bestowed from one subject or self to another, but rather through practices of care that distribute subjectivities through relationality. In my fieldwork I found that while music

therapists sought clinical recognition (chapter three), it did not matter to music therapists if patients "recognized" them as "music therapists"; rather, patients and music therapists recognize each other through practices of care that unfold through musical gift exchange. In chapter five, I argue that music therapists sustain affective connections and attachments with patients by caring through practices of musical gift exchange, co-composing care through relations of reciprocity. Turning to theory on the gift is also helpful in thinking about what science and technology studies scholars have deemed the "non-innocence" of care (de La Bellacasa 2017; Duclos and Criado 2020; A. Martin, Myers, and Viseu 2015; M. Murphy 2015). Since care, like the gift, is predicated on relations of reciprocity, I contend that relations of care in music therapy are marked by affective attachment that linger and weigh on music therapists.

In medical anthropology, attention to the non-innocence, dangers, and violence of care is often considered through the lens of Foucauldian biopolitics. Foucault (1978, 139) delineates between disciplinary power as the "anatomo-politics of the human body" and biopower as "regulatory controls: a bio-politics of the population" (139). As a productive form of power, biopower "exerts a positive influence on life, that endeavors to administer, optimize, and multiply it, subjecting it to precise controls and comprehensive regulations" (137). Biopolitical management entails "techniques for maximizing life," including the governance of reproduction and the "cultivation" of bodies (123-5).

By asking how biomedicine participates in the management and regulation of populations, particularly through techniques that "make live and let die" (Foucault 2003b, 241), medical anthropologists have called attention to the biopolitics of care. For example Joseph Dumit (2012) demonstrates how bodies are valued under biopolitical regimes insofar as they can be continually medicated and profitable to pharmaceutical companies. Anthropologists have

also demonstrated how techniques of making live can be entangled with techniques of letting die. Lochlann S. Jain (2013) shows how the same industries that profit from causing cancer through the production of carcinogens are the very same industries that profit by treating cancer through the production of pharmaceuticals and medical technologies. It is not only diseased lives that are profitable for capital under contemporary biopolitical regimes but also deaths—Jain, for example, illuminates how clinical trial cancer patients are instrumentalized as data that will generate profits regardless of whether they live or die. In her ethnographic attention to suicide hotlines for Inuit youth, Stevenson (2014, 86) demonstrates how biopolitics informs "anonymous care" as both a "privileged mode of care" and "prototype of modern care" insofar as individuals are treated as populations. In practices of anonymous care, "it no longer matters who you are, only that you cooperate in the project of staying alive" (82). Stevenson illustrates how life and death are entangled in practices of anonymous care through what she calls the psychic life of biopolitics: "making Inuit live while expecting them to die" (83).

Social theorist Nikolas Rose (2009) has argued that biopolitical concerns have expanded in the twenty-first century to the governance of "life itself" through microbiopolitics—marked by a shift from *bios* (qualified life) to *zoë* (bare life)—in a scaling down of biomedical science to the molecular level. Anthropologists of science and technology, however, have problematized the governance of "life itself" as a fraught configuration. For example, Stefan Helmreich (2009) argues that it is not a stable concept of "life itself" but life's relationality that emerges in the era of molecularization. In his ethnography of marine microbiology, he demonstrates how ongoing shifts in meanings of "life" expose the boundaries between *bios* (qualified life) and *zoë* (bare life) as unstable. Natasha Myers (2015) questions whether "life itself" can indeed be captured. In her ethnography of protein modelers, Myers demonstrates how animate and lively molecules

and excitable matter evade capture as "life itself." Life, she argues, is rendered excitable through relation. Myers warns that recounting stories of biopolitical capture forecloses imaginaries and risks reproducing conditions of constraint.

Anthropologist Elizabeth Povinelli (2016) considers how the governance of difference and markets in late liberalism hinges on the reification of "life itself" as distinct. According to Povinelli, the continual perpetuation of sovereign, disciplinary, and biopower are contingent on the governance of Life (*bios* and *zoë*) as not only separate from Death (*thantos*) through biopolitics but as ontologically separate from Nonlife (*geos*) through what she calls geontopower, where all existents, lively and inert, are measured by the qualities of Life. Povinelli outlines the aesthetic configurations of two sensory worlds: the world in which the distinctions between Life and Death and Life and Nonlife are sensible (that of the colonizer) and the world in which the distinctions have never been sensible (that of the colonized). For Povinelli, there is manoeuvrability in noise (*phonos*) as it disrupts the concept of Life by challenging the very foundation of the human, analytic language (*logos*).

In this dissertation I demonstrate that music therapy is indeed conscripted into regimes of governmentality as a technique of disciplinary and biopower. As a "gentle" care practice, music therapy exerts disciplinary power, for example by soothing patients medical staff perceive as disruptive, and biopower, for example by "making live" in offering something to look forward to. However, I argue that music therapists stage a dissensus with the dominant aesthetic regimes that govern the biopolitics of care in the clinic. The biopolitics of care, as an aesthetic configuration, hinges on multiple aesthetic beliefs: first, as if all human life is the same; second, as if human life is valuable in and of itself; and third, as if "life" can be contained in and of itself. By instantiating the singularity of a life, attuning to aural vulnerabilities, and

practicing recognition otherwise through musical gift exchange (chapter four and five), I argue that music therapists open up spaces of manoeuvrability that deviate from normative configurations of Life and Nonlife.

Methodology

Sensory-Affective Attunements

To register the aesthetics of care in the clinic, and the ways in which music therapy is sensed and is made sense of, my methodological approach draws from sensory ethnography, transductive ethnography, and affect theory. My dissertation fieldwork entailed cultivating modes of attunement and bodily attention to the clinical sensorium and the in/commensurability of music therapy as a care practice in the clinic. Through sensory-affective attunements, I approach feeling as a way of sensing that does not have to make sense. This mode of attention is important for approaching the moments of music therapy, as Rachel explained, that are "unexplainable."

While the anthropology of the senses has disrupted a privileging of vision in anthropological knowledge production and has encouraged anthropologists to be more attuned to bodies, senses, and sensation (Classen 1997; Howes 2003), the affective turn has influenced anthropologists to confront the limitations of a culturally mediated sensory experience. Affect theorist Brian Massumi (2002) has critiqued the mobilization of culture as an ideological explicatory apparatus for sensory experience; he argues it results in the overdetermination of bodies that are structured, identified, and coded into discursive bodies with signifying gestures. Culturally mediated bodies are interpreted to make sense, he argues, but sensation as an unmediated phenomenological experience is overlooked. Affect scholarship has been criticized by anthropologists for "romanticizing" immediacy (Mazzarella 2009, 348) and privileging the

"universal" over the "particular" (E. Martin 2013, S157); however, such critiques interpret affect as a theory of immanence rather than a theory of *emergence* that opens up sensory possibilities and multiple singularities that a determinate process of cultural mediation attempts to close. Through sensory-affective attunements, I ask why some affective forces instead of others are transduced and materialized by sensing bodies that are attuned (and un-attuned) to other bodies and matter in particular ways, while others fail or escape materialization.

Anthropologist Sarah Pink (2011) promotes "doing sensory ethnography" as a methodology for a phenomenological anthropological that is informed by the anthropology of knowledge and the anthropology of the senses. For the anthropology of the senses, Pink situates human perception as central, as well as a common understanding that the five-sense human sensorium is a Western construct. Pink's critical phenomenological approach understands the constitution of cultural meaning, including sensory categories, as inextricable from human perception. She takes up anthropologist Tim Ingold's (2007) application of ecological psychologist James Gibson's (1979) concept of "affordances" of objects and events to human perception, explaining that "affordances are not fixed" and are instead "contingent on perceptual processes" (Pink 2011, 267–68). Instead of approaching objects and events as the location of cultural meaning, accessible through observational methods that engage the senses, Pink advocates for ethnography that entails "learning in and as part of the world" and that attempts to "share or imaginatively empathize with the actions of people in it" (270). This mode of sensory ethnography extends beyond participant observation and "involves the researchers' empathetic engagement with the practices and places that are important to the people participating in the research" (271). This approach displaces a focus on data collection in favour of the production of meaning with participants through shared activities and experiences.

While Pink situates a phenomenological perception and co-production as modes for doing sensory ethnography and knowing sensory worlds, my thinking on perception is informed by affect theory. Late nineteenth century philosopher Henri Bergson ([1896] 1991) approached the perception of matter as an embodied process mediated by memory. More than the recollections of a mind, memory for Bergson is always of bodies, encompassing the retention of motor habits, attitudes, and acts. Bergson understands memory as necessary for making perception otherwise, informing representation by adding to or subtracting from what he calls images—existents that are "more than that which the idealist calls a *representation*, but less than that which the realist calls a *thing*" (5). Following philosopher Baruch Spinoza ([1677] 2000) who conceptualized affects as bodily feelings, Bergson claims that perception cannot be reduced to what Kant ([1790] 2007) describes as the "pure" perception of matter—a process of the mind is uninformed or uncomplicated by the subjective materialities of bodies, memory, and affect. Instead, for Bergson, perception is always affective, arising from within a body. Bergson exposes Kantian aesthetics as conceptualizing the difference between matter and perception of matter by the mind to be a distinction of kind (spatial). Bergson advocates a relational approach to understand this difference in terms of degree (temporal) through the concept of the *durative* as a process open to the multiplicity of becomings. Philosophers Gilles Deleuze and Félix Guattari (1987, 25) describe the temporal process of the multiplicity of Becoming to unfold through immersion in the present, "in the middle" of things "where things pick up speed." This is a process not of negation and capture but of addition, difference, and repetition.

Massumi (2002) conceptualizes the linear, determinate movement that Deleuze and Guattari (1987) problematize through the concept of "territorialization" as the process of induction that captures and contains an actualization, producing gridded, signified,

representational thought and, alternatively, theorizes the process of transduction to encompass transversal, indeterminate movement. Subsequently, inductive sensing can be understood as seeking to determine and capture an essence of a being that differs in kind from another through taxonomy. Instead of striving to capture an essence or taxonomy of being, sensing as transductive can be understood as an active experimental force that adds-to and extends a body into mixtures with other bodies as variously understood through a process of becoming, where multiple singularities of sensing some-things unfold as discrete yet continuous, differing in degree rather than kind. Transductive sensing can be understood as rhizomatic: instead of determinate movement from beginning to end like a linear genealogy, a rhizome is indeterminate, nomadic, non-linear and anti-genealogical, moving between things transversally through abstract lines of flight, intensifying through an additive conjuncture "and…and…and…" that is never fixed or localized but always in-the-act of becoming and emergence. Transductive sensing unfolds affective materializations of bodies that sense and make sense not in determinate isolation but through indeterminate relationality. I approach sensing and affect as contingent processes of becoming, with sensing as a process of bodily transduction that unfolds an indeterminate virtual multiplicity of sensation into affective materializations that constitute emergent worldings.

My sensory-affective attunements pay close attention to sound. In conversation with Donald Brenneis, anthropologist and ethnomusicologist Steven Feld (2004) discusses "doing anthropology in sound." They consider recordings as a mode of ethnographic attention that encapsulates what Feld (1982) calls an "acoustemology," an acoustic structure of physical and social space-time that shapes ways of knowing and being in the world through sound. Following Feld, anthropologist Stefan Helmreich (2007, 622) proposes a move away from ethnographic

immersion toward "a transductive ethnography" as "an inquiry motivated not by the visual rhetoric of individual self-reflection and self-correcting perspectivalism, but one animated by an auditorily inspired attention to the modulating relations that produce insides and outsides, subjects and objects, sensation and sense data." A transductive ethnography pays attention to the ways in which "hearing and listening are conceived and experienced" through multisensorial modes of attention. It requires a "tuning in" and accounting for the material specificity underlying the phenomenology of sensorial practices. As an "idiom for thinking through anthropologies of sound," Helmreich (2007, 632) states that transduction ethnography "asks how definitions of subjects, objects, and field emerge in material relations that cannot be modelled in advance."

While music has been cited as example of affective intensity (Deleuze and Guattari [1980] 1987), sound studies scholarship has pointed to the multisensorial materialities of music and sound. Ethnomusicologist Nina Eidsheim (2015), following anthropologist Clifford Geertz ([1973] 2000), describes music as a "thick event" and a multisensorial phenomenon—it is not something that can be known but is rather "always coming into being" through intermaterial vibrational practices (Eidsheim 2015, 20). In this theoretical framework, music is not an experience external to bodies since it does not exist separately from the materiality of the body. Instead, music is understood as always materially and relationally contingent, moving us away from questions of music's meaning and effect to questions about "the dynamic of relationality" (162)—a node at which affect and its vibratory impact on the material body take precedence. The human-centric conception of music is similarly abandoned, since "human entities constitute only one of the many materialities through which energy is transmitted and transduced" (167).

I use sensory-affective and transductive modes of ethnographic attention for tuning-into the sensory-affective practices of hospital music therapists. These approaches foreground the practices, techniques, and events through which music and music therapy materialize. My ethnographic attentions entailed a kind of embodied presence, similar to what Myers and Dumit (2011, 249) describe as "a responsive body," that is "uncommitted to one mode of embodiment over another; it is willing to move with and be moved by another." This kind of embodied presence is also similar to what music therapists described to me as a particular kind of "openness" necessary on the part of both a music therapist and a participant in music therapy in order for something to happen in a session. I learned from music therapists how to listen for relational entanglements in their clinical practice. They do not make music "for" people but always "with" people—the music, sounds, and silences in music therapy are co-composed through affective entanglements and audible in minor registers. My attunements are also informed by my music training; having formally studied classical piano through weekly private lessons as a child from the age of five and having completed a Bachelor of Music degree, my music education is similar to the foundational training of many music therapists, as I will discuss further in chapter two. While I am not trained as a music therapist, I am trained in Wester art music theory, form and analysis, history, and performance. I know what it feels like to practice an instrument daily, compete as a performer in music festivals, audition for music schools, prepare for practical and theoretical music examinations, participate in master classes and improvisation workshops, perform music both as a soloist and in an ensemble, and accompany singers and instrumentalists.

Fieldsites and Methods

I conducted preliminary fieldwork for my dissertation over an eight-month period, from January to August 2019, attending public events and conferences, and combing through music therapy archives (the Canadian Music Therapy Archives, the American Music Therapy Archives, and the Helen Bonny and Mary Priestly Archives). I visited music therapy archives to research the history and development of the profession and I attended music therapy conferences to network with music therapists and to learn about music therapy professionalization, professional concerns, dynamics, and priorities. I attended public events, such as fundraisers hosted by the Canadian Music Therapy Trust, as well as public lectures and social events. I also participated in private Guided Imagery and Music (GIM) music therapy sessions as a client.

I conducted formal fieldwork through recorded interviews and participant observation in hospitals over a sixteen-month period, from September 2019 to December 2020. This included nine months of in-person observational fieldwork with fifteen music therapists in four hospitals in Canada and the United States: one large (over five hundred beds) non-profit hospital in an urban centre in Northeastern United States and two large (over five hundred beds) public hospitals in an urban centre of Eastern Canada and one small (less than one hundred beds) public hospital in a rural region of Atlantic Canada. Although music therapy in Canada and the United States has its differences, and the context of the Canadian and American healthcare systems is markedly different, the historical and contemporary practice of music therapy in North America is intertwined across national borders and operates on the margins of hospitals in similar ways—precarious and contingent on philanthropic or discretionary funds.

This research project takes a multi-sited ethnographic approach (Fortun 2009; Marcus 1995). Hospitals and hospital-affiliated long-term care facilities were my primary field sites. As

the central infrastructures of biomedical health systems, hospitals were ideal places to follow music therapists into the clinic and conduct participant observation of music therapy programs, since I could see how they had created hospital programs and advocated for the value of their work (to healthcare administrators, funders, and decision-makers instead of clients), how they navigate medical infrastructures (interacting with other health professionals as part of care teams), how they prioritize patients for music therapy (prioritizing those who are socially isolated, for example), and care for hospital patients (who did not pay for music therapy directly in any of these institutions).

The process of obtaining clinical ethics approval and institutional access offered opportunities for collaboration and relationship building with music therapist interlocutors who challenged me to articulate clearly what my research would look like. The language of "participant observation" was concerning for some music therapists who were comfortable with observation but were suspicious that participation would infringe with the therapeutic relationship and process of therapy—especially as I was a trained musician and not a trained music therapist. I positioned myself as an observer and clarified that any participation would be at their discretion. I did participate in many ways: cleaning instruments, pushing music carts, portering patients, holding patients' hands, talking to and listening to patients, singing, playing percussion instruments, playing piano, handing out instruments and song sheets, suggesting songs for music therapy sessions, fetching water for patients, arranging rooms before and after group sessions, organizing song sheets, helping patients read and follow lyrics, holding lyrics and chord sheets for music therapists as they played and sang, advising interns, recalling information and consulting my fieldnotes for charting purposes, advocating to potential funders and hospital decision-makers, and assisting with structured family visits during COVID-19

restrictions. However, during music therapy sessions I situated myself primarily an observer—Alice, for instance, had been worried that my presence would be disruptive to her sessions, but after I started observing her work, she noted that my presence was not disruptive like she had anticipated. In the context of therapeutic encounters, my "participation" as a participant observer was primarily constituted through my engaged presence.

I conducted multiple interviews with the fifteen music therapists that I observed, as well as with ten other music therapists whose work I did not observe. At hospitals, I observed music therapists working with numerous patients; I interviewed ten patients (nine patients on psychiatric units and one patient on a palliative unit). I also interviewed twenty hospital staff members (including social workers, recreation therapists, department managers, unit managers, ward clerks and attendants, nurses, clinical psychologists, and physicians). In total I conducted seventy interviews with music therapists, patients, and other hospital staff, audio recorded with permission. Interviews were semi-structured and open ended. Interviews with patients were kept short and ranged from approximately ten to thirty minutes. Interviews with other hospital staff typically ranged from thirty minutes to an hour in length. Interviews with music therapists lasted anywhere from one hour to three hours in length. Interviews took place in locations convenient for participants, in hospitals this usually meant offices, studios, patient rooms, and unit lounges; outside hospitals locations ranged from coffee shops, to bars, buses, cars, and homes.

While observing music therapists working in these four different hospitals, I took fieldnotes and audio recorded music therapy sessions with permission. I approached field recordings, following Pink (2011, 272), as "a form of ethnographic note taking," that enabled me to take fewer notes during music therapy sessions so that I could be more fully present.

However, most music therapy sessions I observed were not recorded, and in many instances it was also not possible or not appropriate to take fieldnotes. In these instances, I wrote fieldnotes from memory.

I audio recorded forty music therapy sessions with permission; recordings of these music therapy sessions were shared with music therapists and patients. Feld (2004, 465) highlights the importance of "listening and talking about the recordings" with interlocutors as an additional way of learning how to listen ethnographically. I listened to recordings of music therapy sessions with music therapists when possible and discussed the differences in what we noticed. On occasion, I also shared my fieldnotes with music therapists and they shared their clinical notes with me, often back in their offices after a session; again, we discussed the differences in what we noticed and were affected by in music therapy sessions. Some of these discussions were audio recorded with permission. This process of knowledge sharing deepened my ethnographic insights and taught me how to tune into some of the subtleties in music therapists' practices.

Fieldwork in a Pandemic

The COVID-19 pandemic unfolded in the middle of fieldwork for this dissertation. After six months of observing the work of music therapists in hospitals, my in-person hospital fieldwork was suspended in March 2020, as hospitals restricted access to persons deemed non-essential including visitors, researchers, volunteers, and students. I resumed virtual fieldwork with music therapists working in hospitals in April 2020 by conducting interviews over the telephone or through various video-call platforms (Zoom, WhatsApp, FaceTime, Skype, Facebook Messenger). Although meeting in virtual spaces could feel distanced and disconnected, it could also be intimate and personal. I developed new connections with music therapists, particularly

those in remote locations that I might not have connected with otherwise. Connecting virtually during the beginning of the pandemic was also important for getting a sense of how music therapists working in hospital and long-term care settings were feeling and how they were managing and coping with the uncertainties of those early days.

The COVID-19 pandemic has drawn attention to health systems as precarious, vulnerable, and at risk of collapse. Hospitals and long-term care facilities, institutional embodiments of health systems, have been held up as exceptional spaces in need of societal protection. At the same time, COVID has dramatized some pre-existing aspects of the clinic, such as social isolation and social abandonment of hospital patients and long-term care residents in particular (Cohen 2020). While music and music therapy has been positioned as a modality for offering comfort and solace during the pandemic as well as for maintaining connection amidst the extreme isolation and alienation caused by the pandemic (Baird 2020; CBC News 2020; CBC Radio 2021; Connor 2021; Krewen 2020; Merali 2020; Riches 2020), many hospital music therapists I worked with had to temporarily suspend or radically reimagine their work during the pandemic. The hospital music therapists I worked with, however, continued working within hospitals and long-term care facilities in various capacities (adapting their programs or temporarily redeployed within the hospital—for example, as door screeners and visitor facilitators) and were sometimes deemed "essential workers" (CAMT 2020; Gaddy et al. 2020), while much of their other work outside of these facilities (for example, in private practice and for non-profits) was temporarily or permanently suspended altogether, or moved online.

When I received institutional permissions to resume in-person fieldwork in August 2020, hospitals as fieldsites were eerily familiar sites to move through. Much, however, had changed. Music therapists often move throughout hospitals, from one unit to another; however,

during the pandemic, their movements became more restricted. Sometimes this provided a welcome opportunity to concentrate their efforts on a particular unit where their time would otherwise be limited. Other restrictions on their work, like cancelling music therapy on certain units, restricting in-person music therapy group sizes, moving virtually, and singing bans, were challenging for music therapists. Music therapists had to adjust to singing through masks and visors, frequent temperature and COVID-19 tests, and temporary redeployment, changes they quickly "got used to." More difficult were the fears and anxieties related to PPE supplies, catching COVID, and becoming a COVID vector within hospitals and long-term care facilities; the challenges and impossibilities of physical distancing within healthcare institutions that demand contact; the sadness felt for isolated patients; and outbreaks on units. All in-person fieldwork conducted after the beginning of the pandemic took place in Canada due to international travel restrictions.

Ethnographic Storytelling

My method of ethnographic writing is informed by a recent turn in anthropology toward speculation and fabulation (Biehl and Locke 2017; Ochoa 2007; Little 2010; 2014; 2020; McLean 2011; 2017). Kathleen Stewart (1996; 2007) turns to the productivity of the gap between copies-as-representations and originals-as-reality as an aesthetic opening where ethnography can aspire to an otherwise—refuse any claims to represent a "truth" of an "authentic culture" and instead, through speculative attunement, fabulate stories through a poetic telling and retelling of immanent encounters. Stuart McLean (2017) expands on this line of thought by claiming ethnography has radical potential as a fabulatory art that can subvert the division of documentary and fiction, rendering reality "open to questioning and, potentially, refashioning" (xi). Such efforts in anthropology follow the line of thought advanced by Deleuze

and Guattari (1987, 25) by beginning "in the middle" of things and refusing a Kantian aesthetic divide between matter and mind, seizing the opening exposed by the incommensurability of copies and originals that anthropologist Michael Taussig (2018) calls the mimetic slippage, to participate in the fabulation of worlds in the durative.

In writing stories that "take on a life of their own" through producing an excess of meaning (Kathleen Stewart 1996, 58), ethnography can gesture toward there always being more stories to tell (Little 2020; Kathleen Stewart 1996; 2007). Stories that conjure excess are exemplified by the "bad example" (Little 2010; 2020; Ngai 2004; Kathleen Stewart 2003). Refusing to represent events, bad examples conjure radical singularities of affective intensities, sites, or encounters described by Stewart (2003, 2) as "extreme cases that suggest where a trajectory might lead if unchecked" and the spaces where "forces have gathered to a point of impact to instantiate something." Kenneth Little (2010, 4) describes a bad example as a "scene of becoming" and a "transitional moment of impact" that stages an "emergent vitality[y]" that gestures toward multiplicity.

While the storytelling for this dissertation engages an interpretive and representational practice, I aspire toward writing stories otherwise by refusing to always make sense of stories. I fabulate stories through composite places, stories, and people. A composite narrative that weaves stories together in the clinic is for the purpose of anonymity; the music therapy community is small and easily identifiable. Anonymity was important to many music therapists who I worked with and was a condition of my research inside hospital settings that included observation of clinical work with patients. A multi-sited research design along with the use of composite narratives helps to ensure anonymity. Although all hospitals I conducted fieldwork in had their own local contexts and regional specificities, the compositional narrative gestures

toward a continuity in clinical aesthetics, the aesthetics of music therapy, and the aesthetics of care in the clinic. Names for all music therapists, patients, and other hospital staff are pseudonyms, except when surnames are included upon request for select music therapy scholars I interviewed. For the purpose of anonymity, minimal identifying features and descriptions of physical appearance are included in the writing. The demographics of music therapist participants in this study reflect the general demographics of the profession; most music therapists (approximately eighty percent) are, like me, white middle-class women. The stories told oscillate between the time period before and after the beginning of the COVID-19 pandemic in March 2020; this is not in an effort to bracket COVID but to reflect the continuity of fieldwork across this rupture. Stories that unfolded after the beginning of the pandemic are signaled through the mention of details like mask-wearing and physical distancing.

Chapter Overview

Chapter two, "Classical Training and Colonial Legacies," examines the barriers music therapists face in pursuit of professional training. I illustrate that the professionalization of music therapy, shaped by professional associations, audition requirements, and university music departments, is exclusionary and implicated in colonial legacies. I show that Western art music traditions, values, and beliefs resonate with biomedical knowledge systems; subsequently, I argue that it is through a foundation in Western art music training that music therapy is made sensible as a depoliticized clinical care practice, one that is ostensibly neutral, objective, and universal.

In chapter three, "The Politics of Clinical Recognition," I analyze music therapists' everyday struggles to be taken seriously in the clinic. I contend that music therapy is made sensible as clinical care through processes of clinical recognition—being valued from a biomedical perspective. In analyzing stories of clinical recognition and misrecognition, this

chapter argues that music therapists' make their work sensible as clinical care and not "just music" by mobilizing music therapy in support of biomedicine.

In chapter four, "Reconfiguring Attunements in the Clinical Sensorium," I explore how music therapists care practices exceed the normative aesthetics of clinical care. I argue that their work intervenes in the clinical sensorium by disrupting the dominant structuring of clinical aesthetics or what is sensible in the clinic. Music therapists, I demonstrate, reconfigure attunements by alleviating perceptions of noise, composing atmospheres of care, and structuring feelings in their extra/ordinary care practices. I claim these reconfigurations open up sensory-affective possibilities whereby ordinary experiences of living and dying in the clinic can be sensed and make sense otherwise, beyond the normative *an*aesthetics of the clinic.

Chapter five, "Improvising Care through Musical Gift Exchange: Connection and Attachment in the Clinic," documents how music therapists facilitate what they call "connection"—moments of passing intensities and feelings that are fleeting—in their care practices. I argue that affective connections and attachments are forged and sustained through musical gift exchange, practices of care that are contingent on reciprocity, improvisation, and recognition of distributed subjectivities. Music therapists, I argue, co-compose care *with* patients through improvised practices of exchange that sustain connections and attachments in the clinic.

Chapter 2. Classical Training and Colonial Legacies

"What Must Die in Music Therapy?"

At the World Federation of Music Therapy's virtual World Congress in 2020, Marisol S. Norris, founder of the Black Music Therapy Network and professor of music therapy at Drexel University in Philadelphia, began her video-recorded keynote address by singing the somber African American Spiritual "Poor Mourner's Got a Home at Last."[13] During her performance, she showed photographs of Black Lives Matter (BLM) activists at various protests around the world. Addressing the international music therapy community, Norris staked out colonialism as the political terrain upon which the professional field of music therapy continues to be embedded. She stated:

> Although often narrated as a small but growing profession, even marginalized in comparison to traditional healthcare approaches, music therapy holds the vestiges of White European settler colonialism and is founded upon prevailing cultural values and ideals that support its existence, and that simultaneously benefit and harm client communities. […] Access and empowerment in music therapy have often been linked to a proximation of power that would leverage music therapy's potential. In this, we find the fundamental flaw with our stagnant efforts towards empowerment and access—they are predicated on the unjust system that would substantiate their existence. Any calls for justice from music therapy amplify our position within unjust systems at best. At worst, they amplify our attempt to hide these realities that perpetuate injustice from within, and contend our unanimous desire to help—to do good. (Norris 2020, 4–5)

In calling attention to the pervasiveness of colonialism, white supremacy, and anti-blackness in music therapy, Norris' address is part of current efforts inspired by BLM in the music therapy community to reckon with colonial legacies.[14] By conceptually linking the field of music

[13] The Black Music Therapy Network (BMTN) was established in 2015 at the American Music Therapy Association National Conference "with the aim of fostering continued connectivity amongst a vibrant Black music therapy community and supporting their educational development and professional advancement" (BMTN 2021).

[14] For example, the World Federation of Music Therapy recently created a committee for Diversity, Equity, and Inclusion (WFMT 2021) and in Canada an Equity Advisory Council (EAC) was independently established to advise the Canadian Association of Music Therapists (CAMT 2020b). In the wake of the BLM movement, Canadian music

therapy to the social death of Black people, Norris drew attention to the violence of white supremacy in music therapy; for example, through the "suppression of Black narratives, Black aesthetic discourse, and their theoretical contributions" within the profession of music therapy and through "the psychological wounds inflicted upon Black music therapy participants [that] are relegated invisible" (3). Reminiscent of the calls to "let anthropology burn" (Jobson 2020) and to "let classical music die" (Maysaud 2019), in her keynote Norris (2020, 6) asked: "What must die in music therapy to preserve human dignity? What in music therapy must die so that freedom may be affirmed? And what are our lives worth?"

Norris' presentation points toward three critical tensions in the professional field that I discuss in this chapter: first, that the professionalization of music therapy is predicated upon Eurocentric values and ideals that uphold colonial legacies; second, that care practices in music therapy informed by colonial values can cause harm while intending to help; and third, that injustices within the field are obfuscated by professional desires to "help" and "do good." In this chapter I demonstrate how the field's historical and ongoing commitment to Western art music training as an elevated form of musical knowledge is exclusionary and, simultaneously, resonates with biomedical knowledge systems. I argue that it is through a foundation in Western art music training that music therapy is made sensible as a depoliticized clinical care practice, one that is ostensibly neutral, objective, and universal.

---

therapists Hayley Frances Cann and Priya Shah published *Resources for Everyday Anti-oppressive Practices* (2020) to support clinical work as well as encourage allyship among music therapists. Also "moved to action" by BLM, the British Association for Music Therapy (BAMT) published a *Diversity Report*, based on a survey of music therapists in the United Kingdom that documented demographic information, experiences, and concerns of music therapy professionals in the United Kingdom (BAMT 2020, 3).

Diversity and Multiculturalism

The profession of music therapy in Canada and the United States is comprised predominantly of white women. A 2017 survey of music therapists in the United States indicated that eighty-eight percent of American music therapists were women and eighty-seven percent were white (AMTA 2017a).[15] Although there are currently no demographic data for music therapists in Canada, my observations of the demographics of participants at music therapy conferences and interviews with music therapists suggest that most Canadian music therapists present as white women. In recent years, diversity in music therapy has been a topic of conversation for national professional associations. In a virtual update in November 2020, the American Music Therapy Association's (AMTA) Commission on the Education and Clinical Training of Twenty-First Century Music Therapists acknowledged a need to "increase diversity" in the profession (AMTA 2020b).[16] The Canadian Association of Music Therapists (CAMT) has recently added a Diversity and Equity chair to their Board of Directors and recent conferences have focused on the theme of diversity—"Bridging distance. Honouring difference" in 2021 and "Appassionato: Celebrating the diversity of our professional community!" in 2019.[17]

The policies of Canadian and American national music therapy associations, however, do not address the systemic whiteness of the field. Diversity and multiculturalism are treated as professional competencies for music therapists (see table 1). Multicultural competency, according to music therapy scholar Laurel Young (2016, 127), entails that music therapists have

[15] A 2020 survey of music therapists in the United Kingdom also reflects this trend, with eighty percent respondents identifying as women and eighty-one percent identifying as white (BAMT 2020).
[16] Similarly, the BAMT (2020) *Diversity Report* notes the inaccessibility of music therapy training and calls for "equal access, regardless of race, socio-economic and non-classical background" (6).
[17] In 2019, the CAMT conference only featured white scholars as keynote speakers; the irony of an all-white keynote line-up at a conference ostensibly focused on diversity was remarked upon at the panel on "Women, Culture, and Race in Music Therapy in Canada."

skills and knowledge "beyond learning songs in different languages, studying traditional or indigenous instruments, or gaining in-depth practical and theoretical understanding of the musical elements that define particular music cultures, genres, or styles," such that they can "respectfully and skillfully navigate the complexities of engaging in musical experiences with clients whose cultures and personal histories are markedly different from their own."

Table 1. Diversity and Multiculturalism as Professional Competency Areas in American and Canadian Music Therapy, 2013-2017.

Policy document	Competency area	Description
AMTA (2013) Professional Competencies	Clinical Foundations: Professional Role and Ethics	"Demonstrate knowledge of and respect for diverse cultural backgrounds; Treat all persons with dignity and respect, regardless of differences in race, ethnicity, language, religion, marital status, gender, gender identity or expression, sexual orientation, age, ability, socioeconomic status, or political affiliation; Demonstrate skill in working with culturally diverse populations."
AMTA (2017b) Advanced Competencies	Clinical Supervision	"Apply knowledge of norms and practices of diverse cultures to the supervisory process as indicated."
	Personal Development and Professional Role	"Implement music therapy approaches based on knowledge of and sensitivity to the roles and meanings of musics in diverse cultures; Work with culturally diverse populations, applying knowledge of how culture influences issues regarding identity formation, concepts of health and pathology, and understanding of the role of therapy."
CAMT (2016b) Recommended Professional Competencies	Diversity and Multi-Cultural Issues	"Demonstrate knowledge of various social and cultural paradigms," "knowledge of various social and cultural influences on concepts of health and development," and "knowledge of informed and respectful approaches to cross-cultural therapeutic interaction."

Although the above policy commitments by the AMTA and the CAMT suggest that music therapists are skilled in working with diverse communities, Young (2009) has demonstrated that music therapy supervisors in Canada and the United States, again mostly white women, lacked multicultural training and musical skills, and rarely discuss topics of race, ethnicity, and

multiculturalism with their interns. In critiquing definitions of music therapy as Eurocentric, Norris (2019, 16) succinctly affirms: “As the field of music therapy attempts to create progressively responsive aims, it unintentionally falls short of the multiculturally sensitive practice it seeks to promote.”

Efforts to cultivate multicultural competencies and promote diversity within the field of music therapy ascribe to what political theorist Charles Taylor (1992) calls a “politics of difference.” Whereas a “politics of universal dignity” ignores multiculturalism in striving for equal recognition within liberal democracies, a “politics of difference” recognizes cultural difference in striving for equal recognition. According to this logic, music therapy as a professional field needs to both recognize and respect the cultural differences among their clients and practitioners to be an equitable care practice. Yet Black and Indigenous scholars, such as philosopher and psychiatrist Franz Fanon ([1952] 2008), political theorist Glen Coulthard (2014), and anthropologist Audra Simpson (2014), have illuminated how power imbalances make mutual or equal recognition between the colonizer and the colonized an impossibility.

Anthropologist Elizabeth Povinelli (2011, 42) calls the politics of recognition “a central technique of late liberalism.” What Povinelli defines to be “late liberalism” is a mode of liberal governance that emerged in response to global anticolonial and new social movements of the late 1960s and early 1970s that troubled the legitimacy of colonial and paternalistic liberal governance. By making “a space for culture to care for difference without disturbing key ways of figuring experience,” late liberal governance shifted attention through the politics of recognition while maintaining liberalism as a dominant framework (Povinelli 2011, 26).

Music therapy national professional associations' attempts to account for cultural diversity and multiculturalism operate according to the same logics: while music therapists are encouraged to care for difference—understand and respect the beliefs, norms, and practices of clients from diverse cultural backgrounds—the beliefs, norms, and practices that inform the profession of music therapy are left undisturbed. Similarly, professional associations claim to care for difference by desiring and celebrating diversity among music therapists, yet the training systems and conditions that produce a mostly white profession remain untroubled. As Norris indicated, efforts to improve access, empowerment, and justice within the field of music therapy, however well-intentioned, work to amplify both the field's "position within unjust systems" as well as the field's "attempt to hide these realities that perpetuate injustice from within" (2020, 5). Ultimately, national professional associations' efforts to care for difference through promoting multicultural professional competencies and promoting diversity are efforts that, however well-intentioned, avoid disrupting the underlying colonial system of institutionalized Western art music training upon which music therapy is built.

Classical Foundations

The formalized, institutionalized, and academic study of Western art music theory, history, and practice was established in the mid-twentieth century as the academic foundation for training professional music therapists. A university-level training in Western art music, combined with clinical internship in a hospital setting, established music therapists as professionals and music therapy as an objective, scientific, and evidenced-based clinical practice. In 1946, the Committee of Functional Aspects of Music in Hospitals of the Music Educators Association in the United States recommended that music therapy education include the essential components of musical training at the level of a Bachelor of Music Education degree along with a hospital

internship (Gilliland 1951). In 1952, the first educational and clinical standards for training music therapists in the United States were established by the NAMT as a guide for university programs (Anderson, Gaston, and Underwood 1953). Curriculum requirements included mostly music courses alongside general education courses, psychology courses, social studies courses, physical education, and a hospital internship (see table 2).

Table 2. Educational and Clinical Standards for American Undergraduate-level Training in Music Therapy, 1952.

Discipline	Semester/ credit hours	Courses
Music	60	Music Theory; Music History; Piano; Voice; Organ; Orchestral Instruments (Brass, Woodwind, and Strings; Percussion recommended; Instrumental ensemble desirable); Conducting; Arranging; Recreation Music (non-orchestral instruments, rhythm band, musical games, and community singing).
General Education	30	Such as English, Speech, Biology, Physiology, and the Humanities.
Psychology	16	General Psychology; Child or Adolescent Psychology; Abnormal Psychology; Clinical and Experimental Psychology; *Psychology of Music; and *Influence of Music on Behaviour.
Social Studies	8	Introduction to Sociology; Delinquent and Normal Behaviour; Mental Hygiene; and The Family.
Electives	8	Not specified.
Physical Education	4	"To include as many dancing activities as possible—folk, square, tap and creative dancing."
Clinical orientation	2	*General Hospital Orientation
Clinical training	N/A	Six-month (minimum) internship in a neuro-psychiatric hospital. An additional two months' training at additional institutions was recommended for students planning to work with disabled people.

*Core Course Requirements
Source: "NAMT Minimum Music Therapy Requirements: Undergraduate training leading to BA or BM in Music Therapy or Bachelor of Music Therapy" (Anderson, Gaston, and Underwood 1953).

In Canada, there are six schools that offer undergraduate or graduate level training in music therapy approved by CAMT and, in the United States, there are eighty-eight programs

with AMTA approval.[18] In both countries, music therapy programs are typically located within university music schools or departments that teach Western art music—a Euro-centric tradition consisting of a repertoire composed by mostly white, middle- to upper-class men (Citron 1993). Upon completing of their training, music therapists are required to have music competencies (music history, music theory, music performance on a primary instrument as well as piano, guitar, percussion, and voice, song writing, arranging and conducting), clinical competencies (biology, physiology, and psychology, therapeutic principles, therapeutic relationships, group therapeutic processes, clinical research, diversity and multi-cultural issues, interdisciplinary interaction in client treatment), music therapy competencies (music therapy theory, clinical skills including assessment, treatment planning, therapy implementation, evaluation, documentation, and management), and professional practice competencies (standards and ethics, professional conduct, interprofessional collaboration, supervision, and advocacy) (CAMT 2016b; AMTA 2013; 2017b).

To gain admissions to a music therapy degree program at the undergraduate or graduate level, prospective music therapists must pass audition requirements. Although these requirements vary according to the program, candidates are typically required to demonstrate

[18] In Canada, universities with music therapy programs include: Acadia University in Nova Scotia; Canadian Mennonite University in Manitoba; Capilano University in British Columbia; Concordia University in Québec; University of Toronto in Ontario; and Wilfred Laurier University in Ontario (CAMT 2021b). Undergraduate music therapy programs at Acadia University and the Canadian Mennonite University, undergraduate and graduate music therapy programs at Laurier University, and graduate music therapy programs at the University of Toronto are housed in music schools or departments. Two programs fall outside of music schools or departments: Capilano University's undergraduate program is offered by the School of Allied Health; however, direct entry is only possible through completion of the first two years in programs offered by the School of Performing Arts, either the Diploma in Music program (classical) or the Jazz Studies program. Concordia University's master's program is offered by Creative Arts Therapies department within the School of Fine Arts. The music department, also within the School of Fine Arts, is a separate department; however, admission requirements for Concordia's program include having completed bachelor's level music courses and demonstrate evidence of primary instrument performance abilities at the level of a Bachelor of Music as well as piano abilities equivalent to grade (level) six RCM. In the United States, all AMTA-Approved academic institutions must be accredited or affirmed by the National Association of Schools of Music (AMTA 2021c).

proficiency as a performer on their primary instrument, in addition to being tested on music theory, ear training, sight reading, and piano skills, often assessed according to the Royal Conservatory of Music (RCM) curriculum and standards (RCM 2021a).[19] Additionally, prospective music therapy students are expected to demonstrate vocal skills, an ability to accompany themselves on piano and guitar while singing, and basic improvisation skills. These skills are not typically taught in Canadian or American public-school systems; therefore, to gain acceptance into university-level music and music therapy programs, formal music training through private lessons is generally expected. This limits access to mostly white students from middle- and upper-class backgrounds who received private music training as children.

In this chapter, I illustrate how the privileging of Western art music and university-level music training creates barriers and limits access to music therapy training programs. I explore the ways in which music therapy, like anthropology and other academic disciplines, "inherited a field of significance that preceded its formalization" (Trouillot 2003, 9). By maintaining a foundation in Western art music training structures, I claim that the professionalization of music

[19] The RCM curriculum includes practical and theoretical examinations according to levels (previously referred to as grades), including preparatory to level four (elementary), level five to eight (intermediate), and level nine to ten (advanced). Practical requirements for examinations are detailed in the respective instrument syllabi (RCM 2021b). In the piano syllabus (RCM 2015), for example, each level requires the performance of repertoire selected from the following styles: Baroque, Classical, Romantic, Post-Romantic, Impressionist, Twentieth Century, and Twenty-first Century. Practical examinations also cover technical requirements (e.g., scales, chords, arpeggios, and etudes), ear training (e.g., melody clapback, melody playback, and identification of intervals and chords), and sight reading (sight-clapping a rhythm and sight-playing a passage). Theoretical requirements for each level are detailed in the theory syllabus (RCM 2016). Theory exams assess comprehension of music notational conventions (e.g., key signatures, transposition), music terms and signs (generally in Italian), melody writing and music composition (e.g., compose a melody according to a particular convention), form and analysis (e.g., identify specific components of a composition), and music history (e.g., identification of composer, instrumentation, and style). Although the RCM curriculum has included more diverse music styles (i.e., jazz) and composers (i.e., composers of colour and women composers) in more recent syllabi, classical music remains central. In the piano syllabus, for example, all levels require the performance of Baroque, Classical, or Romantic style repertoire. In the theory syllabus, only classical styles (Baroque, Classical, Romantic, and Post-Romantic) are represented until level seven (with the addition of electronic music and jazz) and only white male composers are represented in guided listening requirements until level seven (with the addition of Duke Ellington).

therapy works to extend the colonial traditions and values of Western art music through clinical care.

Through cultural imperialism, Western art music has been positioned as the superior culturally hegemonic standard to which all other musical traditions are compared, as demonstrated by the colloquial use of "classical music" to refer to Western art music forms and genres.[20] Beginning in the 1990s, "new" musicologists influenced by feminist and critical theory started to interrogate the hegemony of the Western art music canon, identifying the implicit subject of classical music's genealogies to be the white middle- and upper-class autonomous man, as composer, conductor, performer, and listener. Musicologist Marcia Citron (1993) demonstrated how classical music figures, like Mozart and Beethoven, are elevated and canonized through the repetition of their works in concert performances and the teaching of their repertoire in music curricula. Citron's scholarship demonstrates that Western art music is not intrinsically greater than other musical traditions but that it is constructed as superior through canonization. The canon is performative; it materializes through reiteration and citational practices (Butler [1993] 2011; [1990] 1999) that construe classical works as superior, autonomous artworks—the culmination of individual genius—believed to resonate with audiences on a universal level, standing the ostensibly objective "test of time." Musicologist Susan McClary ([1991] 2002, 54–55) challenged the assumption that canonized Western art music repertoire, particularly non-textual works known as "Absolute Music" such as symphonies, is "essentially pure," can transcend bodily and material entanglements, and is therefore devoid of sociocultural meaning. Following McClary, musicologist Timothy Taylor

[20] While I use the terminology of Western art music, in this dissertation I also use the colloquial term "classical music" to refer to Western art music styles and traditions because it is used in this manner both by my interlocutors and in the music literature.

(2007, 4) argues that "the classical music ideology cherishes this idea of transcending the time and place in which a work was written," with culture and history reduced to "incidental or irrelevant matters." Through the work of these and other new musicologists (McClary [1991] 2002; 2000; Ramsey, Jr. 2003; Kramer 1990; Solie 1995; Brett, Wood, and Thomas 2006; Born and Hesmondhalgh 2000; Hisama 2006; Citron 1993; Agawu 2003; T. Taylor 2007; Ritchey 2019), it has been well-established that Western art music and a great deal of music scholarship continue to uphold colonial legacies and capitalist ideologies by espousing Western metanarratives through the values, ideologies, and beliefs of liberal humanism, such as rationality, empiricism, universality, and neutrality, along with the myths of the individual genius, the autonomy of art, and timelessness.

Contemporary music scholars, particularly those participating in the turn to sound studies, have added to concerns about which musical texts and musicians are considered worthy of study within the field of musicology by investigating the ways in which music, sound, race, and personhood are constituted through colonial genealogies. Musicologist Nina Eidsheim (2019; 2011; 2012), for instance, delineates how voice is racialized through techniques such as the conditioning of vocal timbre and practices of listening. Eidsheim illustrates how white audiences in the nineteenth and early twentieth century perceived Black classical singers such as Elizabeth Taylor Greenfield as a "shocking phenomenon," and subsequently projected "visual blackness […] onto auditory timbre" in order to hear Greenfield's voice as Black, producing what she calls "sonic blackness" (2019, 74–75). Similarly, music scholar Jennifer Lynn Stoever (2016) traces the racialization of classical music as white in the nineteenth century, considering how Black classical singers like Greenfield were received by audiences that navigated what she calls the "sonic colour line" as they debated whether Greenfield's voice was white or Black.

These interventions demonstrate how a colonial politics of listening and knowing informs the racialization of classical music as white. Colonialism, according to ethnomusicologist Ana María Ochoa Gautier (2014), produced humanity as qualified life—sounded through language and music—against animality or unqualified life—sounded through noise. She demonstrates this by tracing how colonizers made sense of their encounters with emergent Indigenous voicings in Colombia through listening to and documenting sounds in ways that made sense to colonial sensibilities. While this scholarship demonstrates how Black people, Indigenous people, and people of colour are dehumanized through colonial listening practices, performance studies scholars such as Fred Moten (2003) and Daphne Brooks (2006) have demonstrated how black aesthetics can disrupt colonial sensibilities and instantiate freedom; for example, through the improvisational arts of free jazz and musicked speech (Moten 2003) or through self-making in the performance of Western art music (Brooks 2006).

The aesthetics of Western art music, as a dominant aesthetic regime that informs normative perceptions and understandings of music, and its associated colonial genealogies of listening haunt university music departments, shape who counts as valid subjects of music study and, fundamentally, what is heard as music. Music therapy, institutionalized within academic music departments, relies on Western art music traditions and, as a result, is predicated on colonial logics that privilege whiteness. In the subsequent sections I draw on ethnographic interviews with music therapists to demonstrate the various ways in which they navigate their field's underlying foundations in Western art music. While I discuss how music therapy university program entrance requirements in classical music presents barriers for prospective music therapists to overcome, I also demonstrate that learning to unlearn classical music skills is a necessary component of becoming music therapists.

Barriers to Becoming a Music Therapist

Most music therapists I interviewed had been trained in Western art music through private lessons before pursuing music therapy at the undergraduate or graduate level. Claire, a trained classical musician with an undergraduate degree in music performance, volunteered her musical skills at a psychiatric hospital before returning to school for music therapy training. She explained, "I'd sit down, play a couple songs, and people would start bawling or become agitated or speak rapidly—there'd be some reaction. But I didn't know what I was doing. I thought, I have this tool, but I don't know how to use it. So, I went back to school and became a music therapist." Becoming a music therapist, as Claire implies, requires more than technical proficiency as a musician. After her music therapy training, Claire said:

> I knew how to assess people. I knew my boundaries better. I felt safer in that space. I felt intuitively where I would go with the music, what to look for during a session, what to ask in a session. I knew how to structure a session. I knew how to make people feel safer in the music, to make them feel contained, which is so valuable. I knew to provide closure, to stop the music ten minutes early so we could talk about what we'd done. That brings such a layer of meaning—instead of just making music we were discussing how it impacted us. It was a totally different experience. I knew where a music therapist could step forward. A volunteer can't intervene in that way.

As a trained music therapist, Claire knew how to conduct patient assessments and set boundaries as a clinician. Like other medical staff and therapists, music therapists are trained to assess a patient through observation and interaction in order to determine a treatment plan and are also trained to set therapeutic boundaries with patients and clients. Claire also described feeling "intuitively" where to take the music and how to make people feel safe in music; this is what music therapists, following psychiatrists and psychotherapists (Berne 1949; Marks-Tarlow 2012), refer to as clinical intuition, a form of tacit knowledge (Polanyi [1958] 2015) critical to music therapists' practice.

While Claire's advanced classical music training facilitated her entry into a university-level music therapy program, other music therapists recalled the way in which classical music standards acted as barriers for accessing programs. Lucy told me:

> I always knew I wanted to use music to help people. I thought I'd be a music teacher. I had no idea what music therapy was. I had my entire musical training as a child in piano. In high school, I quit piano at grade ten. Teenage rebellion! I auditioned to university music programs with voice, but I had just sung in choir and never taken a voice lesson in my life. I liked to sing. I think it was this thing of finding my voice, both figuratively and literally. One school was excited about a blank slate. Another was like, "Oh, sweetheart, you didn't complete your application. You didn't write down who your voice teacher was." I told him I didn't have a voice teacher. He said, "No, you need a voice teacher." It was the equivalent of ripping up my application in front of me. It was awful.

Lucy's story demonstrates how a critical prerequisite to becoming a music therapist is formal music training, often cultivated during childhood and adolescence through private music lessons in the classical tradition as well as through participation in school bands, orchestras, and choirs. As a child, Lucy had taken private piano lessons that followed the RCM classical curriculum. Although she completed the grade ten RCM examination in piano, she chose to audition to university music programs with voice as her main instrument. Without prior vocal training through private lessons, despite having sung in choirs, Lucy was rejected in a condescending manner from the university music program that offered music therapy. After receiving vocal training at the bachelor's level, Lucy returned to the school that had previously rejected her and successfully auditioned for a master's degree in the music therapy program.

Kate also had a discouraging audition experience. Kate had also taken private piano lessons as a child, although she "hated" piano lessons, practicing, and the "structure" of the classical music training. She was encouraged by her mother to complete until grade five RCM in piano and, in middle school, she started playing flute in the school band and taking private flute lessons instead of piano, in addition to singing in the church choir. Like Lucy, Kate

thought she would become a music teacher; then, in high school, she heard about music therapy. To meet the entry requirements for the music therapy program with flute as her main instrument, she re-enrolled in piano lessons because, as she explained, "you have to have grade six in piano to get into programs on another instrument." Despite having taken additional private lessons in preparation for her audition, Kate also had an extremely unpleasant experience auditioning for a university with a music therapy program—what she described as "the worst day of my life"—and was not admitted to the program. However, like Lucy, she was admitted to another university music school that did not offer music therapy. She trained at that school for a few years before transferring as an upper-year student to another university with a music therapy program.

Abigail also had to pursue additional formal music training before being admitted to a music therapy program. She explained:

> I always loved music, and singing in choirs, but I never wanted to be a performer or anything like that. In high school my music teacher said, "Have you heard of music therapy? I think it would be a good fit for you." It sounded like a perfect thing for me to do. I went to the university's open house and asked the program director what level I needed to get into the music therapy program as far as musical skills. I told him where I was at and he kind of laughed at me and said, "You might want to come back later." I was like… [*sighs*] "Okay." I think he was just being realistic. I wouldn't have gotten into the classical program there. So, I did a two-year college music program instead. I studied jazz piano for one year and classical piano for one year. And then I auditioned for the music therapy program and got in.

Abigail recalls being "laughed at" in a patronizing way by a music therapy program director upon disclosing her prior musical training. Before even auditioning, she was already told to "come back later" after pursuing additional formal music training. While Abigail subsequently took additional classical and jazz piano training before re-auditioning, Lily took a different approach. Although she had taken voice and guitar lessons, and was auditioning with voice as her primary instrument, she had not taken piano lessons as a child. She recalled, "I memorized a

grade six piano piece for my audition. Even though I couldn't really play at a grade six level, I found the easiest grade six piece, took some piano lessons before my audition, practiced, and got in."

The stories of music therapists like Lucy, Kate, Abigail, and Lily demonstrate the high level of musical training, often in the Western classical tradition, that is a prerequisite for admission to any music therapy program creates a barrier for prospective music therapists. While these music therapists navigated this barrier in creative ways, it was an obstacle they had to overcome to become music therapists—one that often required not only an investment of time and energy, but also money. This creates additional financial barriers to access before the financial burden of a university degree and a lengthy internship, one that is typically unpaid. Richard, a music therapy scholar, elaborated on the implications of classical music training as a barrier for prospective music therapists. He explained:

> People bemoan the lack of diversity in the profession. How do you get to become a music therapist? You have to have the skills, typically on an orchestral instrument, to get into conservatory schools or colleges of music. Who gets that? People who grow up in environments where they have music programs and parents who buy instruments. It's a self-fulfilling cycle.
>
> Most music therapy programs are in music schools. If you don't audition and get in, you can't even *think* about becoming a music therapist. There are a select number of schools where you can start music therapy training at the master's level, and you don't have to have a music degree. It means you have a mostly white profession, often working with minority clients. And there's a real power imbalance, all kind of racial, cultural, diversity problems, and it starts from the fact that the conservatory, that music therapy programs require that admission to a music school. It's a big problem.

Richard was critical of the conservatory-style classical music entrance requirements for music therapy programs and linked these barriers to the whiteness of the music therapy profession. As he suggests, the lack of access to formal music training forecloses access to professional training in music therapy at universities for many. This was a problem for the profession,

according to Richard, because it creates power imbalances within music therapy practice and within the profession more broadly.

Classical Skills

Music therapy educational training programs—operating within university-level music faculties, departments, and schools—are intricately bound with Western art music systems, informed by legacies that elevate and privilege colonial histories, theories, and knowledge systems. Music conservatories in the United States and Canada were first established in the late nineteenth century and, by the mid-twentieth century, many universities had established music faculties, departments, and programs in classical music.[21] It was only later in the twentieth century that conservatories, universities, and colleges in the United States and Canada began to offer music programs in other genres of music, notably in jazz.[22] Nevertheless, Western classical music has been maintained as the status quo for music education; university degree programs in jazz studies have often been added to music programs where Western art music was the standard and privileged curriculum, requiring students of jazz to be well versed in Western art music history, theory, harmony, and counterpoint if not also classical music performance (Alper 2007; D.

[21] For example, in the United States, the Oberlin Conservatory was established in 1865, the Cincinnati, Boston, and New England Conservatories in 1867, the Department of Music at the University of Kansas in 1884, the National Conservatory of Music in America in 1885, the Department of Music at Columbia University in 1896, the Julliard School in 1905, the Manhattan School of Music and the San Francisco Conservatory in 1917, the Eastman School of Music in 1919, the Cleveland Institute of Music in 1920, Curtis Institute of Music in 1924. In Canada, the Toronto Conservatory of Music was founded in 1886 (later the Royal Conservatory of Music and the Glenn Gould School), the Halifax Conservatory of Music in 1887, the Toronto College of Music in 1888 (which merged with the Conservatory in 1924), the Conservatory of London in 1903, and the McGill Conservatorium of Music in 1904. Faculties of Music were later established at University of Toronto in 1918 and McGill University in 1920, a School of Music at Laval University in 1922, a College of Music at Western in 1961, a Department of Music at Laurier University in 1967, and a Department of Music at Dalhousie in 1968.

[22] For example, in Canada, jazz training was established at the Banff School of Fine Arts in 1974, Concordia began offering a BFA in jazz in the late 1970s, St Francis College offered a jazz studies program beginning in 1979, and McGill University began offering a BMus in jazz in 1981. In the United States, Berklee College of Music included jazz and popular music in their curricula from 1945, the New England Conservatory established the first accredited jazz studies program in 1969, Oberlin Conservatory incorporated jazz into its curriculum in 1973, the Musicians Institute established in 1977 taught jazz and rock and roll, and the School of Jazz and Contemporary Music at the New School was established in 1986.

Murphy 1994; Wilf 2014). Richard questioned the maintenance of classical musicianship as the standard prerequisite for music therapy training:

> People coming from music conservatories, often vocalists or on orchestral instruments, are wonderful musicians but those skills are almost never used as music therapists. People who make the best music therapists are the ones, sorry, like me, who are self-taught rock or pop musicians, people who said, "Oh, I want to learn piano, guitar, and singing, I want to write a song." Those are the skills!

From Richard's perspective, self-taught musicians are equipped with the skills music therapists require in their everyday practice. Indeed, in my observations of music therapists working in Canadian and American hospitals and long-term care facilities, popular music repertoire—including folk, blues, rock, pop, and jazz—was used most frequently in music therapy sessions, from playing, writing, or listening to music. Popular music was most requested by patients or assumed to be familiar to patients; this is what music therapists call "patient preferred music" (Silverman, Letwin, and Nuehring 2016). During my fieldwork, classical music was rather infrequently used in live music-making; however, professional recordings of classical music repertoire were used regularly in music listening activities.

Early music therapy literature recognized that musical versatility beyond the genre of classical music was important to music therapy practice. However, Western art music was positioned as superior to other music traditions. In *Music as a Cause of Disease and Healing Agent*, psychiatrist Roberto Assagioli ([1933] 1956, 11) wrote:

> It would seem to be a matter of common sense to adapt the music to be performed to the social and cultural level of the listener. Indeed, in the majority of cases, simple uncultured people ask for, and enjoy, popular music and appear to be unresponsive to, and bored by, classical music. Yet there have been many instances in which such people were deeply affected by music of high quality by the great composers.

In his text, Assagioli reiterated the racist and classist beliefs that "cultured" listeners appreciated Western classical music while "simple uncultured" listeners did not. Examples of "simple

uncultured" listeners being affected by classical music provided further evidence for the genre's presumed superiority, perpetuated throughout the late twentieth century and into the twenty-first century in popular texts like music critic Don Campbell's (1997) *The Mozart Effect* that purported listening to Mozart improved intelligence. The presumed superiority of the classical genre meant that a conservatory-style music education was the foundation upon which music therapy training was established. For example, in the seminal music therapy text *Music and Medicine* ([1946] 2015, xvii), physician Sidney Licht described prospective hospital "music aides"—a professional title in the United States used briefly prior to "music therapist"—as follows:

> Regardless of his other qualifications, he must of course be a musician, and a degree in music is valuable; in fact almost essential. The ability to play a second instrument even moderately well is useful. The universal appeal and advantages of the piano make a working knowledge of it important. The music aide should be able either to play the piano at sight or he should study one of the rapid systems of piano instruction for he will be called upon not only to accompany group singing but to assist visiting artists or talented patients. Although a foundation in classical music is part of any good musical training, a musician who refuses to recognize the importance of popular music in American life is not suited to this work.

Although Licht acknowledged the value of popular music to the practice of music therapy, his assertion that a foundation in classical music is an essential component of "any good musical training" reflects the privileged value of classical music as the underlying "standard" of music education. Similarly, in musician Willem van de Wall's *Music in Hospitals* (1948, 82) he describes the skills necessary for hospital music workers (another professional title preceding "music therapist"):

> The wider the range of the hospital musician's familiarity with the current American music repertory the better service he can render. Not only knowledge of standard classical and sacred music is needed, but also of popular compositions, an unparalleled musical medium of cheerful fraternization.

De Wall encouraged early music therapists to familiarize themselves with popular music in addition to their standard foundations in classical music along with sacred Christian music. In sharing similar advice, musician-physician George W. Ainlay (1948, 329) observed that early hospital musicians "stated that they could not lower their standards by playing popular requests." In response, he argued:

> Musicians should discard temporarily their previous ideas and opinions regarding good and bad or poor music. This is important because any music which helps a patient or satisfies him is good music. For example, hillbilly music, which is certainly distasteful to many trained musicians, may have been and may continue to be a great source of joy and comfort to many individuals, and for these it is actually great music. The same thing can be said about cowboy songs, popular music, and jazz.

Ainlay's reconfiguration of what constitutes "good" music to be "any music which helps a patient" is a belief shared by music therapists today. In order to arrive at this belief, however, Ainlay says musicians have to "discard temporarily their previous ideas and opinions" about music; namely, a belief in the superiority of Western classical music.

The positioning of Western art music as the "standard" for music education reflects the way in which Western music traditions are ascribed cultural capital, what social theorist Pierre Bourdieu (1984) identified as knowledge or skills that carry social currency, status, and power. Coded as "high culture," Western art music is elevated as "legitimate" art that is complex and sophisticated, while other musical genres are regularly devalued as "middle-brow" or "popular" (Bourdieu 1984).[23] Western art music is often believed to require a higher level of technical proficiency compared to other musical traditions; simultaneously, classical music is perceived to be threatened by popular music or so-called low art that is commercialized and consumed (Johnson 2011; Kramer 2007; Ross 2010; 2007; Cook 2000). The continued location of music therapy training within music programs, with audition requirements often assessed according to

[23] On art, taste, authenticity, and high versus low culture, see also Lawrence Levine (1988) and Stuart Hall (1980).

RCM standards, is problematic for individuals like Richard, who are self-taught and acquired their musical skills outside of formal "high art" conservatory-style training structures, are left with limited options for pursuing music therapy training.

While Richard was critical of the classical music training requirements and adamant that self-taught musicians made the best music therapists, not all music therapists shared this perspective; some music therapists thought the training structure made sense. Alex, for example, connected the skills attained in classical music programs to the skills music therapists use every day. He said:

> I've never seen a music therapy program that's not tied to a music school. It makes sense! In terms of the way that music therapists work, I think. Like, accompanists make really good music therapists. Because of how they're listening and how they're following the individual—their nuance and the fluctuation in their voice. They already have that intuition of following the individual in front of them.

In explaining the merits of housing music therapy training within university music schools that teach Western art music, Alex offered the example of accompanists, also referred to as collaborative pianists, as having cultivated the listening and playing skills and sensitivities critical to music therapy practice. As Alex's example suggests, although music therapists may engage Western art music repertoire infrequently in their everyday practice, classical music skills and techniques attained through conservatory-style programs can be translatable to music therapy.

Jonathan thought the technical expectations for music therapy students were not high enough. He told me that music therapists needed to have better musicianship, insisting that his set of skills should be "around the baseline" of what is necessary in order to be a "good" music therapist. I was surprised by this comment, having witnessed Jonathan's proficiency at the classical guitar and knowing that he spent years studying classical guitar at a conservatory,

additional years studying jazz guitar, and had a lengthy performance career as a concert guitarist. Seeing my raised eyebrows, Jonathan maintained:

> Seriously, I'm an okay guitarist. I'm not saying you have to be a virtuoso. I feel like I have a good set of skills for what I need to do. I know other music therapists who have similar skills, and they feel the same way. What's always made me feel uncomfortable is when I see someone struggling to play three chords on a guitar and using that in therapy. Partly because of the relationship that people have, not just with the music, but with the musician. If you're hearing someone playing crappy cowboy chords on a guitar, I don't see how that could possibly contribute to the value of the therapy.
>
> You need to have enough music skills and enough technique on the instrument to be able to play music in different ways. Not just styles or genres but to make music sound good even though you're playing it progressively slower, or faster, or louder, or whatever. Music therapy is about being able to manipulate the music in such a way that it becomes an active part of the therapeutic process and not just a backdrop. Not just, "Let's play a song and let's do some therapy." In the process of playing that song, you could have of course started the therapy. But if people don't have the technical skills to do that on the instrument, it brings the level of the profession way down.

Jonathan believed a high level of musicianship was both necessary for music therapists to be good at their job and to elevate the profession so that it would be taken more seriously. Music therapists who play "crappy cowboy chords on guitar" were not only bad music therapists but were bad representatives of the profession—they needed to be equipped with the "technical skills" to make music sound "good" and mobilize music in "the therapeutic process."

I asked Jonathan if he believed classical training was necessary for prospective music therapists. Jonathan replied, "Sure, it'd be great to be proficient in different styles of music. I don't think you need to be an expert in any one of them. It's good to have a solid base. Having a pretty good idea of music theory is important. But now there are lots of programs where you can study rock guitar. You're analyzing Bach fugues even though you're a rock guitarist.[24] I don't

[24] A fugue is a polyphonic musical form that uses contrapuntal compositional techniques that relate multiple voices or musical lines through imitative counterpoint. *The Well-Tempered Clavier* by Johann Sebastian Bach (1722) is a collection of preludes and fugues in all twenty-four major and minor keys. The analysis of fugues is often taught in upper-level undergraduate courses (e.g., Tonal Counterpoint) in university music programs.

think you *have* to be classically trained. It doesn't hurt." Although Jonathan acknowledges that music therapists could be trained in other genres of music, like rock, his comments suggested that formal music training was necessary, one that included literacy in classical music and tonal counterpoint, to create a "solid base" for music therapy training. Rachel expressed gratitude for her foundational training in classical music. She told me:

> I thank my lucky stars every day that I do have a classical background. Just this morning a patient asked me to play Chopin's *Fantasy Impromptu* because she's from Poland. I was like, "Oh my God…can I?" but I could, and I did! I thought, "Thank God I had to practice the heck out of this as an undergrad!" It wasn't perfect—it wasn't great, it really wasn't. But I managed to access enough that it was familiar, I played a section, I had the right chordal structure. So, I do think it's important to have a solid repertoire of different genres and to have classical in there because patients will ask for classical and you've got to be able to pull it out on a dime. I feel strongly about that.

As Rachel highlights, patients and clients will ask music therapists for classical music; for that reason, Rachel felt strongly that music therapists should have some classical music literacy. She referred to her experience from earlier that day when a patient asked for Chopin's *Fantasy Impromptu*, a technically difficult and advanced piano piece. Although playing Chopin imperfectly as a classical pianist amounts to failure according to conservatory standards, in the context of music therapy the capacity to convey the piece enough so that it is "familiar" amounts to a resounding success.

> I think having a really strong basis in something, whether you're an excellent singer-songwriter, classical musician, jazz musician, is important. I had a student who was a singer-songwriter admitted to a music therapy program—not a classical musician, couldn't read music, had to teach herself. They took a chance on her. Thank God! She's brilliant, she's an excellent therapist. Could she play Chopin's *Fantasy Impromptu*? No, but if someone asked her for Chopin, she would figure something out, she would find a way to adapt to the situation, it wouldn't scare her. You've got to be adaptable.

Rachel thought it was important for music therapists to have a strong foundation in some kind of musical tradition, if not classical music, and was confident that her student, who did not have the same classical training as herself, could find a way to "adapt" to a request for Chopin like

she had earlier that day. Unlike conservatory systems, classical music in music therapy does not have to be "perfect." Through improvisation, adaptation, and creativity, music therapists work with classical music otherwise.

While Rachel mobilized her classical training in her everyday music therapy practice, she also gestured towards the limitations of classical music training. "So many classical musicians are afraid," she said. "I remember when I first tried to improvise with my music therapy professor. He'd say, 'You're afraid, you're so afraid!' I was like, 'Yeah, because I'm a classical pianist!'" We laughed. Having been trained in classical piano as well, I understood the restrictive modality of classical training and the expectation to remain faithful to the composer's text. She remarked, "But it's important that music therapists are not afraid to take musical chances!" Rachel's "fear" of making mistakes, engrained through rigid classical training structures, was also an experience shared by Kate. She reflected on her experience:

> At my school, the music therapy professors spent a lot of time breaking down what we'd call the "classical trauma." For a lot of us, classical training created a really complicated, perfectionist, and problematic relationship with music, that hurt the innate musicality that we all have.

Kate's music therapy program spent time addressing the rigid and perfectionist standards of classical music training, or what they called the "classical trauma," where students are disciplined to interpret musical texts in ways that remain "true" to those texts—any major departures from the composer's score, for example in pitch, dynamics, tempo, or style, amount to error. Repertoire is expected to be practiced and polished for performance in a concert setting. This way of learning music restricts students' capacity to learn how to make music in other ways—for example, through experimentation and improvisation. Kate described this classical conditioning as a pedagogical structure that "hurt" her and her colleagues' "innate musicality." Many people, like Kate, have bad memories associated with not meeting the high

expectations of classical music conservatory structures. Alex told me a story of his encounter with a palliative patient who was referred to music therapy:

> I went into her room and said, "Hi, I'm Alex from music therapy." And she just started saying, "No, no, no, no, no." It was a shocking response. But I found out that she had studied music therapy in college, back in the 1960s. She didn't go into the field, she left it behind, and then, ironically, I show up in her hospital room. She couldn't believe it! She was just in awe. She had a bad experience in college. Her violin instructor said she wasn't good enough, that he was going to fail her because she couldn't play scales. Some faculty like him looked down on music therapy students, like, "Ugh, these people can't even play Chopin and they're trying to be in music? Ugh, music as therapy?" She left it behind and was just in shock that I came to her. She told me she loved to play the fiddle, Appalachian music, country western, reggae. So, we started doing reggae.

Alex's patient, who studied over fifty years ago, left music therapy behind after attending a music school that looked down upon music therapy students, particularly those like her who lacked foundational classical technique such as scales and the ability to play advanced repertoire in the classical curriculum like Chopin. Decades later, she reencountered a music therapy practice that embraced her love of popular music genres.

Although high expectations for Westerm art music literacy are often upheld by music therapy curricula, it can also be through training as music therapists that individuals like Kate and Rachel, who have a foundational training in classical music, learn to unlearn the rigidity of classical structures. They learned how to improvise, take chances, experiment, and make mistakes. Kate told me:

> The music therapy professors helped us break down the classical trauma and open up to the freedom of improvisation, of exploring, of making mistakes, of not sounding perfect. Gradually they got us to this place where we could just jump in. I'm so glad I had that experience because I think it was really healing and also made me a better music therapist. It was transformative to feel such a different experience of music. With flute, I can feel that old baggage come up. "That sucked. You didn't do that properly. What if someone heard this? What if they think this is terrible?" I don't feel that baggage when I'm playing guitar and singing because I know how to connect it to what I'm doing in music therapy. With flute, I can feel it separate and go into my head and out of my heart.

Kate associated the flute with the rigidity of her classical training, whereas she had learned to sing and play guitar outside of conservatory structures. Like Rachel and others trained in the classical tradition, Kate was afraid of making mistakes or interpreting a piece incorrectly. By unlearning the rigidity of classical music structures, music therapists trained in classical traditions like Kate and Rachel learned how to take musical chances, make mistakes, and embrace the "freedom" of improvisation—skills necessary for music therapy practice.

Although a foundation in Western art music is central to many music therapists' training, music therapists must unlearn a classical music *habitus*—embodied dispositions, cultivated practices, and ways of being (Mauss [1935] 1973; Bourdieu 1977)—that engender a rigid text-based approach to music-making informed by structure, discipline, and perfectionism. Unlearning, for philosopher Michel Foucault (2005), is a vital practice of caring for the self—a "critical reformation" that requires "a stripping away of previous education, established habits, and the environment" (95). According to Foucault, the subject's transformation through care of the self is a process whereby "access to truth" is attained through a process of unlearning, which is not a return to a previous state but rather produces a "rebound effect," whereby "the truth he knows, and which passes through, permeates, and transfigures his being, can no longer exist" (19). Foucault argues that possibilities for knowledge open through the process of unlearning, as a practice of caring for the self. Kate and other music therapists' experiences of unlearning classical training offered a "transformative" and "healing" process of opening up new ways of knowing music.

While the profession elevates Western art music training and skills, music therapists navigate the constrictions of classical music structures in various ways, such as creatively overcoming audition requirements, translating their skills, and imaginatively adapting standard

repertoire. Learning to unlearn a classical music habitus—for example, by embracing improvisation, adaptability, and imperfection—is a critical step in the process of becoming music therapists. This suggests that classical music skills are retained as foundational to professional training not because they are essential to the practice of music therapy but because they act as a marker of prestige, cultural capital, and legitimacy. In the following sections, I discuss how the field's institutionalization through Western art music bolsters the legitimacy of the profession as an evidence-based practice and as an inherently good "helping" profession within biomedical systems—characteristics that mask the field's operation in the shadow of colonial legacies.

An Evidence-Based Practice

Like Western art music, music therapy as an evidence-based practice is grounded in claims to rationality, empiricism, objectivity, universality, and timelessness. In a conversation with one music therapy scholar and practitioner, she told me that she understood it was important to have conversations about increasing diversity within the field of music therapy but that she was frustrated that this seemed to be all that was discussed at conferences lately. Although noting that diversity, equity, and inclusivity was important for the field and expressing her own commitment to those principles, she expressed a desire to "get back to the work"—as if clinical research and practice in music therapy were objective concerns, separate from the politicized concerns about diversity and racism.

Anthropologists of science and medicine and science and technology studies scholars have demonstrated the ways in which scientific research does not uncover inherent "truths"; rather, scientific knowledge is constructed (Latour and Woolgar 1986; TallBear 2019; Haraway 1988; Myers 2015; Dumit 2012). Kim TallBear (2013) identifies how the so-called "truth" of

Western scientific objectivity is positioned as depoliticized, with critiques, challenges or alternatives dismissed as "political" concerns. In her study of the politics and limitations of scientific genomic articulations of Indigenous identity, TallBear argues that, "in arenas in which both indigenous people and scientists are invested, scientific activities are often granted exclusive jurisdiction over knowledge production, with indigenous contributions and critiques understood as 'political' superstructure" (510). Claims to authority, objectivity, and "truth" thus enact what Donna Haraway (1988, 581) refers to as "the god trick of seeing everywhere from nowhere." Without situatedness, claims to objectivity and universality of science—like classical music—are depoliticized.

As "the clinical and evidence-based use of music interventions" (AMTA 2021d), music therapy is positioned as an objective scientific practice (see also CAMT 2021a). This has long been an integral aspect of the field's professionalization. In 1944, the National Music Council in the United States conducted an influential survey on the use of music in hospitals for the treatment of psychiatric conditions that stressed "thorough scientific testing" was necessary in order "to arrive at definite conclusions on the treatment values of music and the desired qualifications of hospital music workers" (van de Wall 1944, 7). The report concluded that: "two outstanding practical needs shown by this survey seem to be the medical testing of music as to its therapeutic qualities and the development of standards and curricula for training of qualified personnel by educational institutions on the basis of careful planning and cooperation with hospitals" (van de Wall 1944, 8). Although it was believed that music had therapeutic qualities, it was thought that scientific testing was necessary to thoroughly understand its value and that expert, qualified professionals must be trained as experts to administer music as a therapeutic treatment.

In opening remarks of the 1948 inaugural conference for hospital music therapists—then referred to as hospital music workers or musicians—educational psychologist Everett Thayer Gaston (1948, 3) called for the establishment of an association of hospital music workers for the purpose of "Cooperative study in which a number of us together work on the same research […] This would be a decisive step forward, not only of great help to therapy, but toward the establishment of hospital music on a professional basis." This led to the establishment of the first professional association for music therapy in the United States (the NAMT, which later merged with AAMT to form the AMTA). Similarly, the first news bulletin of the Canadian professional association for music therapy (CAMT) stresses the importance of collecting data and documenting results from therapeutic interventions (Sharpe 1973).

The early professionalization of music therapy was entangled with efforts to accumulate scientific data and evidence on the role of music therapy as a legitimate form of clinical treatment—these efforts continue today. For example, increasing evidence on the efficacy of music therapy is a priority for the AMTA, which publishes two peer-reviewed journals: the *Journal of Music Therapy,* which strives to advance the science and practice of music therapy" (JMT 2021), and *Music Therapy Perspectives*, which focuses on the "clinical benefits of music therapy" (MTP 2021). Similarly, the CAMT publishes the *Canadian Journal of Music Therapy* with the goal "to raise international standards of music therapy knowledge and practice" (CJMT 2021). Evidence-based practice is central to music therapy as a formalized profession on the margins of healthcare because evidence-based medicine is considered the "gold standard" of clinical practice (Timmermans and Berg 2003, 27), with the randomized controlled trials the "gold standard" of clinical research (Timmermans and Berg 2003; Dumit 2012). To operate within Canadian and American biomedical health systems—to be eligible for government

funding, covered by insurance policies, and to be taken seriously as a healthcare profession—music therapists must attain professional legitimacy and make their work legible to biomedical communities (see chapter three).

Through the universality of Western art music and scientific practice, the profession of music therapy is depoliticized—grounded in the values of empiricism, rationality, and objectivity—and aligned with biomedicine. It is within such a context that critiques of the profession's whiteness can be understood as political concerns separate from the scientific research and evidence-based practice of music therapy.

A Helping Profession

Participating in a broader discursive nexus that includes the abundance of neurological research on the effects of music as "good for" the brain (Thaut and Hodges 2019) as well as longstanding traditions of mobilizing classical music training for cultivating discipline and productivity (A. Bull 2019; Kramer 1996; Stainova 2021), the profession of music therapy uniquely renders Western art music training applicable and commodifiable as a "helping" profession within biomedical healthcare systems. State and philanthropic patronage of music therapy is for the benefit of the public and investing in music therapy is not investing in "art for art's sake" but rather an investment in health; this democratizes classical music training, operationalizing it for the public good and not only the concert-going elite.

Music therapy's foundations in depoliticized Western art music training structures work to reinforce a prevalent narrative that music therapy is an inherently good "helping" profession within biomedical systems. As Norris stated, music therapists share a "unanimous desire to help—to do good" (Norris 2020, 4–5). This "desire to help" was reflected by the music therapists I interviewed and often cited as the reason why they pursued music therapy as a

career. Lucy, for example, initially wanted to be a music teacher so she could "help people with music." When she later heard about music therapy, she recalled thinking, "This is what I have been put on this Earth to do!" Music therapy offers a career path where musicians like Lucy can mobilize their musical skills and training into a helping healthcare profession that offers a sense of meaning and purpose in life. Described to me as "like a religion," music therapy is a vocation—a moral and spiritual calling (Weber [1905] 2002)—to which many are dedicated.

Perceptions that the profession of music therapy itself is *inherently* good is a fiction bolstered by narratives that music is "inherently," "intrinsically," and "naturally" human. "We're all musical beings," music therapists told me, and music should be recognized as a human right and entitlement. Such universalizing conceptions of music are informed by Western art music traditions that decontextualize and depoliticize music from its social, cultural, economic, and historical contexts. Notions of music-as-good minimize the ways in which music can be weaponized—for example, through torture and warfare (Cusick 2008; 2020; Friedson 2019; Cloonan and Johnson 2002; Pieslak 2009; Daughtry 2015; Goodman 2010)—as well as the ways in which music and music therapy can be, as Norris (2020) highlighted, both beneficial and harmful. Narratives of inherent goodness of music therapy that seek to promote and legitimize the profession simultaneously work to both align the profession with biomedicine and mask the field's entanglements within colonial systems.

Conclusion

This chapter illustrates the ways in which the institutionalization of music therapy training through university music programs in Canada and the United States situates the field in the shadow of colonial legacies. Prospective music therapists with formal Western art music training throughout childhood from white middle-to-upper class backgrounds are less likely to

encounter barriers gaining entry to music therapy programs. In these programs, however, classically trained music therapy students must learn to unlearn classical music techniques and skills to become music therapists. This suggests that requiring prospective music therapists to have Western art music literacy is not a necessary prerequisite for the everyday practice of music therapy; instead, I claim that a foundation in Western art music work to bolster professionalism, expertise, and legitimacy, and maintain a mostly white professional demographic. The field's foundations in Western art music implicates the profession of music therapy in knowledge systems that perpetuate liberal humanist Enlightenment values. The professionalization of the field is ultimately built upon these same values—including objectivity, empiricism, and universality—that also inform evidence-based practice in medicine, uphold the narrative that music therapy is inherently good, and depoliticize the field.

Chapter 3. The Politics of Clinical Recognition

Code Xylophone

One early winter evening, I accompanied Liz to her group music therapy session on a locked cognitive support unit of the hospital's long-term care facility. As we were pushing the music therapy cart through a hallway of the locked hospital unit, Liz noticed five security guards and a nurse holding a needle standing around Charles, who was sitting on a chair in front of a table in the open-concept nursing station and patient lounge. The security guards looked like police officers in their black uniforms with blue badges on their sleeves, their hands resting on their chests with their thumbs hooked into their tactical vests. Like all hospital staff during the COVID-19 pandemic, their faces were covered by surgical masks and a couple also wore protective eye wear. Presumably called upon by the nurse for assistance with Charles, a tall and heavily built man in his seventies, the security guard in the front of the group, who seemed to be the leader, was talking to a disgruntled Charles, attempting to persuade him to be receptive to the needle. In line with standard regulations, the hospital had a "last resort" restraint policy if the staff consider the patient a threat to their own safety or the safety of others.

Leaving me with the cart in the hallway, Liz walked into the open lounge and approached the lead security guard. She introduced herself as "Liz, the music therapist" and asked, "Would it be okay if I do a song?" After getting enthusiastic permission from the guard, Liz returned to the cart to retrieve her guitar. Her eyes bright above her mask, she confidently instructed me to follow her: "You're going to want to see this!" Liz approached Charles as the five security guards stood in a semi-circle behind her, keeping their watchful eyes on Charles. This time, Liz asked Charles if it would be okay if she played a song for him; he replied gruffly, "Do what you want to do."

As I searched for the television remote control to turn off the news channel, Liz sat on the table in front of Charles, maintaining the requisite two metre distance. She crossed her legs, rested her guitar on her knee, and moved into an upbeat rendition of the song "Don't Fence Me In" (1934). Through her mask, Liz sang:

Oh, give me land, lots of land under starry skies above
Don't fence me in
Let me ride through the wide-open country that I love
Don't fence me in

As he listened to Liz's country-western groove, Charles began tapping his toes and nodding his head along to beats one and three of the methodical plodding pulse, in 4/4 time at 60 beats per minute (bpm). The lead security guard clapped along.

Let me be by myself in the evening breeze
And listen to the murmur of the cottonwood trees
Send me off forever, but I ask you please
Don't fence me in

Liz moved her body as she sang, swaying back and forth; visually imitating the ascending and descending vocal lines by lifting her head up with "cottonwood" and then down with "trees," sitting up straighter to emphasize "ask you" before leaning into "please."

Just turn me loose
Let me straddle my old saddle
Underneath the Western skies

The nurse holding the needle started to move closer to Charles, suggesting an intent to give him the injection during the song. Charles' attention remained focused on Liz, who continued to sing. The lead security guard shook his head. "After this song," he told her, and the nurse paused. Liz noticed this out of the corner of her eye and relaxed with relief when she saw the nurse hang back.

On my cayuse
Let me wander over yonder

Till I see the mountains rise

Charles started to move his hands in front of his body in a back-and-forth gesture, conducting Liz's performance.

I want to ride to the ridge where the West commences
And gaze at the moon till I lose my senses
And I can't look at hobbles and I can't stand fences
Don't fence me in
Don't fence me in

After Liz repeated the last line, a scattered applause from Charles, the security guards, the nurses, and me echoed through the open lounge area. "Thanks Charles," Liz said as she stood up. He nodded to her as she stepped away. The lead security guard started talking calmly to Charles: "The nurse is going to give you something, we're here to help." The four other security guards moved in closer to Charles, holding down his arms and shoulders as the nurse stepped in and quickly plunged the needle into his right arm. Liz and I waited. Charles clenched his fists and winced. As the nurse pulled the needle away and the security guards let go of him, Charles shouted at the lead security guard, "You have to tell me next time!" The security guards were deferential and apologetic, they did not argue with Charles or tell him they had indeed explained what would happen. "Yes sir, sorry sir," the lead security guard repeated as they stepped away from Charles, their job done.

As the security guards left the lounge, Liz and I went back over to Charles, asking him if he'd like to hear another song. This time we found chairs and sat the mandatory two-metre distance away from Charles. In our small group, no longer under the watchful eyes of security guards or medical staff, Liz played "Has Anybody Seen My Girl?" (1925). Charles focused again on the music as he tapped his toes and nodded his head as Liz sang the upbeat lyrics:

Five foot two, eyes of blue,
But oh what those five foot could do,
Has anybody seen my girl?

Saying goodbye to Charles, Liz and I continued on our way down the hall. Liz told me that I had just witnessed a "code xylophone." Mirroring hospital codes (white for violent patient, blue for cardiac arrest, and so on), code xylophone was a colloquial term that music therapists at Liz's hospital used to refer to the urgent need for music therapy, specifically to calm or soothe acutely agitated or distressed patients. It was a playful expression that music therapists in this hospital only ever used amongst themselves; medical staff never called a code xylophone over the hospital's public address (PA) system like standard hospital codes, nor did they page music therapists for immediate support. They regularly receive referrals—sometimes from medical but often from other allied staff—and prioritize music therapy for patients experiencing social isolation, a common plight for people institutionalized for long periods of time. But they were not typically called upon in a moment of crisis.

Liz's intervention with Charles was self-directed; she noticed the security guards and nurse hovering over Charles and knew she was well positioned to intervene. The nurse and security guards, although receptive to Liz's offer to intervene, had not thought to ask her for music therapy support. Based on her previous therapeutic relationship with Charles, Liz knew that he enjoyed music, especially country-western songs, and was likely to receive music therapy as a soothing and comforting experience in that moment. When I asked why she chose the song "Don't Fence Me In" in that particular moment, Liz said that she thought that he "might relate to the lyrics" that articulate feelings of confinement. "But it's more about what music he likes. I know he likes country, and I know he has a good sense of humour, so if he

tuned into the lyrics while he was being fenced in…" Liz trailed off. "But you never know. It could go differently next time," she said.

Music therapists like Liz struggle to be recognized as skilled clinical professionals in hospital settings. Back in the music therapy office, as Liz charted her intervention with Charles in his electronic medical record, her colleague Abigail shared her own code xylophone story. That same evening, Abigail had noticed that Betty was pacing around another locked cognitive support unit, appearing agitated and distressed. Using a technique called music sedation to calm and soothe Betty, Abigail exclaimed with satisfaction, "I got her sitting in a chair!"[25] However, during her music therapy intervention, Abigail recounted how she was interrupted by a nurse who told her that she "shouldn't be singing." Exasperated, Abigail stressed, "She came over *three times*! I smiled and was polite, but in my head, I was thinking, '*Fuck off*, you'd never tell a physiotherapist how to support someone to walk!'" In her encounter with the nurse, Abigail experienced a moment of misrecognition. She was not seen or heard by the nurse as a skilled professional colleague supporting the health and wellbeing of patients. Instead, the nurse thought Abigail didn't know what she was doing and, moreover, that she was aggravating instead of ameliorating Betty's agitation and distress. Abigail's frustration faded as she reflected on how the nurse's comments elicited internal self-doubt. Questioning her skill, knowledge, and expertise as a music therapist, Abigail had wondered momentarily if she was "doing the right thing" by continuing to support Betty with music therapy. Finally, she was vindicated when Betty fell asleep in her chair to Abigail's soothing music therapy intervention. Elated, Abigail emphasized, "It *worked*!" In response, Liz encouraged her to "chart that" in Betty's medical records to provide documented evidence that music therapy was effective.

[25] Music sedation refers to a technique where music therapists use music with a waltz or lullaby time signature like 3/4 with a slow tempo to calm (i.e., sedate) patients (Joanne Loewy 2009; 2020).

Charting is one of many strategies that hospital music therapists like Liz and Abigail mobilize in order to have their work recognized and taken seriously by medical staff as contributing to patient care. Despite often feeling uncertain whether medical staff actually take the time to read their progress notes, hospital music therapists documented their work meticulously. Just a couple days after her impromptu music therapy intervention with Charles, Liz eagerly shared with me an email she received from the unit's attending psychiatrist who, during the pandemic, was consulting on care remotely:

> Hi Liz, I hope you're doing well. I was reading Charles' chart yesterday and saw your note about how you intervened when he was super agitated, with security guards present. This is just brilliant! What a gift that was for him and it sounds like for everyone involved. So, just a note of thanks for your caring, skilled, and wonderful presence on the units, and your willingness to remedy an unpredictable situation that could have been much worse for the patient (and one that many people would try to avoid). Please feel free to forward this on to any staff/manager that would appreciate knowing this. It deserves to be acknowledged. All the best and stay well.

Unlike Abigail's experience with the dismissive nurse, Liz was seen by the psychiatrist as a professional colleague whose skilled presence in the hospital supports the health and wellbeing of patients in a way that "deserves to be acknowledged." Indicating an awareness of the weight of a physician's recognition, the psychiatrist suggested forwarding her message to other colleagues. Receiving this note from the psychiatrist made Liz feel valued and appreciated; in her reply, Liz expressed her gratitude while adding that it was a "real boost to hear" the psychiatrist's words of recognition. I interpret such instances, when music therapists are seen, heard, and understood as valuable to a biomedical perspective embodied by medical staff, as moments of clinical recognition important to hospital music therapists.

In this chapter I demonstrate why clinical recognition is important to hospital music therapists and what strategies they use in the clinic to be taken seriously as clinical professionals and to get their work taken seriously as clinical care. By exploring how music therapists work to

integrate into the clinic, I link contemporary efforts to establish and grow hospital music therapy programs to the historical professionalization of music therapy in hospital settings. In analyzing stories of recognition and misrecognition, this chapter argues that everyday processes of clinical recognition shape the professionalization of music therapy and that mobilizing music therapy in support of biomedicine makes music therapy sensible as clinical care.

Clinical Recognition

Music therapists want their work to be recognized as clinical, valued in its contribution to patient treatment and care. Through specialized training, clinical internships, and board-certification, music therapists situate themselves as specialists in the therapeutic facilitation of music for health and wellbeing. As Alice explained to me, "I think it's worth paying a professional to be an expert in the field. I can't volunteer my time to be a music therapist, and I don't think I should." Alice and other music therapists need their unique expertise to be recognized as holding clinical value in order to be compensated by institutions like hospitals for their labour.

Expertise, as an assertion of authoritative knowledge, manifests through power relations and enactments that distinguish professional experts from laypersons (E. S. Carr 2010; Latour and Woolgar 1986; Star and Griesemer 1989). According to anthropologist Dominic Boyer, the figure of the expert is contingent on the expert's jurisdiction of expertise and "at the core" of the expert as a social figure is the fear that their unique expertise will be negated (2008, 42). Yet the boundaries of expertise, as anthropologists and other social scientists have illustrated, are contingent and always in flux (Epstein 1995; E. Martin 1994; MacDonald 2008; M. Murphy 2012). In this chapter I ask, how are music therapists sensible as experts in the clinic?

Music therapists struggle to establish clear boundaries of expertise in a crowded professional field and are in a perpetual struggle to assert their unique value to health and wellbeing. Marilyn explained:

> We're on everyone else's turf. When we work with speech, we are on Speech Therapists' turf. When we work with gait, we're on the Physical Therapists' turf. We're on Recreation Therapy's turf. Occupational Therapy's turf. Psychologists' turf. We work on the same goals, but we bring music to all of it. But we are not seen as needing to be consulted if anyone else is using music. We don't own music. And at the same time, there is this other side, "Well, you're not really musicians. We'll bring in the real musicians." So where do we live? We don't have a place to live. Professional recognition—that's what it comes down to. Respect and recognizing what the profession of music therapy can do.

Professional recognition for music therapists, as Marilyn suggests, is to be seen and respected by non-music therapists as professionals who can "do something" of clinical value by contributing to patient treatment and care.

Processes of recognition are critical to the construction of subjectivity and social identity, as well as regimes of governmentality (Butler [1993] 2011; Coulthard 2014; Hegel [1807] 2018; C. Taylor 1992; Povinelli 2002; Fanon [1952] 2008; Fraser and Honneth 2003; Simpson 2014; J. S. Taylor 2008). Recognition has been acknowledged as important to the establishment of professional expertise, particularly through formal processes, such as registration with professional associations (Aronson 1982; Collins and Evans 2002; Eyal 2013; Zola 1972). The *clinical* qualifier in clinical recognition gestures toward a desire for membership not in a cultural group (C. Taylor 1992) but rather within the normative culture of the clinic, a space dominated by biomedicine and the biomedical model of care. I claim that the politics of recognition are entangled with the politics of aesthetics. For music therapy to be recognized as clinical care and for music therapists to be recognized as clinical professionals,

the care practices of music therapy must be sensed (felt, perceived, experienced) and make sense (be legible) as care within the dominant aesthetic regime of the clinic.

To be recognized as clinical experts, it is not enough for music therapists to be trained, certified, licensed, and credentialed. As Marilyn pointed out, American music therapists are trained with "more hours of direct clinical experience than nursing!" yet music therapy is still "not taken seriously" as a clinical profession.[26] Recognition of professional expertise unfolds in everyday processes and social interactions, where music therapists strive to be seen and heard as valuable. Because the clinic is a central site for the normative construction of medical knowledge and expertise (Canguilhem [1943] 1998; Foucault [1963] 2012), everyday processes of recognition from others in the clinic inform how music therapists and music therapy is acknowledged as valuable to structures and systems of healthcare.

Recognition for music therapists, however, can be difficult to attain. Marilyn's comments that music therapists are "on everyone else's turf" suggest the problem is that the boundaries of professional expertise for music therapy are unclear and unstable. The use of music for therapeutic purposes is accessible to anyone, as music therapists often reiterated the phrase that they "don't own music." As Sam told me, "We have to justify what we're doing in some sense, even though in a way that's ridiculous because the medical team is going to leave the hospital and get in their car and turn on the radio. They're going to go to the restaurant and listen to music. They're going to go home and put on music. You don't think about how important music is to you until you don't have it." The struggle to assert professional

[26] In the United States, the required number of clinical hours for nursing students varies by state and ranges from four hundred to seven hundred and fifty hours (Bowling et al. 2018). There are no standard guidelines for clinical hour requirements in nursing (O'Flynn-Magee et al. 2021); however, for example York University nursing students complete approximately one thousand and four hundred hours of clinical experience throughout the undergraduate nursing program (York University 2021) and, in Ontario, individuals applying to register as nurses but who have not practiced in the previous three years must complete from four hundred to seven hundred clinical hours (CNO 2021).

boundaries of expertise, reflected by the lack of authority over the use of music for therapeutic purposes, makes it difficult for music therapists to differentiate and validate their work. According to music therapy scholar Kenneth Aigen (2014), the profession is in a "vulnerable position" as it strives "to be seen as offering something sufficiently unique to warrant its existence and yet similar enough to other domains in order to be able to fit into social structures" (14).

During my fieldwork, I regularly witnessed music therapists encounter moments of clinical misrecognition in the form of well-intentioned yet belittling comments from visitors, patients, and staff. "Look, we have our own minstrel!" someone said with a smile upon seeing Liz with her music cart in the elevator. "The music lady is here!" a family member announced when Abigail entered a patient's room. "How fun!" someone remarked to me in passing as I pushed Alice's music cart. These passing moments of clinical misrecognition, perhaps seemingly innocuous, are frustrating for music therapists who want non-music therapists to understand that their work is not just fun and games, with entertainment value. Rather, they want music therapy to be sensible as clinical care.

Alice, like many music therapists I spoke to, found it exhausting to be consistently not taken seriously in the clinic. Alice sighed,

> So many times, I'll be walking down the hallway, and someone sees my guitar and they're like, "Oh, that must be so much fun!" Sometimes I'm kind of passive aggressive, like, "Well, actually, I'm headed up to the palliative care unit right now to work with someone who's actively dying." And wait for the shocked face. I mean, that's definitely tiresome. Well-meaning people don't necessarily understand that it's not all entertainment, laughing, and smiling. We're not the clowning team. I think that probably contributes more than anything to be tired or nearing burnout. As a professional, having to explain what you do over and over and over and over again. It's tiresome.

Similarly, Claire explained, "People always say, 'Oh, you're so lucky! Your job must be so much fun!' I always say I'm lucky, I see that side of it, but like…" Claire scoffed, "They never

see how hard it can get. You can be working in palliative care, helping a family grieve their loss." Shuddering, she continued, "It's not fun! Or sometimes it's fun but it's also really difficult and emotional work where you need to decompress afterward, write an assessment, and drive to the next place because you don't have a full-time job! But I do love it, I do love it…" Claire and other women who are music therapists are careful to qualify their frustrations with gratitude, often telling me how lucky or privileged they are to be working as music therapists. After detailing how she too was tired of not being taken seriously, Rachel said, "But I really can't complain. I schedule my own days. I manage my own caseload. And I'm playing music all day. I can't complain." In the clinic, music therapists' labour is often devalued as not real work as they are perceived to be having fun all day instead of engaging in emotionally draining affective labour, caring for patients through music therapy.

Part of the problem of recognition, according to some hospital music therapists, is that music therapists do not consistently represent the profession in a way they believed to be serious enough within a hospital setting. An alignment with new age healing modalities, in particular, was perceived negatively. Jonathan was dismayed that his clinical work could be perceived as "new age-y." He remarked off-hand, "You don't want to be seen as the hippie roaming the halls." And, according to Matthew, some music therapists "don't help themselves" in being understood as valuable and respectable within a hospital setting. "An esoteric approach doesn't help the profession at all," Matthew said, mimicking a soft and slow vocal prosody, "*With the energy, the sound, the frequencies*—Okay. You have the right to think it, but if you work in a hospital setting, you have to be science and evidence based. I'm sorry to say it. You know? You can't come here and just say I'm gonna play with my crystals and stuff. Seriously, that happens sometimes. That doesn't help at all the profession being taken seriously."

Representing music therapy as too "alternative" in the clinic was perceived by many hospital music therapists to have repercussions for the entirety of the profession, including music therapists like Jonathan and Matthew who wanted to be taken seriously by medical professionals in hospitals. In order to be perceived as "serious" within a biomedical setting, music therapists have to embody a clinical *habitus* (Bourdieu 1977; Mauss [1935] 1973)—dispositions, comportments, and ways of being that are learnt, negotiated, and practiced in the clinic so that they and their work can be sensed and make sense as clinical.

For music therapists, I claim that embodying a clinical habitus in order to be taken seriously by medical staff requires downplaying an association with alternative healing practices and emphasizing competency in biomedical knowledge systems. While Jonathan associated music therapy with shamanistic healing practices and instructed his interns to pay attention to the "energy" and the "feelings" of the space, he warned them: "Be careful of using that language with medical staff!" Jonathan insisted that music therapists had to exude professional competency in a medical setting, not only as technically skilled music therapists but also as serious clinical professionals. This meant explaining music therapy in medically legible ways. He explained, "Say, for instance, that senior patient who has horrible sundowning and gets agitated at 4 p.m. every afternoon, was totally calmed down by music therapy, they were able to give him a shower, he didn't lash out at anybody.[27] That's when people *really* learn about what we do. They've seen it, and then you have the explanation, 'Well, I wasn't just playing music, I was downregulating his autonomic nervous system by doing such-and-such.' You need to show and explain to medical staff that you have something of value to offer." As Jonathan's comments indicate, "just playing music" is understood as entertainment and, consequently, not

[27] Sundowning refers to the worsening of responsive or reactive behaviours (such as restlessness, agitation, aggression, irritability, or confusion) for people with dementia in the late afternoon or early evening.

clinically valuable. In order for the work of music therapy to be recognized as *clinical,* it must produce clinical outcomes legible to biomedicine. For music therapists to be recognized as clinical professionals, they must demonstrate their knowledge and expertise; for example, by articulating how their work can produce biomedically legible outcomes.

In order to prove that music therapy has value to offer biomedicine, music therapists like Jonathan insist that medical staff needed not only to witness the work but to understand the work in the right way, as a scientifically grounded and evidence-based practice. This can be achieved by following particular scripts of expertise (E. S. Carr 2011)—using the "right" language that indicated to staff that their work was intentional, that they aren't "just entertaining" patients. Sophie shared, "In rounds, I might be afraid of what I'm saying coming across as being trivial or unimportant because, as music therapists, we think people don't understand us or just think music therapy is entertainment.[28] So, I worry and want to make sure that what I'm saying in rounds really carries the weight of what we're doing as music therapists." As Brian explained, music therapists need to "join the culture" of medicine. "You speak the language so that you can then embellish and bring what you have," he said. "I always go that extra mile to explain music therapy to medical staff, not only to educate the person making the referral as to what we're looking at, but because it informs the work better. Can I go and entertain a child? Absolutely. I can pacify a situation just by going in and getting the child to laugh. I don't have to explain that getting that child to laugh and play is re-igniting a part of identity that's been supressed because they're scared or frightened. The science is there, the social science is there." Indeed, over the years music therapists have contributed toward a

[28] Rounds, also referred to as medical rounds, clinical rounds, or multidisciplinary rounds, are a standardized element of medical practice in hospitals whereby staff gather to communicate, discuss, plan, and coordinate patient care.

comprehensive body of empirical literature, including both quantitative and qualitative studies, on the benefits of music therapy for health and wellbeing.[29] Music therapists working in hospitals like Jonathan, Sophie, and Brian, regularly offer educational in-services and presentations for medical and allied healthcare staff to teach them about music therapy as an evidence-based practiced.

In the clinic, music therapists must use the "right" language to explain the relevancy and value of their work to biomedical care, not only by explaining their work to medical staff in physiological, neurological, or psychological terms but also by framing their work in terms of clinical goals and measurable outcomes. The legitimacy of clinical goals and measurable outcomes in music therapy are bolstered by quantitative research on the effects of music therapy, especially research studies modelled after the randomized controlled trial.

Although music therapists have their own academic journals published by national associations (including *The Journal of Music Therapy* and *Music Therapy Perspectives* in the United States, and *The Canadian Journal of Music Therapy* in Canada), they assume that articles published in music therapy journals are unlikely to reach an audience of interdisciplinary healthcare professionals. Many music therapists working in hospitals aim instead to publish quantitative research in high-impact medical journals that are taken seriously by their medical colleagues. As Brian explained, "Quantitative research is sellable to the medical community. Especially high-impact medical journals." Jonathan also noted that high-impact medical journals "don't care about the stories" or "the narrative," just the "hard

[29] Music therapy research is published in music therapy journals like *The Journal of Music Therapy*, *Music Therapy Perspectives, The Canadian Journal of Music Therapy, Nordic Journal of Music Therapy, British Journal of Music Therapy, Australian Journal of Music Therapy,* and *VOICES: A World Forum for Music Therapy*, as well as in interdisciplinary journals such as *Music and Medicine* and *The Arts in Psychotherapy,* and medical journals like *PLoS One, Pediatrics, Respiratory Medicine, Palliative Medicine, Journal of Psychosocial Oncology*, and *Journal of Clinical Nursing*.

numbers." To grow and advocate for hospital music therapy programs, it is important to address medical audiences, especially influential clinical actors like physicians, unit managers, department heads, and other upper-level management.

I met with Joanne Loewy, founding Director of the Louis Armstrong Center for Music and Medicine and head of the music therapy department at Mount Sinai Beth Israel Hospital in New York City, at a coffee shop in Philadelphia. Loewy is a prominent music therapist who consults globally on the establishment and growth of music therapy programs in hospitals. She told me that the field of music therapy could often be "misrepresented." In order to be taken more seriously, she said, "I think we have to speak more scientifically. Be more knowledgeable about our science." Doctors and stakeholders, she explained, are looking for the sample size (N-value) and the statistical significance (p-value) of the results in published quantitative studies. Loewy told me, "It's sad that not all doctors seem to have time for what they consider the extras. But it may take a case or two. And it definitely takes leaving them research, a hard copy in a nice folder with a little sticky note highlighting the number of patients in the study and what we found."

Publishing in high-impact journals has tangible effects for music therapists and their work. Referring to her article on music therapy in the neonatal intensive care unit (NICU), titled "The effects of music therapy on vital signs, feeding, and sleep in premature infants," published in *Pediatrics* (Loewy et al. 2013), a high-impact medical journal (with an impact factor of 7.1 according to the 2021 Journal Citation Report from Thomson Reuters), Joanne noted that, "Having that one seminal NICU article truly has changed my life." The article published results from a randomized clinical trial which provides quantitative evidence that music therapy interventions can lower babies' heart rates; improve sucking behaviour, caloric intake, and sleep

patterns; and decrease parental stress. She explained that the article helped her to establish the NICU programs in her own hospital and in hospitals in other countries and develop the training model "First Sounds: Rhythm, Breath, and Lullaby," as well as influenced colleagues to treat her more seriously as a researcher.

Measuring quantifiable effects and showing the "hard numbers" through the ostensible neutrality of metrics is what matters to biomedical audiences, as medical anthropologists have demonstrated (Adams 2016; Biruk 2018; Ruckenstein and Schüll 2017). But the stories numbers tell are not the only stories mattered to music therapists in hospitals. Joanne lamented that, in the music therapy field, "People think because I'm a researcher, work in a hospital, and publish in high-impact medical journals, that I'm a medic-type behavioural physiological music therapist. But I'm not. I think everything comes from understanding someone's personal belief system, their culture, their upbringing. In a way, I'm a medical music anthropologist, but we just call it medical music psychotherapy." The anthropological sensibilities that Loewy explained are crucial for hospital music therapists include the ability to ascertain what was important to people—both patients and medical staff. This means taking patients' "illness narratives" (Kleinman 1988) seriously, because "a lot of times patients know best because it's happening inside them." Like traditional anthropological methods, observation is key: "When we went in the NICU, they said we don't want this, please step away. We spent a year Margaret Mead-ing. Just going around. For our interns, in their first couple weeks on a unit, we say 'Go Margaret Mead.' It means go sit there and just watch, don't bother people, write questions, experience." In order to integrate into the culture of medicine, Loewy and her team work to first understand and immerse themselves within the culture of medicine through observation.

When describing how music therapy made an impact in a hospital environment, Joanne explained, “In the most difficult circumstances that are unplanned and unstructured, we can make people feel loved and held during those times with music because music therapy happens in the moment.” Similarly, Brian told me that numbers are “not the whole story.” Passionately, he claimed, “You can’t measure love, beauty, warmth, or compassion.” Sam also told me, “As music therapists, we are conscious of how we interface with medical professionals. They value quantifiable effects, and we pay attention to the breathing rate and heart rate, but most importantly we pay attention to the person. The aesthetic sensibility we’ve cultivated is the most important skill we have.” Music therapists working in hospitals who made their work legible to biomedicine by measuring quantifiable effects did not restrict their work on quantifiable terms. In caring for patients, music therapists affirm the personhood of patients by supporting them in feeling unquantifiable feelings like love, beauty, warmth, and compassion.

Hospital music therapists must navigate various obstacles to integrate their care practices into the clinic. One of these challenges is integrating music therapy as a care practice within or alongside the standard model of care that is biomedicine. According to Joanne, music therapists had to understand that hospitals are medical facilities that prioritize a biomedical model to care that focuses on the diagnosis and treatment of disease. She argued, “Our problem as music therapists is that we go into hospitals with this agenda, and it’s bullshit. We need to understand medicine’s agenda because it’s a medical facility. We have to get on the same page as doctors and nurses and understanding the ailment, the disease, the most important medical thing. Socialization is not really what they’re looking for. It can help medicine. But we’ll show them that later.” Getting on the same page as medical staff, for Joanne, means making music therapy “useful to the roles and needs of doctors and nurses” by structuring music therapy in support of

biomedical care, while not getting in the way of medical staff. Sam framed this problem as a question: "We need to ask, how can we fit what we're good at into medical settings? We can't bulldoze in." He told me that music therapy can support medical staff by "making their job easier to do." For Sam and other music therapists, music therapy can support biomedical care directly as a method of procedural support either before, during, or after medical treatments or interventions.[30] According to Brian, music therapy can have a more generalized effect on improving the biomedical model of care by offering "emotional engagement" which, in turn, "affords more efficient treatment." He explained:

> Music therapy changes the emotional engagement of staff, patients, and caregivers who are visiting. That in itself disrupts a biomedical narrative. It's easier to treat the body when the body isn't thinking and dreaming and complaining. So, if we're going to engage the emotions through the use of art forms, then we're changing that biomedical model. There are lots of disciplines, not just music therapy, that disrupt that medical narrative. They're disruptive because they demand a little more time, a little more thought.

For Brian and other music therapists, music therapy can disrupt, transform, and improve the standard biomedical model of care. Many music therapists, while deeply appreciative and respectful of medical staff, are critical of standard biomedical care as impersonal, disconnected, and rushed. According to Jonathan, "Staff offer good care but perfunctory care. Medical staff don't have time to spend with patients." What Jonathan characterized as a "perfunctory"

[30] Music therapy as procedural support refers to the provision of music therapy during invasive and non-invasive medical procedures (Claire M. Ghetti 2012) or as the provision of music therapy either before, during, or after medical procedures (Beer and Lee 2017). For example, music therapy as procedural support can reduce pain and anxiety for adults and children undergoing medical procedures (C. M. Ghetti 2013; Klassen et al. 2008; J. F. Mondanaro et al. 2021; Yaman Aktaş and Karabulut 2019; O. S. Yinger and Gooding 2015); and in pediatric care music therapy as procedural support can improve coping during child immunizations (Olivia Swedberg Yinger 2016) and reduce the use of sedation, decrease the length of procedures, and decrease the number of staff members present for medical procedures (DeLoach Walworth 2005).

approach to care is similar to what a physician told me was a standard model of "detached concern."[31] According to this physician:

> How physicians define their role is variable. There are some physicians who feel that their role is diagnosis and treatment and that the human role is auxiliary. And there are some, like me, who feel that a therapeutic connection is both important on its own merit and important to diagnosis and treatment. The classic paternalistic attitude is, "If I come and see you at all, that is enough, and you should take that as sufficient." But recognizing that patients are people is important.
>
> Detached concern is the model. But it doesn't take a long time to forge a human connection. I tell this to my trainees. I'll round my team, take them to the bedside, and I'll sit on the patient's bed. I'll hold their hand and I'll look in their eyes and I'll talk to them about what they care about. We'll leave and four minutes have passed. I think being overworked cognitively, or being uncomfortable with the role, are bigger barriers than not having enough time.

The standard model of biomedical care—one that privileges diagnosis and treatment of patients' disease, while maintaining detached and distanced from patients as people—is one that is not only critiqued by non-medical care providers but also by medical staff themselves, such as physicians like the one I spoke with who insisted that it was important to recognize "that patients are people." This physician also highlighted how biomedical care practices vary according to the quality of time spent with patients as well as the quantity of time spent with patients. He also highlighted how biomedical care practices are shaped by pedagogy. While the normative biomedical model of clinical care has traditionally taught students how to objectify and dehumanize patients (Good 1994), this is contested by alternative biomedical pedagogies as well as by alternative clinical care practices like music therapy. Biomedicine, as medical anthropologists have demonstrated (Livingston 2012; McKay 2018; Mol 2002; Street 2014; Wendland 2010), is always in the making. Hospital music therapists position their work as

[31] "Detached concern," a concept introduced by medical sociologist Renee Fox (1988), refers to the way in which medical students learned how to balance "distancing themselves from the emotion-laden experiences they faced as medical students and professionals and maintaining appropriate amounts of concern for patients" (Underman and Hirshfield 2016, 95).

capable of ameliorating the biomedical model of care through not only enhancing the care patients receive in hospital but also by enabling more efficient and effective biomedical treatment, in support of medical staff.

In pursuit of clinical recognition, music therapists strive to represent themselves as serious practitioners that offer a service valuable to clinical care by assuming a clinical habitus, distancing themselves from new age perceptions, and making their work legible to biomedical communities through demonstrating measurable effects that support biomedical care. Yet the stakes of clinical recognition extend beyond the construction of an expert professional identity. In mobilizing their work in support of biomedicine on an everyday basis, music therapists make their work sensible as clinical care. At the same time, they offer an implicit critique of standard biomedical care as limited—in the clinic, their care practices exceed the normative model of biomedical care (as detailed further in chapters four and five). However, through assimilating to biomedical structure and integrating their work into hospitals in the pursuit of clinical recognition, music therapists situate themselves as capable of ameliorating biomedical systems and structures from within, propelled by an ethical imperative to care not only for patients but also for clinical institutions like hospitals.

Creating Hospital Programs

Through the clinic as a critical site of scientific and medical research, learning, and practice, music therapists position themselves as clinicians and their work as clinical in relation to biomedical systems (see chapter one). Creating hospital music therapy programs and jobs is the necessary first step for music therapists to integrate into the clinic and pursue clinical recognition from significant actors. Today, a significant proportion of music therapists work in clinical institutions like hospitals. Although there is no existing survey data on the proportion of

music therapists working in Canadian hospitals, an American survey of music therapists found that nearly half of music therapists in the United States worked in various clinical settings including hospitals (AMTA 2020a).[32] However, permanent, full-time music therapy positions with benefits in hospitals are perceived as rare in the field. Hospital jobs are coveted by music therapists as prestigious and important, even though they are, as music therapist Alice described them to me, "usually just another contract" that often lacked the security of full-time permanent employment with benefits.[33] The loss of hospital jobs as a result of institutional funding cuts are understood as a loss to the field. As Marilyn explained to me, "Sometimes you work for twenty-five years and then they can just take it away. No other profession would they do that. Especially when you haven't done anything wrong. It's like, you're just not essential anymore." The struggles music therapists face in creating and sustaining hospital programs and jobs are struggles for clinical recognition.

In order to create hospital programs, music therapists have to navigate both hospitals as institutions and biomedicine as the normative model of clinical care. When advocating for music therapy programs in hospitals, music therapists have to consistently justify that music therapy "works" in terms that are clinically legible. I asked Rachel why she thought music therapy was important for hospitals and she responded decisively, "I believe it needs to be a

[32] A 2020 survey of American music therapists (N=956) indicated that the largest proportion of music therapists (forty-four percent) worked in clinical settings, including geriatric facilities, mental health settings, and other medical institutions. The detailed distribution was as follows: fourteen percent worked in a medical setting (including general hospital, oncology, home health agency, outpatient clinic, partial hospitalization, and children's hospital or unit); fifteen percent worked in a mental health setting (including child/adolescent treatment, community mental health centres drug/alcohol program, forensic facility, and inpatient psychiatry); fifteen percent worked in a geriatric facility (adult day care, assisted living, geriatric facility – not nursing, geriatric psychiatry, and nursing home); eleven percent worked in a children's facility/school (including children's day care, preschool, early intervention program, and school); ten percent were self-employed or working in private practice; and thirty-five percent were categorized as "all other" (AMTA 2020a). Comparably, in the United Kingdom, thirty percent of music therapists worked in public hospitals and community health centres in 2020 (BAMT 2020).

[33] Neoliberal structural adjustment policies triggered government funding cuts to public social services in Canada, including hospitals, leading to an increased reliance on private funding (Terris 1999).

standard of healthcare." Pausing, Rachel continued, "Because…well, I keep coming back to the fact that it's cost effective. That's not the real reason music therapy is important, but it *is* cost effective!" We laughed and I remarked, "That's a good argument for hospitals!" Rachel elaborated on the ways in which music therapy is effective, "I can help manage people's pain, anxiety, mood, depression, all kinds of stuff. We see pain scores improve. Today, a patient was having trouble breathing at the beginning of the session when she took off her oxygen prongs.[34] I asked about her breathing at the end of the session. She said, 'I didn't even think about it!' I asked if she wanted to put her oxygen prongs back on, she said no!" Trying to get at her point, I commented, "Right, so it works!" Rachel reiterated, "It works! It works and it's cost effective. It's a uniquely human way of caring for the whole person—the physical, cognitive, emotional, social, spiritual, etcetera. And it fits nicely with an interdisciplinary care team in a hospital."

It can be difficult for music therapists to convince others that music therapy "does something" productive in a hospital. Liberal capitalist logics inform a relegation of music and the arts, as ethnomusicologist Jim Sykes (2018) argues, to expression and representation. Music therapists not only have to advocate that music therapy "works" by contributing to biomedical care in measurable ways but, in order to justify their programs, they also have to argue their contributions to biomedical care are cost-effective. As Barbara explained:

> You still have to show that music therapy is effective for a hospital in terms of economics. Right now, the dollar is the most important thing. I'm not on side, personally, with people that do studies just to show music therapy is saving money. On the one hand, it is cost-effective, but on the other hand, we all know from decades of experience that that's not what really matters. This is a philosophical position. But when you're caring for people who are suffering, what's the most important thing? Cost-efficiency isn't the most important thing in music therapy, it's the potential and power of music and music therapy. It's the ability to evoke and work with what is well in people but it's also connecting them with what's beautiful.

[34] Oxygen prongs refers to a section of a medical device known as the nasal cannula which is inserted into the nostrils to provide supplemental oxygen or airflow to a patient to support respiration.

From Barbara's perspective, demonstrating that music therapy is cost-effective may be necessary for establishing and growing hospital programs yet "isn't the most important thing." Similarly, for Rachel, cost-efficacy was "not the real reason music therapy is important." Many music therapists, like Barbara and Rachel, mobilize arguments that music therapy is cost-effective for pragmatic purposes—to advocate for their hospital programs—while maintaining that music therapy is valuable regardless of its cost-efficacy as a "way of caring for the whole person," as Rachel described it, and a way of "work[ing] with what is well in people" through aesthetic engagement.

It is typical for hospital music therapists or their predecessors to create their own programs. Whereas in private practice, clients typically pay for music therapy services directly (out of pocket or, in some contexts, through private health insurance) in clinical settings patients usually do not pay directly for music therapy services. It is often donor or philanthropic funding (for example, through hospital foundations) that is used to finance music therapy programs in Canadian and American hospitals. However, through advocacy efforts, music therapists are also sometimes able to access discretionary operational funds for their programs. In sharing stories about how they created hospital programs, finding funds for music therapy is described as a significant challenge.

Marilyn established a hospital music therapy program in the late 1990s. As a music therapy student, she convinced the psychiatrists on an inpatient psychiatry unit to allow her to work as a music therapist on a volunteer basis for her music therapy internship hours. After integrating herself onto the unit, Marilyn began to advocate to the nursing manager to establish music therapy as a paid position after she finished her student hours. She conducted a patient survey for the nursing manager who, after reviewing positive feedback from patients, agreed to

a part-time paid position. As Marilyn recalled, “I thought that was great! I was getting something. I felt as long as it remained volunteer, it would not be taken seriously.” But when she was called into the psychiatrist’s office to sign her contract, she remembered, “He was very obviously upset. He said, ‘I don’t know why they’re hiring you. If it was my choice, that money would be going to a Social Worker, that’s what we need here—Social Workers.’ I thought, ‘You’re not going to get a social worker to work for fifteen dollars an hour with no benefits for six hours a week! You don’t know what I’m giving you.’ It was so undervalued; it was shocking in a way.” Marilyn persevered in building her program with the support of the unit’s nursing manager who “had a sense of the clients” and knew that music therapy made them “feel better,” on top of being cost-effective. Through the nursing budget, Marilyn became permanently employed on the unit as a music therapist three days a week with benefits. She continued to grow the music therapy program at the hospital, applying for additional start-up funds through a non-profit music therapy organization for students to start music therapy programs on other units. Today, the music therapy position she created remains well-established as a full-time position with benefits, funded through the unit nursing budget, while other music therapy positions at the same hospital are contract-based and reliant on donor funds.

Music therapists recounted similar stories of creating hospital programs by working on a volunteer basis as a music therapy intern, building relationships with medical staff allies, demonstrating patient demand for music therapy services, and advocating for funds. Like Marilyn, Rachel had established the music therapy program at her hospital with the support of a physician, who “kindly” let her work for free during her internship. Because of patient demand, Rachel and her physician-ally were able to secure hospital foundation funds to create a full-time paid position when her internship hours were complete. The clinical legitimacy of medical staff,

particularly physicians and nurses, is influential in securing funds for music therapy. Alice noted that it was often easier for allied staff, like Social Workers, Occupational Therapists, and Recreation Therapists, to understand their work, but allied staff are perceived as less influential in the clinic than medical staff and administrators like unit managers.

Advocacy and visibility were critical elements in creating the music therapy program at Lachy's hospital. He began the music therapy program at his hospital as a pilot project with funding from a local non-profit organization. Told to make himself "essential," Lachy integrated his work across multiple hospital units and consistently advocated for music therapy through creating presentations and videos to demonstrate the value of the work to medical staff so that his salary could be paid through departmental budgets after donor funds were exhausted. It is often difficult, however, for music therapists to advocate for and secure donor funds. "Foundations want things they can put their names on," Matthew explained, "Like iPads. They don't want to pay for staff." At Matthew's hospital, the foundation would on occasion provide start-up funds for programs like music therapy. Alice explained, "It's important to keep the Foundation happy." At times, she had to prioritize music therapy programs the foundation valued rather than structuring her clinical work in a way that she thought would be more impactful for patients in the hospital. Similarly, Rachel worked diligently to maintain a positive relationship with her hospital's foundation. Music therapists have to constantly prove their value to the clinic and make themselves indispensable to medical staff, administrators, and funders in order to sustain hospital music therapy programs.

Music therapists struggle for clinical recognition in advocating for, creating, and maintaining hospital music therapy programs and jobs. Their programs are typically under-resourced and under-staffed, systematically devalued by the clinic. While nearing the end of her

short-term contract, Sophie's hospital offered her a permanent job on a new unit before promptly terminating the position. Diplomatic and professional, Sophie was disappointed by the job being taken away but did not voice any frustrations with the hospital administration, unlike her colleague Julia who criticized the administration as "screwing over" Sophie. "They re-classified the unit beds, they're no longer 'behavioural' beds, so the administration doesn't think they 'need' music therapy," Julia explained, exasperated. "Meanwhile, leadership loves highlighting that we're here! 'Look, we have music therapy! Isn't it *nice*?!' Hospitals love 'pimping out' their music therapists," she quipped. "They love to take pictures or videos of someone banging on a drum with a big smile on their face in a hospital bed. It's sellable." Music therapists like Julia resent being used in promotional and marketing materials, particularly when they felt like their programs are being devalued by the hospital administration. Such forms of superficial recognition, when hospitals use music therapists and music therapy programs in campaigns to soften perceptions of hospitals through "nice" representations, can feel insincere to music therapists if not accompanied by clinical recognition and a financial investment in clinical music therapy programs.

On Biomedical Terms

To create and sustain hospital music therapy programs, music therapists integrate themselves into the clinic on biomedical terms. As Brian argued, it "wasn't sustainable" for music therapy to be on the fringes of biomedicine. In hospitals, music therapists pursue clinical recognition by working hard to integrate into biomedical care structures, for example by establishing themselves as members of interdisciplinary care teams.

Interdisciplinary collaboration informs music therapists' work. Sophie, for instance, said she felt more equipped in her clinical work as a member of an interdisciplinary team compared

to her previous experiences as a private contractor working independently in long-term care institutions. She valued being included in unit medical rounds; she learned more about patients by listening to interdisciplinary perspectives and valued sharing her perspectives and experiences with patients to her colleagues in order to inform their work. Other music therapists, like Alice, wanted to attend rounds and participate in interdisciplinary care team conversations, but simply did not have the time. Alice's time at the hospital was limited to two days per week and her clinical work with patients, scattered across multiple units, was her priority. In hospitals, music therapists are often expected to move throughout the space. Rarely working exclusively or consistently on a single unit like medical staff, music therapists often struggle to feel like a part of the interdisciplinary team.

Although music therapists might not interact with interdisciplinary teams consistently on hospital units, they communicate with medical and allied staff regularly through charting. In patient charts—electronic medical records where the medical team notes patients' clinical information including vitals, medical history, diagnoses, test results, treatment plans, medications prescribed, and care services provided—music therapists chart by adding progress notes about their work with patients. Music therapists instruct their interns how to chart the "right" way—be concise for medical staff, focus on medical aspects they care about, substantiate your observations, and so on. When charting, music therapists follow medical charting standard formats such as DARE (data, action, response, evaluation) or SOAP (subjective, objective, assessment, plan) which, as anthropologist Michael Taussig (1992) notes, is an everyday professional practice that facilitates the alienation and objectification of patients in the clinic.

After working for many years as the only music therapist at his hospital, Lachy was excited to be finally granted access to the hospital's electronic charting system. From a quick scan of hospital charts, music therapists like Lachy can learn if there had been any new admittances, recent discharges, or deaths on their units. They can also glean their patients' current health status based on the medical staff's notes before music therapy sessions. Although they always adapt music therapy sessions to meet patients' needs in the moment, having additional information about patients can inform how music therapists approached their session. By entering his progress notes in the electronic system, the medical staff would be able to read about Lachy's work with patients in music therapy, whereas beforehand his progress notes were simply on his computer, only accessible to him. Attaining access to the electronic system was a slow process; Lachy, supported by his manager, had been advocating to the hospital administration for a long time. One of the reasons it took so long was that they didn't have an existing code in the electronic system that could be used for music therapy and had to create a new code. Lachy was excited to finally have access to the system—not only did it mean that medical staff would be able to read his notes and, presumably, be more informed about his work, but also it meant that medical staff could submit patient referrals to music therapy through the system like they would for other staff.

At Sophie's hospital, documentation through charting (adding progress notes to hospital patients' medical charts) was coded under "recreation therapy." This was sometimes frustrating for her and her colleague Julia who wanted their work to be differentiated from recreation therapists. Their manager was inquiring about the possibility of music therapists to document under the code "psychological," like social workers and spiritual care, within their hospital's information system. Sophie and Julia thought this shift was a positive development, since it

might help their work to be taken more seriously by medical staff. They only charted if there was something "different" or "extraordinary" to report for their medical colleagues. Otherwise, they made sure to update care plans when they were due, for example before a patient was being discussed in rounds or at a family conference. Other music therapists, such as Alice, Kate, Rachel, Brian, Jonathan, and Lachy, charted after every music therapy session.

In hospitals, music therapists strive for clinical recognition by integrating into biomedical care structures and situating themselves as members of interdisciplinary clinical care teams. Like medical students who learn to construct disease as their object of inquiry by relearning ways of writing and speaking through medical rounds and charting (Good 1994), music therapists articulate their work as clinically relevant to interdisciplinary care teams through relearning how to write and speak to a medical audience. They strive for clinical recognition through making themselves visible in medical charts and attending medical rounds. In pursuit of clinical recognition, music therapists make their care practices sensible as clinical care by integrating into the clinic on biomedical terms.

Moments of Clinical Recognition

Demonstrating that music therapy "works" according to biomedical logics can be a catalyst for clinical recognition. Music therapists consistently told me that it is important for medical staff, in particular, to witness their work. "Seeing is believing. As soon as one nurse sees that you're in this moment with a patient, you don't have to explain it again," Alex said. Similarly, Jonathan told me, "You can feed people as many elevator speeches as you want and do as many in-services as you want. But medical staff need to actually see the benefits of what you're doing. 'Does it do anything for the patients?' If not, why bother with it." He continued, "You can't see intentionality. Unless you can see results. That's one of the reasons I'm such a stickler on having

medical staff be able to actually see what happens. Staff need to witness the work." To be recognized and valued within a biomedical setting, music therapists strive to demonstrate to medical staff, as important clinical actors and representatives of a biomedical perspective, that their work is beneficial to biomedical practice. Seeing and witnessing the work of music therapy meant sensing, feeling, and perceiving music therapy—and understanding music therapy—as effective clinical care.

Music therapists were palpably excited when they recounted stories when they felt recognized by medical staff who had felt the impact of their clinical work. Often, these were moments of procedural support. Alice told me, "One of my favourite music therapy moments was during my first weeks at another hospital where I used to work. There was an elderly woman in acute care who was really sick. They had inserted a chest tube and she was in lots of pain. She and I had sessions twice a week. I was able to offer procedural support for her chest tube removal. I remember her eyes went so wide, I remember she said, "Play 'Abide with me'!" and clutched my arm as they removed the tube." Alice paused, reminiscing. "It was the most integrated into a healthcare team I ever felt." Supporting the significant medical event of a chest tube removal made Alice feel as if she was part of the healthcare team and provided affirmation that she offered a service of value to biomedicine—her work was affirmed as clinical care.

Opportunities to support staff in the provision of necessary care could be both exciting and validating for music therapists. A month after I had stopped observing her hospital work, Kate was excited to tell me over the phone about how she had provided shower support for Dorothy, a patient who I had gotten to know while observing their music therapy sessions. Dorothy was very musical and would sing, scat, and dance in her music therapy sessions. On the phone, Kate explained that she had arrived for Dorothy's music therapy session as staff were

trying to assist Dorothy in having a shower. Dorothy was irritable and refusing to comply with staff's attempts to shower her.[35] Kate offered to play some music and the staff enthusiastically agreed. Playing familiar showtunes and songs from musicals that Kate knew Dorothy enjoyed, like "Singin' in the Rain" (1952), Kate refocused Dorothy's attention onto the music. As Kate played and sang, staff were able to bathe Dorothy, her anger toward staff soothed through musical engagement. Kate was pleased that her work could be mobilized in support of other staff, who were both appreciative and amazed. They asked Kate if she could help them again the following week.

Witnessing that music therapy "worked" is not necessarily predicated on staff's presence during music therapy but rather recognizing that music therapy can have a demonstrable clinical effect on patients. Lucy recounted a meaningful memory when a nurse was amazed that music therapy could act as an alternative to a medical intervention altogether. She said, "I remember this one time, there was this nurse that I wasn't too familiar with, and a baby who was crying incessantly. I happened to be walking by. I knew the baby. I asked the nurse, 'Do you want me to help?' She was like, 'I don't know, she's not okay. But if you'll stay here with her, I'll go get a morphine bolus.' I said yes, I'll stay with her. So, the nurse went to get morphine and I started singing to the baby. She responds so well to music. I knew this because I already had a relationship with her. So, I matched her, I was there, I brought her down, I calmed her, she was settled, and eventually she fell asleep.[36] The nurse came back with the morphine, and asked, 'Did another nurse come and already give the morphine?' I said, 'No, nobody came.' She was shocked. '*Nobody* came?' I told her, 'No, it's just been me since you left.' She couldn't believe

[35] On the shower and the entanglements of violence and care in the clinic, see "*La Olla Y Los Patios*" by Andrés Romero (Forthcoming).

[36] "Matching," in music therapy, means improvising music that "matches" the patient by complementing the rhythms, tempos, dynamics, timbre, pitches, and sounds they are making.

it. She checked the chart [to make sure another nurse didn't administer morphine] and was like, 'You just saved me a morphine bolus, that's amazing. What's your pager number again?'" Lucy laughed. "So, that's how I get the buy-in, essentially. She witnessed that, she experienced it, and she knows how I can help and support them to do their job. To support the best needs of the child." In this instance, Lucy was not providing procedural support for a medical intervention but was able to support the work of medical staff by producing an outcome that staff had previously thought only a medical intervention, like morphine, could provide.

Medical staff also recognize the clinical value of music therapy not only in moments when music therapy facilitates their work providing medically necessary care for patients but also in moments when it makes themselves feel better. "Often, nurses don't know what music therapy is," Lucy said. "On a unit, it can get noisy and busy, but as soon as I'm playing, the whole atmosphere changes. It's a different vibe. Everyone is softer, it's calmer, more relaxed. Nurses will come up to me afterward and tell me, 'I don't know what you just did or who you are, but can you please come back and do that again, thank you!' So, they can still get the vibe, they get that it's important for the environment, that it's important to them, it's important to the families, to anyone who experiences it." Through the presence of music therapy, medical staff can feel a tangible aesthetic shift in the clinic. As a psychiatric inpatient nurse explained, "It makes a huge difference in the overall feeling in the unit. It lightens the mood completely. The unit becomes warmer, a little more relaxed, more comfortable." Her colleague, a psychiatric ward attendant, added that, "It helps make it feel less like a hospital."

Music therapists consciously provide opportunities for staff to witness or engage with their work. While frustrated by not having a studio space for music therapy sessions in his hospital, Lachy explained to me that a benefit of holding group sessions in more public areas of

a unit, like a patient lounge, is that that medical staff have more opportunities to see and hear music therapy in process as well as the positive impact it had for patients. On the inpatient psychiatry unit, Lachy would encourage staff participation in his group music therapy sessions. Over time, Lachy learned different musical genres and artists that were staff favourites and would intentionally incorporate staff musical preferences into the patients' group music therapy session, audible to them in the nearby nurses' station and staff lounge, so that they too could feel part of the group. Hearing their favourite songs often inspired active staff participation from passing compliments—"I love that song!"—to direct involvement with the group through observation, listening, singing, and instrumental playing. Cultivating moments that brought medical staff and inpatients together in music was an important element of Lachy's approach to music therapy. Other music therapists like Brian and Alice worked systematically to engage staff, for example through organizing music therapy support for staff wellness or facilitating staff choirs.

Moments of clinical recognition can be glimpsed in music therapists' stories of feeling seen, heard, and valued as clinical colleagues by medical staff. Significant clinical events—procedural support for a medical intervention like a chest tube removal, supporting the facilitating of necessary care like showering, and substituting a medical intervention like morphine provision—are important moments when staff recognize that music therapy has clinical value in supporting the biomedical care they provide. Medical staff also recognized music therapy when it made them feel better.

Moments of Clinical Misrecognition

Music therapists do not always receive clinical recognition and buy-in when staff witness their work. Marilyn told me, "When you work very closely with someone in a hospital setting, you

can demonstrate how important music therapy is, and they still don't always get it. One time, a behavioural health therapist said to me, 'Oh, we had an entertainer here yesterday, she came onto the unit and played her guitar and sang with this beautiful voice. It was so therapeutic, *that* was therapy.' And I thought, okay, so I don't do anything here? For the behavioural health therapist, the experience of the entertainer was, 'This sounds so good.' The experience of watching me work with clients was, 'They're making a lot of noise here, it doesn't sound so great. There she is screaming on the top of her lungs and everyone's shaking their instruments... it's not so pleasant.' No, I'm not a performer, my voice wasn't as great as hers, but it does the job. So, even people who you respect and who respect and like you, will still point out to you that 'You're not a performer' or 'You're not a therapist.'" Regardless of whether or not music therapy had a beneficial impact on patients, medical staff can devalue the work of music therapists if it does not make them, the staff, feel good.

Encountering misrecognition from medical staff—who do not always understand or value their role as a music therapist and do not always take them seriously as clinical colleagues—is distressing for music therapists working in hospitals. Rachel told me, "A doctor literally said, behind my back to another doctor, 'I want her job. It's so easy!' But a friend of mine, a social worker, was in the elevator with them. She spoke up for me, she said to them, 'You have no idea what she does!' She told me this afterwards. I was like, 'Thank you!' Those moments make me feel icky." I was told that it was easier for allied health professionals, such as social workers, occupational therapists, and recreational therapists, to understand the value of music therapy compared to medical staff. Allied health professionals are often literal allies who, like Rachel's friend the social worker, will advocate for music therapy. However, it is the

perceptions of medical staff—nurses and especially physicians—whose influential opinions and perceptions carry weight in the clinic.

Quotidian moments of clinical misrecognition, when hospital staff do not quite understand music therapists' scope of practice or assumed them to be untrained volunteer musicians, spending their leisure time at the hospital to entertain patients with a concert instead of trained and skilled professionals at work, are challenging for music therapists. "Advocacy and education become part of your job," Rachel explained pragmatically. "You're constantly explaining what it is that you do."

Alice mentioned in passing how there are very few medical staff who paid attention to music therapy program at her hospital. She, like many hospital music therapists, works across several different units and typically spends no more than half a day each week on a singular unit. This means that she often misses medical rounds, spends limited time with the medical staff on a unit, and does not necessarily feel like she was part of a unit's interdisciplinary care team. "I wish there were more ways to be noticed by the medical staff," she said, somewhat defeated. Alice explained how she makes sure to remember all their names and how she is intentionally "over the top" with "niceness and appreciation" toward medical staff, and nurses in particular. "I try to give the nurses reminders, like stopping onto the unit in the morning on the way to the office still in my coat, to remind them I'll be on the unit that day."

In addition to medical staff not noticing music therapy, sometimes medical staff forget about music therapy or music therapists in different ways. This was apparent when I accompanied music therapist Kate to her small music therapy group on a chronic care unit for five nonverbal and non-ambulatory patients who were described in their charts as in an unaware and unresponsive state, although Kate was quick to qualify that "we don't know" their degree of

awareness. While three of the group members were consistently accompanied to the group by their spouses or paid caregivers, Kate and I would porter the remaining two unaccompanied group members, Ruth and Michael. Often, the nurses would forget to help Ruth and Michael get ready for the group by ensuring they were out of bed and in their wheelchairs, despite Kate's regular reminders, including signs that read "Music Therapy on Mondays at 10 a.m. with Kate" on their hospital room walls. Kate was frustrated by the nurses' forgetfulness on Ruth and Michael's behalf. "This could be the only activity they have all week," Kate said, upset that they would have to miss the group music therapy session. At the nurses' station, Kate switched tone into her typical bubbly and friendly self as she gently reminded a nurse if they could make sure Ruth and Michael were ready for music therapy the following week. In addition to forgetting about music therapy sessions for patients, other times medical staff exclude music therapists from communication channels, such as email updates about patient status. As Alice flatly noted, "You can spend all weekend working on songs for someone, then show up to their room on Monday and find out they've died."

In other instances, medical staff notice music therapy but misrecognize the work as a general music group or sing-along, confusing music therapists with volunteer musicians. This conflation became apparent in some of my interviews with hospital staff, who often equated music therapy in the hospital with the presence of any musical performances or activities. In an interview with one music therapist's manager, she insisted it was important for staff to understand the difference between volunteer musicians and music therapists. "How would a music therapist demonstrate that they are different from a volunteer that's really good at connecting with people?" she asked. "You have to show what the difference is. There are a lot of people that love to come to the hospital and play music. What is the difference between the

music therapist and the volunteer that plays music? If staff are unaware, there has to be strategies to increase the fact that, yes, they're a great musician but they're an even *better* therapist. If the people you work with know the difference and they can articulate the difference, then you've established yourself as a music therapist." For music therapists to have their work sensible as clinical care, they have to differentiate themselves from musicians and music volunteers. Medical staff, as the manager notes, often cannot distinguish between a music therapist and a music volunteer, or between music therapy and the recreational use of music in hospital settings.

Medical staff can paradoxically misrecognize music therapy as a profession while recognizing a specific music therapist as a colleague. In telling me how great she thought Lachy was and how much she valued him as an important asset to the unit, a nurse qualified her comments: "But I'm sure there are probably music therapists that are not as good, you know what I mean? It's subjective," she said, displacing the legitimacy of music therapy as a valuable clinical profession with the notion that Lachy was an exception to the rule. "I suppose the same could be said for doctors!" I countered. Laughing, the nurse agreed. The nurse's laughter in response to my comment registered the comparison of a music therapist's competency with a physician's as outrageous; of course, the same would not be said in relation to physicians, whose value is perceived as objective rather than subjective in the clinic.

Managers and medical staff regularly acknowledged to me that there are not enough resources for music therapy in their hospitals and comment that they would like to have more music therapy on their units. This was often qualified by noting that resources are scarce, and that, unfortunately, if there are budget cuts music therapy would be one of the "first things" to go, since medical staff and equipment are the obvious priority. As one manager indicated, if the

hospital had to decide between spending funds on blood pressure monitors or new instruments, clearly the priority would be blood pressure monitors. Music therapy could be simultaneously perceived by medical staff as valuable and desirable while also supplementary and non-essential in the clinic. Moments of clinical misrecognition and devaluation from medical staff made music therapists feel unseen and devalued as clinical colleagues and excluded from interdisciplinary care teams.

Patient Misrecognition

Music therapists are regularly misrecognized by patients as a result of music therapy's partial opacity in the clinic. Most hospital patients have never heard of music therapy and often assume music therapists are volunteer musicians. Unlike in private practice, where clients purposefully seek out music therapy, music therapists working in institutional settings like hospitals either seek out patients who they think would benefit from music therapy or are referred to patients by other staff who think music therapy would be beneficial for their care.

Introducing music therapy to patients is a regular aspect of music therapists' work in hospitals. Sophie consistently greeted her geriatric patients with a simple, "Hello George, it's Sophie, the music therapist." On a geriatric unit, an elderly man referred to music therapist Sophie affectionately as "my music teacher," while another asked what she did for work. Gently, she reminded him that she was a music therapist who worked in the hospital. On a geriatric psychiatry unit, Alice would leave educational brochures about music therapy on the unit for patients to read.

Even if patients do not always understand what music therapists' scope of practice consisted of in technical terms, these same patients recognize music therapists otherwise when receiving music therapy services, deeply appreciating music therapists' time, attention, and care.

Unlike medical staff, music therapists noted that they do not have to implement unwanted care like medication, showers, or restraints. Music therapists acknowledge that they generally "get to be the nice guys" in a hospital setting.

On rare occasion, I observed a music therapist become mildly frustrated by patients' resistance to music therapy because of their misunderstanding of their work. In a group music therapy session on an inpatient psychiatry unit for addictions, Brian tried encouraging group discussions and reflections about the music, but the patients seemed rather uninterested in verbal processing or engaging in therapeutic reflections about music; instead, they simply requested song after song. Brian did not push them to engage in verbal discussions; he obliged their requests for mostly Beatles' songs. After the session, however, he seemed ever so slightly irritated as he commented on how the session made him "feel like a jukebox" instead of a music therapist. "But you just have to go with it," Brian added as we left the addictions unit.

In another instance, on palliative care, Alice was referred to a patient who was considered to be "actively dying" and in substantial pain. Alice attempted to introduce music therapy to Esther on several occasions, but Esther declined, saying that she was in too much pain. Alice explained to Esther that music therapy could help ease her pain, but this didn't seem to register for Esther, to Alice's minor frustration. One day, I accompanied Alice to Esther's room where Alice intended to ask Esther again if she would be interested in music therapy. When we reached the threshold of Esther's private room, we found her calling out in distress for the nurse as she lay in the hospital bed, wincing in pain. Alice pressed the call button for the nurse as I fetched ice and wet paper towel for Esther's forehead. As we waited with Esther, reassuring her that the nurse was on her way, Alice noticed that Esther's eyes began to focus on the guitar slung across her back. "Would you like to try?" Alice said, as she held out the guitar.

Esther strummed the guitar strings gently. No longer wincing, Esther focused her attention on the textures of the cool steel under her fingers and the dissonant sounds of the guitar as Alice quietly hummed a calming, ambient-style melody. When the nurse arrived to administer morphine, Alice moved aside with her guitar and began to improvise a lullaby softly, alternating melodic humming with repetitive vocalizations of "la," accompanying herself on the guitar with a gentle finger-picking style, continuing patiently until Esther was soundly asleep. This was exactly the kind of music therapy support Alice had been trying to offer previously, but it didn't make sense to Esther who thought she was in too much pain to listen to music.

Both Brian and Alice had been mildly frustrated wanting to support patients with music therapy who, in different ways, were perceived by music therapists to misunderstand the care they offered. However, these moments of misrecognition did not make music therapists question their value in the clinic—they followed what Annemarie Mol (2008) calls the logic of care, to "try and try again" (93). Such moments of misrecognition from patients ultimately do not undermine music therapists' legitimacy as clinical practitioners. Whereas medical staff are influential decision-makers in the clinic, patients have been historically objectified by the clinical gaze (Foucault [1963] 2012)—subjected to but not representative of a biomedical perspective. Although music therapists value patient appreciation and gratitude, patient recognition does not register as clinical recognition.

Exceeding Biomedicine

Despite their efforts in pursuit of clinical recognition, normative clinical aesthetics that privilege a biomedical model of care constrain the ways in which music therapy and music therapists can attain clinical recognition and be enfolded into the clinic. While music therapists attain clinical

recognition by mobilizing music therapy to support, supplement, and substitute biomedical care, music therapy always exceeds the biomedical model.

Always relationally entangled, music therapy lacks the concrete "charms" of medicine outlined by medical anthropologists Sjaak Van der Geest and Susan Whyte (1989) through which "healing is objectified" (345). Music therapists lament that they need more clinical research—especially clinical trials—to demonstrate the efficacy of their work to biomedical audiences. But this was a point of frustration for Marilyn, who told me:

> People keep saying, "Well you don't have enough research." The thing is, we have pain research up and down...we have a lot of research, in a lot of areas. Any other fledgling field, like occupational therapy, did not have one tenth of the research that we had when there was a law instituted that they had to be in every hospital, every department had to have an occupational therapist. The people who are making hospital cuts are not going to cut fancy machines or nice buildings or their offices. They're going to cut from the bottom up. What they see as non-essential. "You might use music for pain but, you know what, we've got really good drugs."

As Marilyn mentioned, there is a great deal of clinical research that music therapy reduces pain.[37] But music therapists are unlikely to be called upon to reduce pain—unless medicine has failed. Medical staff's desires to use morphine are therefore informed not only because morphine is a powerful drug that alleviates pain but because of morphine's "charms" (van der Geest and Whyte 1989)—medical staff and patients, as well as hospital administrators and policy makers, also *believe* morphine to be the best solution for pain. As medicine, morphine represents the power of biomedical science and technology which music therapy does not.

The clinical priorities of music therapy in hospitals are not necessarily determined by clinical research, as the example of pain relief suggests. In the clinic, music therapists noted that

[37] Music and music therapy has been demonstrated to alleviate pain for adults and children with various conditions (Colwell et al. 2013; Hsu, Chen, and Hsiep 2016; Cole and LoBiondo-Wood 2014; Engwall and Duppils 2009); reduces pain in palliative care (Gutgsell et al. 2013; McConnell, Scott, and Porter 2016; Warth et al. 2015); and reduces pain and/or anxiety for adults and children undergoing various clinical procedures (D. W. H. Lee et al. 2002; Costa et al. 2010; Chan 2007; Hayes et al. 2003; Yeo et al. 2013; Tse, Chan, and Benzie 2005).

their work seemed to "just makes sense" with certain populations, like end-of-life care, when biomedical efforts to cure or treat disease have failed. At the 2019 Canadian Music Therapy conference, in her keynote presentation music therapist Wendy Magee joked about how music therapists are perpetually called as a "last resort" when there is "nothing else" medicine can do. Lucy reflected that, "It's interesting in the different hospital settings I'm in, like in palliative care music therapy is essential, there's nothing more medicine can do. Whereas in rehabilitation or other areas, music therapy is just an afterthought." Notably, music therapists are not called in as a last resort in a heroic medical way—to cure disease and save lives—but as a "nice" consolation for patients when biomedical efforts have been exhausted. When I asked Brian why he thought music therapy was relegated to certain patient populations, he explained:

> First is that I think we can really go back and, in terms of biomedical models, look at the Hippocratic oath, which is to heal, with benevolence, to do no harm. And yet in a biomedical model, with some of these extreme cases where there's not a lot that can be done medically, then the natural turn of focus is to the psychosocial or helping professions that deal with the integrated body, mind, and spirit. That's why I think you see music therapy in those areas where there's not a lot that can be done medically. Long term rehab, neurologic rehab, minimally conscious. I think that makes sense, right? It's like, we want to help, we're driven in a benevolent way to provide help and service. But it's not going to happen from a medical or physiological frame, it's going to happen with the other aspects of the human being. Second is that I think it goes back to, in terms of why you see a central focus in paediatrics. In North America, our roots are Western religion, Puritanism, and that biblical proverb: "as a child I did childish things and as an adult I put childish things away." I think that the arts, by many people, are construed as childish, relegated to sentimental consideration only. Meredith I wouldn't know how to really substantiate what I'm saying to you, it's just a gut feeling.

Although music therapy can be mobilized in support of biomedicine, music therapy always exceeds a biomedical model of care through engaging "other aspects of the human being"—caring for patients by attuning to "the integrated body, mind, and spirit," while a biomedical model continues to focus on the diseased body. The normative aesthetics of the clinic, despite

efforts to move toward "patient-centred care," remain overdetermined by the biomedical curative model where the priority is sustaining quantifiable life over quality of life.

In exceeding a biomedical model of care, music therapy is not considered essential to biomedicine, rendering full clinical recognition unattainable. A behavioural psychologist explained to me that physicians on her unit are "in favour of music therapy" because they were aware it was supported by "actual evidence." At the same time, she explained, "Resources are so low, we have to operate no matter what. If the music therapist is sick, they'll get by without it, if I'm sick, they'll get by without me. We're not essential, they'll manage without us. But do we contribute positively to the wellbeing of the client? Yes." Matthew also explained, "If I'm not there the inpatient unit is fine. They don't need me. I don't consider myself an essential service even if patients will say, 'Yes, it is essential'—you're not going to die if I'm not there." Matthew considered himself non-essential because, unlike physicians, he could not prevent death. Similarly, during the COVID-19 pandemic music therapists like Brian and Rachel moved their music therapy services online, not wanting to take up space or personal protective equipment (PPE) in the clinic. However, in the provision of "ordinary medicine" (Kaufman 2015) as well as during the extra-ordinary conditions of the COVID-19 pandemic, physicians cannot necessarily prevent death and patients regularly die in the presence of medical staff. In an interview with a COVID-19 physician a few months into the pandemic, he explained that there was not really much they could do for patients medically, so what "really matters" on the COVID-19 ward is "holding someone's hand." Yet the reduction of non-medical personnel in the clinic during COVID-19 heightens the visibility of care practices that privileges biomedical intervention. Clinical recognition is ultimately elusive to music therapists because they are not considered essential to a biomedical model of care.

Conclusion

Music therapists care for patients on the margins of the clinic. They desire clinical recognition—to be taken seriously as clinicians and to have their care practices taken seriously as clinical care. In this chapter I argue that making music therapy sensible as clinical care within the sensory world of the clinic happens through processes of everyday clinical recognition, as music therapists strive to have their work sensed and made sense of as clinical care. In pursuit of clinical recognition, music therapists support biomedical care and the work of medical staff. They make their work legible through strategies like charting and participating in medical rounds. Yet, they struggle to have their work recognized and considered valuable within the clinic, where reason and rationality is privileged over sensibility and affect. Through their care practices, music therapists exceed normative clinical aesthetics that are overdetermined by the biomedical model of care. They pay attention to and work to achieve measurable effects from a biomedical perspective while, as I demonstrate in the following chapters, intervening in the dominant aesthetic regime of the clinic through composing care otherwise.

Chapter 4. Reconfiguring Attunements in the Clinical Sensorium

Clinical Aesthetics

Pushing her music cart with her guitar slung across her back, Kate takes her music therapy practice from one unit to another through fluorescent-lit halls, up and down elevators, and across lobbies. Rarely designated to a single unit, it is typical for hospital music therapists like Kate to move their clinical practice throughout these institutional spaces. But Kate loathes crossing the large, open atrium of the hospital to get from one building to another. The sight of her guitar and music cart draws unwanted curiosity.

Her main concern is sound. The ridges between the ceramic tiles, laid over a concrete floor, jostle the wheels of the music cart. The vibrations shake the percussion instruments—tambourines, shakers, hand drums, triangles, and chimes—balanced precariously on the shelves of the plastic four-legged utility cart. The clattering instruments reverberate through the open space of the atrium. Conscious that this noise could disturb patients, families, staff, and visitors in the hospital, Kate avoids crossing the atrium with her loud cart and takes an alternative route between buildings. With a swipe of her ID card, she accesses a restricted hallway for staff-only. The sterile scent of disinfectant chemicals, characteristic of hospitals' sensory stasis (Rice 2003) and managed by air quality ventilation systems, dissipates as Kate and I pass the departments of catering and waste management, hidden to patients and visitors. The stench of garbage and the smell of hospital food once overwhelmed Kate, but she says she got used to it.

Music therapists like Kate are sensitive to sensory experience, especially the affective impact of sound, within the clinical infrastructures of hospitals. They are attuned to clinical aesthetics—what is sensed and how it makes sense in the clinic. Music therapists' sensitivity to clinical aesthetics shapes all aspects of their care praxis; it informs the ways in which they move

throughout the spaces of hospitals and guides their interactions with patients whom they care for on hospital units.

One sunny autumn morning, before the COVID-19 pandemic, Alice told me that we would be visiting Helen on the palliative care unit. Without family nearby and only a single friend who visited, Helen was what music therapists refer to as "socially isolated" and therefore a high priority for individual music therapy at the hospital. Music therapy provided much needed support for Helen in her final days. Portable speaker and iPad in hand, Alice led the way through the hospital. As I followed Alice up the stairs to the palliative unit, she told me that Helen loved classical music and was discerning in taste, once having pronounced the London Philharmonic to be "the only good symphony orchestra" to Alice's amusement. Knocking gently and announcing our presence, we tentatively entered the open door to Helen's private hospital room. Lying in her hospital bed, eyes closed, Helen did not stir. The noise of the adjacent nursing station and lounge trickled into the room. The sounds of voices, rustling papers, photocopiers, telephones, and medical devices, saturated the space. Presuming that the nursing staff had left the door open purposefully, yet irritated by the distracting noises, Alice closed the door to Helen's room behind us only partially, dampening but not eliminating the unwanted sounds. Sitting at her bedside, Alice touched Helen's arm softly. Opening her eyes, Helen fixed her gaze on Alice. Returning her gaze, Alice spoke clearly but gently, explaining to Helen that she thought they could listen to some music together like they had before. Helen's eyes closed as she began to drift out of consciousness. Sensing that music was appropriate for Helen in the moment, Alice placed the portable speaker on Helen's bed so that she could feel the physical vibrations of the sound from the speaker.

Pulling up YouTube on her iPad, Alice played recordings of Beethoven's Violin Romance No. 2, Op. 50 (1805) and the third movement of Mozart's "Gran Partita" Serenade No. 10 for Winds (1781). These carefully chosen Adagio movements are slow in tempo, gentle in dynamics, and warm in tone. Alice cautiously increased the volume loud enough to mask the disruptive sounds filtering into the room from the nursing station, while ensuring that the music is not too loud for Helen. With her eyes again closed, Helen's brow furrowed as she touched her left index finger to her cheek, suggesting to Alice that she could not only hear the music but was listening intently. Alice held Helen's right hand tenderly. Touch was a way of reminding Helen that they were listening *together*. Moving onto some of Helen's operatic favourites, Alice chose recordings of the virtuosic soprano arias "O patria mia" from Verdi's *Aida* (1871) and "O mio babbino caro" from Puccini's *Gianni Schicchi* (1918). Paying attention to subtle bodily cues and visible physiological reactions, Alice noticed Helen's breathing deepen and slow. After the second aria concluded, Alice sat quietly beside Helen, listening to her breath and observing her bodily movements until she was certain that Helen was asleep. This was Alice's last session with Helen before her passing later that week.

As Alice's last music therapy session with Helen illustrates, music therapists pay attention to the contours of sounds and silences that envelop and infuse moments of care. Music therapists seek to mitigate what they perceive as potentially harmful noise for patients in hospital rooms, such as Alice's efforts to modify the sounds in Helen's room. By managing and minimizing what she heard as disruptive noise, Alice worked to reconfigure aural attunements to support Helen's capacity to sleep and rest peacefully in the clinic. It was a similar sensitivity that prompted Kate to drive her cart through the back hallway instead of the lobby.

Music therapists' sensitivities to hospital sound environments can be understood as informed by an awareness of what musicologist Olivia Bloechl (2018) calls "aural vulnerability." An awareness of aural vulnerability reflects the ways in which abled and disabled hearing bodies "cannot not register environmental sound, including sound produced by human and non-human others" (125).[38] Music therapists are acutely aware that their work cannot *not* be heard. As Rachel explained:

> I can't hide. We don't have soundproof rooms in the hospital, so people hear me. People hear patients sing and play and that's complicated too. I just try and own it, to be transparent about it. I have to be.
>
> You can't hide from the vibrations and not be affected by them. The molecules in the room change and everything shifts.

Rachel is aware that the sounds she and her patients make travel through the space of the clinic, affecting hospital staff and visitors passing through the hallways. Like other music therapists I spoke with, Rachel understands music and sound not as fixed objects but as unfolding phenomena and material vibrations that affect bodies. This is similar to musicologist Nina Eidsheim's (2015) theory of sound as intermaterial vibrational practices. However, unlike Eidsheim who argues that sound is not an object that can be known, music therapists like Rachel are cognisant that listening, as ethnomusicologist Ana María Ochoa Gautier (2014) reminds us, "is simultaneously a physiological, a sensorial, and an interpretive cultural practice" (25). It matters *who* listens as well as *how* they listen.

This chapter explores how music therapists work with aural vulnerability in the clinic, striving to mitigate harm and cultivate care through managing the way in which sounds are perceived, sensed, and felt. Through ethnographic attention to the ordinariness of encounters in

[38] On listening beyond able bodied hearing, see Jessica A. Holmes (2017) on listening beyond hearing and Nina Eidsheim (2015) on sound as a material, vibrational practice.

environmental, group, and individual music therapy sessions, I argue that music therapists reconfigure clinical attunements by alleviating perceptions of noise, modulating atmospheres, and structuring feelings. This work of reconfiguring clinical attunements intervenes in what I call the clinical sensorium—the dominant structuring of clinical aesthetics or what is sensed and makes sense in the clinic—to open up sensory-affective possibilities where the everyday experiences of living and dying in the clinic can be sensed and make sense otherwise, outside of the anaesthesia of the clinic.

Listening in the Clinic

Music therapists situate their work as capable of mitigating the dangers of aural vulnerabilities in the clinic through reconfiguring attunements to sound. This, they explained, is beneficial for both patients and medical staff. As Joanne Loewy told me, "Doctors don't want any distractions, any more noise, any more specialities. What's the biggest problem that we can address? Noise. Noise creates medical error." Indeed, clinical research has identified hospital noise as harmful for patients in terms of causing sleep deprivation, which can lead to psychosis or delirium, increased agitation, anxiety, and stress, and increased pain perceptions; furthermore, hospital noise has also been found to negatively impact medical staff by increasing stress and decreasing efficacy (Mazer 2012; Choiniere 2010; Falk and Woods 1973; Ryherd et al. 2012; Messingher, Ryherd, and Ackerman 2012; Hsu, Chen, and Hsiep 2016; Busch-Vishniac et al. 2005; Morrison et al. 2003). Through an intentional introduction of music into the clinic, music therapists work to alleviate perceptions of hospital noise not only to support the work of medicine but also to make people—including patients, families, visitors, and staff—*feel* better in the space.

Through divergent listening practices, certain hospital sounds are coded as "good" and others as "bad." Barbara insisted, "It's important to recognize the benefit of good sound versus noise, or how sound affects the human body. I think of that when I talk about sound environments." Music therapy, in Barbara's framework, is "good" sound; however, music therapy is not always heard as "good" sound and can at times be heard as "bad" sound (noise) in the hospital. For music therapists, the sounds made in music therapy are ascribed the value of being "good" so long as they are beneficial in the care and support of patients. For example, sounds that can be considered "good" in the context of music-making in music therapy might include singing or vocalizing off-pitch, playing dissonant clusters of keys on a piano, or pounding loudly on a drum arrhythmically. However, these sounds can be considered "bad" and even "noise" to listeners shaped by Western music sensibilities. Perceptions of music-making can be complex for music therapists to navigate in group music therapy settings, as "good sound" for one participant can be "bad sound" or "noise" for another.

Noise, according to sound studies scholar David Novak (2015, 126), can be understood as a "metadiscourse" and "social interpretation" of sound that falls into undesirable aesthetic, technical, and social contexts. In hospitals, music therapists are concerned that the sounds of music therapy can be ascribed negative value by being perceived by outside listeners as noise if heard as bad music (aesthetic), non-therapeutic (technical), or as disruptive to the hospital environment and the provision of medical care (social). The auditory ambiguity of music therapy, and the indeterminacy of noise, is a significant concern for music therapists. They actively strive to have their work heard as music therapy and to avoid being heard as the sonic transgression of "noise." Their attunements toward noise can be understood, following anthropologist Marina Peterson (2021), as attunements toward the atmospheric.

Like Kate's attunement to the sonic atmosphere of the hospital atrium, Lachy was mindful of the offices behind a wall of the patient lounge where he held group music therapy sessions. He did not want the group music-making to disturb the physicians, administrators, and other staff working in these offices and be heard as "noise." When the volume of the group music therapy session became particularly loud, Lachy would subtly intervene to bring down the dynamic. As discussed previously in chapter three, music therapist Marilyn highlighted the challenge of medical staff perceiving the music in music therapy as "noise" with patients compared to the "beautiful" music provided by volunteer musicians. Additionally, the experience of music therapist Abigail highlighted how, even when sensible as music or even music therapy, music therapy could be perceived as unwanted "noise" to staff when it was thought to be detrimental rather than therapeutic for the patient. Barbara's music therapy work with an infant in the neonatal intensive care unit (NICU) was also perceived as disruptive "noise" by medical staff:

> There is so much research on the benefits of music therapy in the NICU. The staff need to understand what music therapy is and its role. Not that it's just sound or noise. I had a negative experience in the last year of being referred to a palliative patient, in a very precarious state. Mom had the baby, skin to skin, she was just holding him. I provided some very, *very* gentle music for her to be with him in that moment. The next time I went to see them, I was told that the doctor said he shouldn't have music therapy. I tried to find out which doctor. I figured out it was the resident that worked nights. I tried unsuccessfully to contact this person and after a while I just gave up. And, very sadly, the child did die. I feel sad about that because I know how much music therapy meant to that mom and what it offered.

Stories like Barbara's demonstrate the stakes of the aesthetics of care in the clinic. Hospital patients and families who could benefit from the support of music therapy are deprived of this care modality if medical staff sense and make sense of music therapy as noise rather than as clinical care. In striving to make music therapy be heard by medical staff as "good sound" in the

clinic, music therapists seek to reconfigure the clinical sensorium and modify what can be sensed and make sense as care in the clinic.

Through intervening in the sound environments of hospitals with music therapy as "good sound," music therapists work to mobilize their care practice and operationalize music to mitigate the dangers of hospital noise by reconfiguring clinical attunements to sound. Barbara insisted:

> The sound environment in hospitals is just nuts. Especially in intensive care because there's non-stop stimulation. You'll have four patients in one room, all critically ill, and there's no privacy. A crisis can happen, and others witness, it's vicarious trauma.
>
> I recall going into a patient's room once. The child was not able to communicate verbally. I can't remember his diagnosis. There were five devices that were on, the TV, radio, tablet, and so on. The staff were trying to find something to offer him, and the parents too, but they weren't thinking about the sound. Let's get *rid* of all the sound, then offer something!

As Barbara suggests, sound permeates the open spaces of hospitals, trespassing through curtain room dividers and travelling across open-concept lounges. Listening to a crisis unfold behind a curtain contributes to what she refers to as "vicarious trauma." She also perceives sound as somewhat of an afterthought for well-intentioned medical staff and family caregivers. Unlike Alice's purposeful use of an iPad in music therapy with Helen, Barbara hears the cacophony of entertainment devices in the child's hospital room as overwhelming distractions that are potentially detrimental for the child. Instead, she wants to offer the child "something that feels like *some*thing" (Kathleen Stewart 2007, 2).

When music therapists like Barbara and Alice offer music therapy in hospitals, they strive to reconfigure clinical attunements not through "distraction" or "entertainment"—terms that many music therapists I spoke with detested—but through "refocusing attention" by offering "support," "beauty," "meaning," "opportunities," "space," "time," "connection," or

"engagement." Their aesthetic intervention disrupts what philosopher Walter Benjamin ([1935] 2007) identifies as the desensitized and alienated consumption of art-as-entertainment. Distracting or overwhelming hospital patients' senses with devices like televisions is what philosopher Susan Buck-Morss (1992) calls a technique of *an*aesthetics that—alongside technologies of medicines and drugs—blocks out reality and numbs bodies to sensory experience.

The controlled, totalizing, and stultifying clinical sensorium can be understood as what Buck-Morss, following Benjamin, calls a *phantasmagoria*—a technoaesthetic that assumes a compensatory collective reality, where environmental stimuli are managed and controlled. Televisions in every hospital room and unit lounge, bland food, thin blankets, and harsh lighting all work as techniques of anaesthetics, "to *numb* the organism, to deaden the senses, to repress memory" (Buck-Morss 1992, 18)—not only to distract from the pain, anxiety, stress, fear, alienation, and loneliness of patients, but also to make the control and management of patients easier for medical staff.

As an aesthetic intervention, music therapy does not hinge on the introduction of art-as-beauty (in a neo-Kantian sense) into hospitals but rather on accessing a sensory-affective perception so often unavailable within the clinical sensorium. Music therapists work against the dominant phantasmagoric aesthetics of the clinical sensorium by cultivating space and time to access sensory-affective perceptions and retrieve what Benjamin conceptualizes, following Marxist thought, to be a sensual material world accessed through the phenomenological singularity of experience.

Modulating Atmospheres

One of the ways that music therapists intervene in the clinical sensorium and reconfigure attunements is through environmental music therapy. Developed by Joanne Lowey and colleagues, environmental music therapy is a music therapy intervention whereby music is integrated into a sound environment for therapeutic purposes, often deployed to decrease stress and pain, and to promote relaxation and sleep.[39] According to Loewy (2020, 7), environmental music therapy is "an improvisatory process that relies on the agility and sensitivity of music therapists to gently incorporate the existing aural elements of ambient sounds into a purposeful soundscape/soundtrack of music." In environmental music therapy, Sam told me that "the clinical space becomes the patient" and the goal is to "heal the healing environment." For Jonathan, perceptions of hospital noise could be shifted through environmental music therapy, but the bigger goal is to "change the perception of the hospital environment" more broadly. The hospital, he noted, is perceived as a "hostile environment" where "bad things happen" and anticipatory anxiety and grief is rife. Elaborating on the role of environmental music therapy in modifying hospital soundscapes and creating atmospheres of familiarity and safety, Jonathan explained:

> Environmental music therapy is all about trying to modify how somebody is perceiving the space. You have the environment, which is the physical space, and you have a soundscape. I can't really modify anything physical. But a soundscape is a big part of the environment. And atmosphere, what somebody *feels* about a space, contributes to soundscapes. We're looking to create an atmosphere. Music is a perfect tool for that because music is full of emotional clues. We work to create specific emotional contexts, to make this feel like a more familiar and safer place. The space of hospitals should make people feel safe and there should be something familiar about the everyday world in that space. But it seems like the philosophy was, "Let's create the opposite of that."

[39] Environmental Music Therapy (EMT) has been researched extensively by music therapists for its efficacy in hospitals, including intensive care units, for chemotherapy infusion with oncology patients, and in the neonatal intensive care unit (Canga et al. 2012; Rossetti 2020; J. W. Zhang, Doherty, and Mahoney 2018; Joanne Loewy 2020; S. Schneider 2005; K. Stewart and Schneider 2000).

In environmental music therapy, music therapists subtly work to shift how people sense and make sense of the clinic—transforming how patients, families, visitors, and staff feel (sense) in the space and understand (make sense of) the sound environment—by curating affective atmospheres that feel safer and more familiar.

I accompanied Sam as he provided environmental music therapy on an oncology unit where patients were receiving chemotherapy treatments. It was a way to "warm up the space," Sam explained, before providing individual music therapy sessions on the unit. He placed a chair in the hallway, a few feet to the right of the nurses' station, double checking with a passing nurse that his location was appropriate and not in their way. The beeping sounds of medical devices along with the sounds of staff talking to each other and patients about medical aspects of their treatment—such as medications, intravenous insertions, bruising, and calcium levels—could be heard throughout the open unit, where outpatients receiving chemotherapy infusions were separated only by curtains. Pausing first to listen to and look around the space, noting the sounds and feeling the presence of patients, caregivers, and staff, Sam slowly and softly began to improvise gently on his guitar in a classical finger-picking style. His subtle intervention drew only the occasional glance from patients, their companions, and medical staff. Ever so delicately, Sam drew various sounds, pitches, and rhythms of the unit into his instrumental improvisation, such as echoing the interval pitches of a perfect fifth (C and G) sounding from a monitor alarm—incorporating mechanical and ambient sounds into the music but not overemphasizing or "pandering" to these sounds as he later explained. This "modulates but doesn't mask" these "ambient stressors."[40]

[40] The sounds made by ventilators, I was told, were "often in the key of G."

In taking care not to mask mechanical alarms, music therapists like Sam demonstrate their attention to multiple perceptions of sound in hospital environments. While mechanical beeping sounds can be perceived as noise or "sonic stressors" for patients, visitors, and staff, music therapists are mindful that alarms can sound important technical signals that indicate to medical staff the need to carry out various tasks, from monitoring vital signs to replacing oxygen tanks and replenishing intravenous bags of saline solution. This practice of modulating clinical atmospheres extends beyond the intervention of environmental music therapy to ordinary group and individual music therapy sessions. Like Sam's effort to incorporate alarm sounds into his improvisation, Alice similarly worked to minimize the sounds of the nursing station in Helen's room by closing the door only partway, careful not to block the nursing staff's attempts to keep a visual and audible grasp on Helen.

Informed by what music therapists describe as clinical intuition, Sam worked to add music therapy into the clinical soundscape through an improvisational practice grounded in listening. Unlike recorded music, which as Sam noted, "doesn't listen back," music therapists listen to and compose-with the spaces of the clinic in a multisensorial fashion, paying attention to happenings by picking up on not only to what is sounded or audible to the ear but also to visual, tactile, and olfactory cues. Through this multisensorial listening practice, music therapists' sense what they refer to as the "feelings" and "energies" of a space. But integrating environmental music therapy into the clinic, Sam explained, was guided not only by clinical intuition but also an "aesthetic intuition." Sam insisted, "As music therapists, our strength is our aesthetic sensibility. It's the most important skill we've cultivated." For Sam, the aesthetic sensibility of music therapists was a capacity for humanistic, relational, and intimate attunement.

The aesthetics of music therapists' care practices work against the dominant aesthetics of the clinical sensorium where, as Sam remarked, "hospitals strip away meaning and beauty just to keep you safe and alive." Through offering "a shared aesthetic experience" through the "temporal-aesthetic space" of music, Sam works to open-up sensory affective space for feeling feelings, facilitating access to beauty, pleasure, memories, and meaningful experiences through music therapy. "Music creates containment," Sam said, "it creates its own space within that aesthetic experience. Even in the most cramped of hospital rooms, music creates a different sense of space, of environment."

Joe's Blues

On an inpatient oncology unit, I sat next to Alex as he provided environmental music therapy in the hallway, also in view of the nursing station. In "responding" and "interacting with the environment," as he put it, Alex improvised intentionally with the clinical space, gently playing arpeggiated chords on guitar before transitioning into slow, soft rendition of popular songs that he knew were favourites of staff and patients. Busy medical staff continued with their tasks behind the nursing station, again only occasionally glancing over at Alex. Moving into a slow rendition of "Part of Your World" from *The Little Mermaid* (1989), a passing nurse locked eyes with Alex and smiled, "You're playing my song!"

Alex tuned-into the affective atmosphere of the unit by "listening and feeling the energies." While at first "matching the energy" of the space, he worked to subtly "change the energy, even if only briefly," by singing and playing guitar in relation to clinical soundscapes and the people, machines, and multisensorial happenings on the unit. Alex worked harmonically and melodically to build his musical interventions around the tonal centre of C in order to match the pitch and expand the resonance of a persistent beeping sound made by a monitoring device.

“Listening is the most beneficial tool,” Alex explained, telling me that he is “always changing the plan” and “always adjusting” his practice in the moment.

While Alex was playing guitar on the hospital inpatient unit, Joe was walking slowly down the hallway assisted by his physical therapist, Sylvia. Casually, Alex greeted Joe. “Hey.” Joe’s laboured breathing was audible as he paused and stood in front of Alex, making eye contact with interest. “Is there a particular song…” he trailed off, realizing Joe couldn’t respond verbally because of a large tumour on his neck. “Blues?” Alex suggested, as he began strumming a standard blues progression on his guitar, increasing both the dynamic and tempo, intensifying the energy. Sylvia spoke words of encouragement, “Do you like blues? Blues are good!” Alex improvised song lyrics based on the very little information he had learned in that brief moment about Joe.

Getting my daily workout
Walking back and forth
Getting my daily PT
Getting the blood to my knees
Exercising
Reviving me

Joe smiled and swayed back and forth along with Alex’s playing.

Da da dum
Oh right now baby
Yeah
Working out
My frustrations

When Alex concluded, Joe, Sylvia, and I applauded. Joe then extended his hand toward Alex. “My pleasure, sir,” Alex said as they shook hands. Joe and Sylvia continued on their walk around the unit as Alex returned his playing to a more restrained, gentle, and calming character.

Despite Joe’s inability to verbalize a greeting or articulate a musical preference, Alex listened to Joe by paying attention to the rhythms of his bodily cues and responses, as subtle as

they were, from the pause in his footsteps to his engaged eye contact accompanied by laboured breathing. Through a multisensorial listening practice, Alex sensed Joe's engagement and responded with the blues and improvised cathartic lyrics, offering an energetic interruption to what might otherwise be considered a banal clinical routine of "walking back and forth."

Both Alex and Sam engaged a multisensorial listening practice in observing, feeling, and sensing the clinical environment they care for. Listening to the soundscape meant hearing ambient sounds produced by machines and people, observing the structural layout, smells, and textures of the unit while attuning to gestures, movements, and interactions of people throughout the space. Informed by their aesthetic sensibilities, they intervene in the atmospheric as they sense the public feelings and affective flows (Berlant 2011; Cvetkovich 2003; 2012) of the clinic; this mode of attention is also attuned to the intimacies and intensities of encounters and the singularity of experience. As Alex's encounter with Joe illustrates, caring for people is deeply enmeshed in environmental music therapy efforts to "heal the healing environment."

Through environmental music therapy, music therapists like Sam and Alex compose affective atmospheres of care by reconfiguring attunements to technoaesthetic clinical soundscapes. By modulating ambient hospital sounds, music therapists transform what and how people hear in the clinic. They also open up possibilities for what and how people *feel* in the clinic. This intervenes in phantasmagoric anaesthetics that numb, distract, or overwhelm sensory-affective perceptions. Joe's clinically managed exercise routine of "walking back and forth" the unit's hallway, for example, was opened up in his encounter with Alex—if only momentarily—to a multiplicity of feelings, sensations, and becomings through its modulation into the blues. While phantasmagoric aesthetics persist, structuring the *an*aesthetics of everyday life in the clinic, music therapists' reconfiguration of clinical attunements opens up possibilities

for sensory-affective perceptions and atmospheric space-times that intervene in the dominant aesthetic distribution of the clinical sensorium, supporting people like Joe to feel otherwise.

Extra/ordinary Therapeutic Encounters

While in environmental music therapy, music therapists reconfigure clinical attunements by working with the sonic environment to compose atmospheres of care, an attunement to the atmospheric infuses their everyday work in hospitals with patients in group and individual music therapy sessions.

Alice's last session with Helen and Alex's fleeting contact with Joe demonstrate, music therapy offers *some*thing. But what exactly these music therapy encounters *do* and what they *mean* for hospital patients like Helen and Joe—what music therapists interpret as "clinical outcomes"—can be ambiguous. An ethnographic attunement to ordinariness acknowledges the limitations of analytic interpretation and representation. I am interested in the ordinariness of music therapy—the intimacies felt and experienced in music therapists' everyday encounters. Writing about place and affective intensities in rural North America, Kathleen Stewart (2007, 3) asserts that the significance in ordinary encounters "lies in the intensities they build and in what thoughts and feelings they make possible." In the context of political and sexual violence during the partition of India, anthropologist Veena Das (2007) argues it is not through a *transcendence* of the everyday but rather a *descent* into the ordinary where healing can be found. An attention to the ordinary, as anthropologist Zoë Wool (2015) demonstrates in her ethnography of American military veterans at Walter Reed medical centre, does not disregard the extraordinary but rather explores the everyday entanglement of the extra/ordinariness of life.

Against the Kantian ([1790] 2007) transcendental, whereby the bodily entanglements of sensations, perceptions, and feelings are transcended by the mind of a judging subject to access

the sublime, I understand the ordinariness of everyday music therapy encounters to lie in the immanence, immediacy, and indeterminacy of moments of sensuous contact. Sensing, as a world-making process, unfolds in what philosophers Gilles Deleuze and Félix Guattari call "the middle" of things (1987, 25)—or philosopher Henri Bergson ([1896] 1991) calls the *durative*, the non-linear temporal process of the present—where affects intensify, resonate, emerge, and differentiate, become eventful and potentializing. Through the following stories of ordinary music therapy encounters, I illustrate how music therapists care for hospital patients by reconfiguring clinical attunements and opening up sensory-affective possibilities. Exceeding the dominant *an*aesthetics of the clinical sensorium, I show how, in ordinary music therapy encounters, music therapists strive to make life in the hospital more liveable and death in the hospital more bearable.

Feel the Same Way Too

In the locked inpatient psychiatry unit, Lachy provided group music therapy sessions in the open-concept patient lounge. Unlike other hospital units I spent time in, the lounge on this inpatient psychiatry unit was surprisingly well-lit. Large windows looked out onto the hospital parking lot; however, like most North American hospitals, the windows did not open. Lachy would sit at the tables and chairs in the open lounge, under the surveillance of the adjacent nursing station. The group was intentionally unstructured so that, unlike the locked unit, patients could come and go at their leisure; the lack of pressure or expectation for patients to participate was a subtle strategy to encourage their presence.

A large whiteboard hanging on the wall beside the nursing station caught my attention. The PATIENT SCHEDULE listed three daily meals (breakfast, lunch, and supper), the weekly medical team rounds, and music therapy sessions (see figure 1). The programming that had

existed prior to the COVID-19 pandemic was volunteer-run; volunteer services, along with visitors on units like inpatient psychiatry, had been suspended during the COVID-19 pandemic as a precautionary measure. Missing from the schedule were the four daily smoke breaks. These fifteen-minute outings to the outskirts of the hospital grounds were supervised by the psychiatric ward attendant.

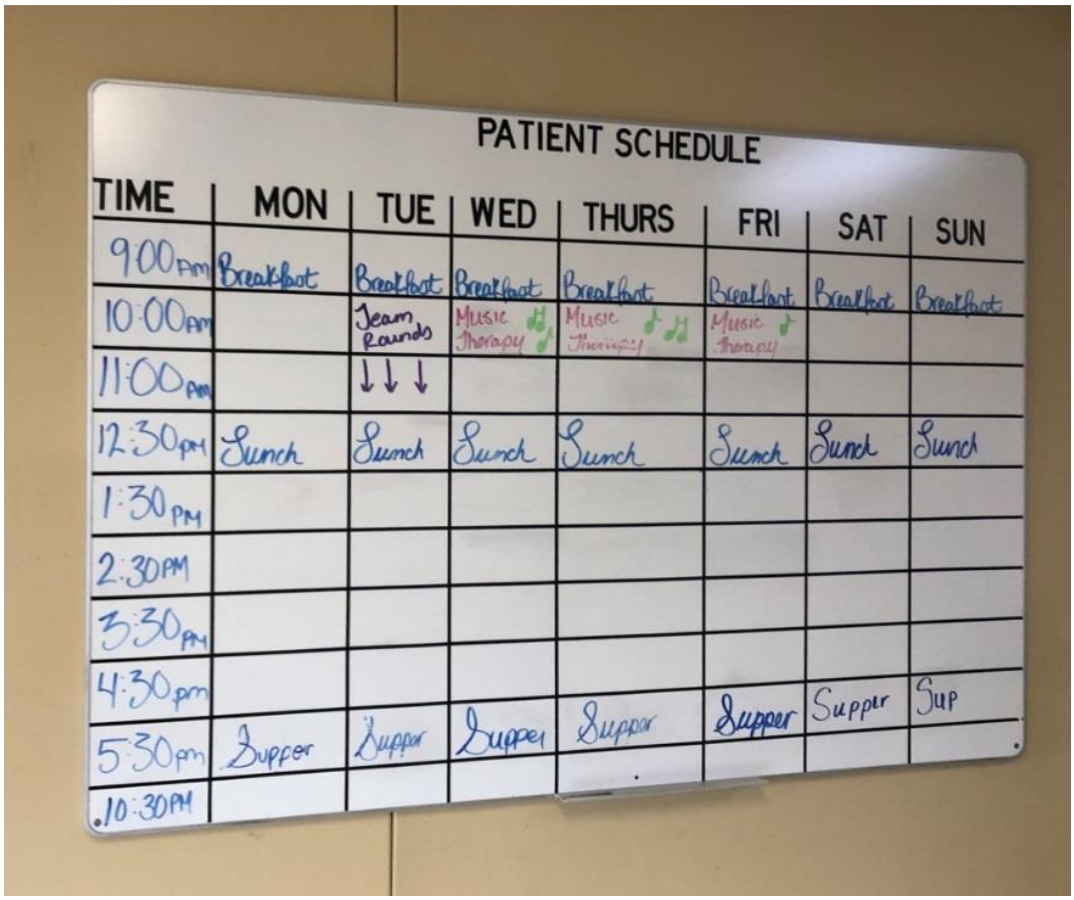

Figure 1. Patient Schedule.

In the centre of the lounge stood a rectangle pillar wrapped in a mural of trees (see figure 2). Below an analogue wall clock, TIME is painted across the tree branches. The hands of the clock point toward a surveillance mirror and security camera. HEALS, the adjacent side of the pillar read. “Isn’t that great?” A psychiatric nurse beams, “A *patient* did that!”

Figure 2. Time Heals.

“Donald’s back,” Lachy told me in his office. I peered over his shoulder as he reviewed the inpatient psychiatry charts. “He’s a great musician. You’ve got to hear him play.” Lachy shared how he had met Donald outside the hospital years ago. It was the middle of a warm and quiet summer night. As Lachy biked home, he heard someone playing the fiddle. “It was beautiful. I took a video on my phone. I think I still have it!” I watched Lachy’s video pan over the handlebars of his bike, turning the scene into a blur as it refocused on the dimly lit street. Coming as if from far away, I could hear a slow, serenading, fiddle melody. The video ended. Lachy recounted how he followed the sound of the fiddle to a bench where Donald was sitting,

playing in solitude. Lachy struck up a brief conversation by complimenting Donald on his playing. They sat together on the bench for a while before Lachy continued home. “It’s one of my fondest memories,” he said.

The first day I met Donald it was quiet on the unit. Several patients had been recently discharged. It was overcast and the mood was dreary and melancholic. Lachy and his intern, Sarah, started a group music therapy session in the lounge with Kimberly and Liam, two young adult patients. In his warm and friendly manner, Lachy put them at ease, asking casually if there were any songs they’d like to hear. Seemingly indifferent, with flat affect, they deferred to Lachy. “Anything,” Liam shrugged, as Kimberly averted her eyes, gazing out the window into the distance. Strumming a G major chord on his guitar, Lachy began to sing a slow and gentle rendition of the song “I Want to Hold Your Hand” by the Beatles (1964). Sarah joined in with her vocals, providing warm textures as she harmonized softly during the chorus. Through the muted rendition of this typically energetic Beatles song, Lachy had matched the subdued energy of the unit. Staying with the melancholy, Lachy subtly intervened in the collective feeling of the space, adding a palpable yet indefinable atmospherics to the unit. As we listened collectively to his modified interpretation of a familiar song, Liam listened intently, relaxing into his seat, and Kimberly redirected her gaze over to Lachy. A nurse emerged from the staff room to listen, standing at the periphery of the lounge.

Donald entered the lounge as the song concluded, telling us he had heard the music from his room all the way down the hall. After greeting each other, Lachy asked Donald if he’d play, offering him his guitar. Donald started to improvise a solo guitar riff, increasing the tempo and dynamics as he played, inflecting the melodic tune with embellishments like slides and harmonics. As his playing intensified, medical staff came out from behind the nursing station to

join us in the lounge, watching and listening in awe. Finishing his riff with a flourish, we applauded. Lachy beamed. “Every time I hear you play it reminds me that I have to go practice!” Light-hearted laughter rippled through the room. Donald smiled bashfully. “Aw Lachy, you make a guy feel good about himself!”

The next day, Lachy brought an extra guitar to the unit for Donald. Resting his head in his hands, averting his eyes downward, Donald said he didn’t feel like playing. Lachy reassured him that he could just listen. Lachy began to play “That Lucky Old Sun” (1949) by Beasley Smith and Haven Gillespie. Midway through the song, Donald picked up the extra guitar off the table and, unfamiliar with the tune, began improvising a solo. “I really felt it,” Donald smiled. “I developed a feel for it right from the start, I was having a really bad day but you put a smile on my face today Lachy, hopefully it’ll last!” He laughed, “Forever!”

Donald took the lead the following week. “Want to do an instrumental, Lachy? One of the first ones I ever learned as a kid, it’s pretty simple, this will bring me back to the good old days, I’ll start off slow on A.” Donald called out the chord changes: A, D, E. “That’s it! Good backup!” Donald began to pick up the intensity, stomping his feet along with the accelerating tempo as he played faster and faster. Lachy struggled to keep up as Donald drove the tune to a big finish.

Pausing to catch his breath, Donald spieled, “I love to just experiment, the guys used to call me Wolfgang, my mother would say ‘stop it Donald you're just showing off’ when I played the fiddle sometimes I’d go way up the neck like classical players just experimenting. I’d play the whole weekend didn't sleep just drank and played. My friend told me to forget about the paper just play, it’s the power of music, you just need to go with the flow, you never know where it’s going to take you, it’s good when your mind needs a break. I really love playing, time

flies when I'm playing music with you guys, the sound of the music there's power there, it's how you feel inside you, especially with good players you want to do your best. I don't have a good guitar anymore I have to get another."

"Oh you need a guitar Donald," Lachy told him.

"Thanks a lot Lachy, I'm really honoured when you give me compliments, thanks for letting me play along with you when I'm here I really enjoy it."

Lachy suggested another instrumental improvisation. This time, Lachy took the lead, steadying the tempo in a lilting 6/8 time, tempering the energy in the room. A brief silence ensued. Donald looked up. "That was fun, good to do stuff like that once in a while," he said.

"I was listening to you. I know you were listening to me," Lachy said gently.

"When I'm feeling really good, I play a little better," Donald smiled shyly.

Back in the office, Lachy told me that although Donald was a great guitar player, I really *had* to hear him play the fiddle. The next week, Donald went to fetch his fiddle from home on a pass from the psychiatric unit.[41] The fiddle was old and a little dusty, with a clothespin on the bridge, muting the vibrations of the strings with the effect of producing a warmer and richer tone. The hairs on his bow were loose and frayed. Turning to Lachy, Donald asked, "Do you know 'Feel the Same Way Too' by the Rankins?"

"Yeah! Does the key of C work?"

"Oh Lachy, you don't have to play it, I just thought of it!"

They began to play the instrumental opening of "You Feel the Same Way Too" (1995). Donald pushed the tempo, assertively instructing Lachy, "A little faster."

"Faster?"

[41] On a locked inpatient psychiatric unit, a therapeutic pass (colloquially referred to as a "pass") refers to "a physician-authorized leave of absence from the hospital for two or more hours" (Donner et al. 1990, 93).

"A little faster, Lachy, I think…" Donald hesitated, his doubt palpable. "No no, whatever you think Lachy…"

"Faster, you sure?" Lachy smiled playfully through his mask. Their mutual uncertainty eased the tension and light-hearted laughter spread through the room. Lachy sang:

Hey hey sweet darlin'
Let's go dancing tonight
My clock has been ticking
It's telling me the time is just right
Well I woke up this morning with a feeling
Lonesome and blue
And there's no need in asking cause I know
You feel the same way too

Donald embellished and harmonized the melody on the fiddle, staying with Lachy's tempo and matching his dynamics and tone.

Hey hey sweet darlin'
Let's lay the whole thing down, yeah
This world if you let it
Will drive you into the ground
And I got twenty dollars and you know
We'll get inside the door, yeah
When the band starts playin'
Can they ask us for more

Lachy crescendoed into "more" as Donald bounced his bow in a spiccato style, building in intensity.

We may do the bump and grind
Shake around our little behinds
Do some things that we normally do
On a Saturday night
That's alright, yeah
We may drink a little too much
We lose our fancy touch
Oh step outta line with reality, yeah
That's the way she be
There's no need in asking cause I know
You feel the same way too

Donald launched into a solo, arpeggiating up and down the fingerboard. Looking on, Lachy cheered in encouragement. Bringing down the volume, Lachy sang the next verse quietly as Donald matched his soft dynamics with gentle bowing:

Hey hey sweet darlin'
A lot of words have been unkind
But that was yesterday
Why don't you leave the past behind

Together, they brought up the intensity again.

You know that I love you and you know
I'll always be true
And there's no need in asking cause you know
I feel the same way too
And there's no need in asking cause you know
You feel the same way too
Yeah, yeah, Yeah, yeah, Yeah, yeahhh

Singing the last "Yeah" together, they grinned as applause erupted in the lounge. From behind the nursing station, a psychiatric nurse exclaimed, "Donald, you still got it!"

"Alright, I know I lost it a while back! Maybe I had it again for a little while!" The audience chuckled. Donald grinned, "Lachy you brought a smile to my face today, you know that? A very good feeling, a good smile."

"The feeling is mutual Donald, it really is, totally. I love playing with you man."

"Aw thanks a lot Lachy, it's one of the highs of my life in here, anywhere, I'm telling ya, you never think you're going to reach a high in here outside of medication!" Donald laughed. "That's the best I've ever played that tune and I've played over and over, in bands."

"I think it's great. You've got a gift, Donald."

"Oh Lachy, it's people like you that bring it out in me, my friend used to say you're only as good as the people around you but it's true."

"Right."

"But my god, it's people like you that bring out the best in me, make me a better player, make me enjoy music more, etcetera."

"That's the way it should be."

"It means a lot. Since I met up with you Lachy I became a better person."

Back in his office, Lachy and I reflected on the high energy that day. I compared it to the previous week where Lachy had intentionally worked to calm the intensity of Donald's rapid instrumental improvisation by responding with a gentle, soothing improvisation in 6/8 time. "You don't want patients getting too high from the music," Lachy said. "But today, there was no holding back the energy. You just have to run with it." This energy swept through the unit lounge, drawing Lachy, Donald, patients, and medical staff into the excitement of feeling and sensing together in music.

The affective porosity between bodies feeling music and sensing sound together—often described in music therapy as the "energies" of the space or the "group dynamics"—can also be understood, following philosopher Michael Serres (1985), as "veiled in skin" (54), where the sensing of another body and one's own body cannot be delineated. Instead, varied senses mingle discretely and continuously, constituting not autonomous objects and subjects but bodily mixtures—hybrid relational existences in knotty states. Such collectively composed and affectively charged atmospheres intervene in the dominant aesthetics of the clinic by reconfiguring attunements otherwise; it "felt more like a party or a concert" and "less like a hospital," according to Lachy.

The clinical monotony of meals, smokes, television programs, and psychiatric assessments was temporarily displaced in Lachy's group music therapy sessions not through an Enlightenment transcendence of bodily entanglements but rather through what anthropologist

Todd Ramón Ochoa (2007, 487) describes as lingering in the "immediacy of sense experience […] in the chaos, in infinite 'indefinite' nature" of immanence, where sensory-affective possibilities open up. The extraordinary intimacies of Donald and Lachy's relationship were collectively felt and experienced through music; in these moments, "time flies" as life on the hospital's locked psychiatric unit is rendered ever so slightly more bearable.

Holding Space

Rachel facilitates a music therapy group at the hospital for outpatients with chronic obstructive pulmonary disease (COPD). Held in the hospital's music therapy studio, a windowless space with a piano, a couch and chairs, and a smattering of percussion instruments, Rachel explained to me that the small group was meant to be casual and comfortable. Social isolation was a common experience for people living with COPD, Rachel explained, so she worked to cultivate a supportive group dynamic in support of socialization.

Only two group members showed up to the late afternoon group in the autumn before the pandemic. Anthony seemed laid back and relaxed, but Sean appeared stressed; after arriving late, he explained that he had just come from the doctor where he had learned he would be having surgery. We listened quietly while Sean spoke about feeling fearful, distressed, scared, and sad about the impending surgical procedure. A nervous silence gripped the room. Rachel interjected with soft-spoken words of affirmation; it must be difficult news to process, she said, and, if he'd like, perhaps they could arrange extra music therapy support for him around the procedure. Distracted, Sean half-acknowledged the suggestion with a subtle nod. He seemed not fully present, almost as if he was in a state of shock, consumed with anxiety, worry, and fear as he contemplated his mortality. The weight of Sean's feelings was tangible.

Rachel asked if she could provide an induction for relaxation. “That would be nice,” Sean said. After dimming the lights, Rachel guided the group through some deep breathing exercises. “You can close your eyes if you’d like. Let’s breathe in through the nose and hold,” she instructed. “And out through the mouth.” Breathing out together, the group made a collective whoosh-ing sound. Passing a wooden rainstick over to Sean, Rachel moved to the piano and began improvising a slow, soothing melody with sustained arpeggiated chord progressions. Her cascading textures, accompanied by Sean’s gentle movement of the rain stick, was meditative. A peaceful silence followed her final cadence. She turned toward the group, picking up her guitar. “How about some songs?” she asked, handing out songbooks. As Rachel strummed the chord progressions to lighthearted popular, folk, and Motown classics, the group alternated singing, playing pipe flutes, and percussion instruments of drums and shakers. Skipping over songs that were too energetic and upbeat, Rachel matched the song selections with the subdued tone of the session. A final breathing exercise closed the session.

As we walked back to her office, I remarked that the session had felt heavy. Rachel told me she hadn’t planned on such a somber session and had adapted her plan to meet the needs of the group. “It’s important to hold space for participants to feel their feelings and feel the music,” she said. “I like to think of music as a container. You can be in it together, with them.” In this temporal-aesthetic space of containment, structures of feeling unfold in the immediacy of the present through an emergent process of becoming, not yet fixed into being, forms, structures, definitions, and representations. Philosopher Raymond Williams (1977, 132) describes changes in structures of feeling as qualitative “changes of presence” that are always social and material but “do not have to await definition, classification, or rationalization before they exert palpable pressures and set effective limits on experience and on action.” Music therapists like Rachel

work to structure feelings by conditioning, enabling, and facilitating—but not determining—changes of presence, for example through breathing exercises and meditative listening practices, while remaining open to an infinite alterity of sensory-affective possibilities and potentialities. They hold spaces to feel feelings unfold. As Rachel explained, "Music therapy allows you to feel feeling, period. It doesn't have to be good, bad, it's whatever you need to feel in that moment, you're able to feel it."

Yet the sensory-affective flows of such extra/ordinary music therapy encounters always evade capture. Within the dominant aesthetic regime of the clinical sensorium, where medicine, science, and technology march forward in a linear fashion, an ostensible progress toward innovation, medical breakthroughs, and curative discoveries, being in music therapy is to bask in the non-linear temporality of the present, lingering sensory-affective excess and in the indeterminacy and immediacy of life and death.

John's Song

Alice ran a weekly music therapy group on the inpatient psychiatry unit for seniors. She began the first session of the new calendar year of 2020 with a welcome song, asking each of the six group members to share one word about their day.[42] Strumming her guitar, Alice sang:

I'll welcome you here today
It's kind of you to come
Welcome Maureen
How are you doing John
One word for you Glenda
Welcome here today
One word for how you're doing Robert
And you Belinda
How are you Hannah
I'm glad you're here today
And I'll welcome you here today

[42] "Welcome" or "Hello" songs and "Goodbye" songs are frequently used in music therapy practice to structure sessions by providing familiarity, routine, and stability (Wigram, Pedersen, and Bonde 2002, 179).

“I thought we could work on a song together today,” Alice said. “We could use the tune of ‘Annie’s Song’ [1974] by John Denver. Do you know it?” Several group members nodded. Alice played the chords on her guitar, humming the melody; in D major, the song is structured around a repeated harmonic progression of a verse, without a chorus or bridge. She then asked the group to brainstorm synonyms for *wish.* On one column of her whiteboard, she wrote the group’s suggestions: hope, imagine, dream, anticipate, expect, foresee, trust, and wonder. Then, she asked the group of patient participants to brainstorm things that they *wished for*, “for yourself, your community, or society.” She wrote their responses in another column on the whiteboard: joy, healing, music, learning, experiences, change, health, gratitude, peace, hope, travel, discovery, and success. “Sometimes, success for me is taking off the covers in the morning,” Alice related as she wrote “success” on the board. Alice handed out percussion instruments to the group—options included a woodblock, shakers, cabasa, hand drums, and a triangle—along with melodic bells tuned to a D major chord: D, F-sharp, and A.

While strumming the tonic chord of D major, Alice told the group “I’m going to attempt to stick these words together—we’ll see what happens, let’s see what we can create. I’ll try to get every word in there! It’s going to be random, I’ll improvise. You’ll keep a steady beat!” The group followed Alice’s lead, keeping a steady 3/4 waltz-like tempo.

I hope for more joy
I imagine healing
I dream about music
I anticipate learning
I expect experiences
I foresee some change
I expect better health
For all of us again

I trust there will be gratitude
I expect more peace
I hope for more hope

I foresee travel
I wonder about discovery
and I hope for more success

"What do you think?" Alice asked the group, "Any additional wishes?"

"Happiness."

"Cooperation."

"Negotiation."

"To cope."

Alice added these to the board. "We'll sing it again next week," she told them. "But now, how about we turn the lights off and do some listening to classical music."

The adapted guided imagery exercises that Alice always closed the sessions with were popular with this group of older adults, many being classical music fans.[43] Standing to turn off the institutional overhead lighting, Alice suggested, "See if you can do some imagining around the words of 'joy' and 'health.' These words can mean something different to everyone, from day to day." Alice spoke in a soft, soothing, meditative vocal prosody as she inflected phrases upward until the concluding statement. "As the music shifts and changes, let your imagination change with it, roll with the images, don't force yourself to imagine a certain way. Close your eyes and breathe comfortably and deeply, in through the nose and out through the mouth. Notice the chair holding you up, feel the chair underneath you, let your muscles relax. Let your imagination go free. Imagine the coming months and see where it takes you." Alice paused.

[43] Guided Imagery and Music (GIM) is a method developed by influential music therapist Helen Bonny (Bonny 1989; 2002). GIM, according to Bruscia ([1989] 2014, 230) is "a model of psychotherapy and healing which involves imaging to specially designed programs of classical music while in an altered state of consciousness and dialoguing with a trained guide."

"In a moment the music will join us," she said. Using her iPad and portable speaker, Alice gradually faded into the lyrical soaring strings of Warlock's Capriole suite's (1926) fifth movement, "Pieds-en-l'air," Andante tranquillo, in G major.

After listening to the piece, Alice told the group to take their time and allow any images to come to a close. "Move your bodies gently to come back into the space." Guiding the group to take two deep breathes, Alice asked, "Does anyone has reflections they'd like to share?" Maureen, a vocal participant in the group sessions with a love for classical music, described how she imagined walking at a sauntering pace in her neighbourhood in autumn, before she was admitted to the hospital, and feeling the sun on her face. John, a quiet man, began to speak up. "I felt melancholy," he uttered before breaking into tears and covering his face with his hands. Supportively, Alice intervened, "Whatever comes up is fine to feel. Music can bring up difficult emotions. Did anyone else have a different experience of the music? All I could imagine today was the colour orange. We all experience the music differently. Next week we'll return to the song that you all wrote, maybe we can add a title."

As participants filtered out of the room and I started to put away the chairs, Alice went to check on John privately. She was worried about him and felt uncertain about how she had structured the music therapy session and had handled the situation when John had begun to cry. I reassured her that it seemed to me as if she had said all the right things in the moment by affirming John's feelings and redirecting the group's attention away from him. However, despite Alice's and other music therapists' description of music therapy as a space to feel feelings—to feel "whatever comes up"—they take responsibility for structuring those feelings, holding space, and offering containment. John's feelings spilling over into a kind of sensory

excess that was ambiguous—unclear whether it was cathartic or distressing for John—made Alice feel uncertain whether she had been "doing the right thing."

Peaceful Memory

I followed Lachy's music therapy intern, Sarah, as she knocked on the door of Margaret's private hospital room on the transitional care unit. Gently, Sarah asked Margaret if she could come in to "do some music" together with her. Elderly and frail, Margaret was dressed in a hospital gown and sitting in a wheelchair beside her hospital bed, covered in a pink fleece blanket and accompanied by a plush skunk.

Sarah began this first session by asking Margaret what kind of music she enjoys. Margaret told Sarah that she liked anything but especially country western. She asked if Sarah knew "Take Me Home, Country Roads" (1971) by John Denver. Strumming her guitar, Sarah sang through her mask:

Almost heaven, West Virginia
Blue Ridge mountains, Shenandoah River
Life is old there, older than the trees
Younger than the mountains, blowing like a breeze

Sarah slowed to match the tempo of Margaret's singing, prolonging her articulation of the lyrics so that they could sing in unison.

Country road, take me home
To the place, I belong
West Virginia, Blue ridge mountains
Take me home, country roads

Sarah modified the lyrics, following Margaret.

All my memories, gather round her
Miner's ladies, strangers to blue water
Dark and old here, older than the trees
Younger than the mountains, blowing like a breeze

Margaret's voice quivered into the chorus. Closing her eyes, she mouthed the words, not making a sound as her eyes welled up with tears.

Country roads, take me home
To the place, I belong
West Virginia, Blue ridge mountains
Take me home, country roads

I hear her voice in the morning hour she calls me
The radio reminds me of my home far away
Driving down the road, I get a feeling
That I should've been home yesterday, yesterday

They sang the final chorus together softly.

Country roads, take me home
To the place, I belong
West Virginia, Blue ridge mountains
Take me home, country roads

"Beautiful," Margaret said.

"You've got a beautiful voice. Thank you for singing with me today." Sarah replied.

"Thank you for coming. Music touches…" Margaret trailed off, her voice breaking as she started to cry. "It means a lot to me. Especially when I have to be in here and I can't leave. To be able to listen to the music and hear the words and remember. It means a lot. It brings back beautiful memories. It's such a gift. It really makes a difference. A *positive* difference."

In subsequent music therapy sessions, Margaret would always request "Country Roads" and this song would always bring her to tears. Knowing that it was such an emotionally overwhelming song for Margaret, Sarah would move into this song cautiously—asking if Margaret would like to hear another John Denver song instead. But without fail, Margaret would consistently choose "Country Roads."

During their music therapy sessions, a nurse would often bring another patient on the unit with dementia to sit in the hallway outside Margaret's room so she could hear the music.

“She’s out there, but she’s a part of it. The music touches her, you can tell, that’s what’s important,” Margaret commented as she peered into the hallway.

“Absolutely.”

“It’s like everything else, these people are here, it’s like they’re lost and the music touches a part of them that they need, that’s beautiful.”

“Music can help lots of people,” Sarah affirmed.

“It can. Like everything else, if people know that you enjoy it, then it is much more special to them than just words,” Margaret replied.

“That’s true.”

“I used to be a nurse. There are so many nurses around here that are so tied up in their job. Sometimes they don’t take the time to look and see the little things.” Margaret looked toward the hallway. “She’s sitting there, I know when she’s connecting. I know when she isn’t. The nurses don’t have the time to be able to find that connection and it’s a shame. It’s a shame that they don’t.”

One day, as she gazed at the artwork on the wall across from her hospital bed (see figure 3), Margaret told Sarah, “When you’re singing, I’m walking along that bridge to wherever it goes. I don’t know where it goes, but I’m walking along that bridge. I’ll find out sometime where it goes.”

Figure 3. Bridge.

After a contemplative silence, Sarah suggested, “We could write a song together, talking about the things you see when you imagine walking down the bridge.” Margaret looked over at Sarah.

“The chorus could be, ‘*Oh I close my eyes and I walk down that bridge, I see the most marvellous things*,’” Sarah sang.

“Oh, that’s nice.”

“Are there particular things that come to mind when you imagine walking down the bridge?”

Margaret hesitated. “I’m just trying to think what would fit,” she said.

“We can make anything fit!” Sarah said, optimistically.

Margaret closed her eyes. "*What I would like to experience…It touches a part of me. It touches a part of me that needs to see,*" Margaret whispered softly. Sarah leaned forward, straining to hear Margaret's softly spoken words.

"It touches a part of me that I would love to see. Where does the bridge take me in my memory," Margaret repeated loudly and clearly. Sarah scribbled down her words. Margaret continued, whispering *"The beauty of the day…*I see in the distance the beauty of the day displayed so well by the bridge and no one seems to know where that bridge goes."

"Okay! Anything else?"

"We listen together to the music that brings me memories, some good some bad, but all are entwined around the bridge that crosses the river."

"Alright. This is going to be a great song!"

Margaret closed her eyes, "How can one picture give such joy to a person. And sometimes, a little bit of pain."

"Do you think there's a reason it brings you a little pain?"

"Because it brings the memories of my mom and dad singing to us as kids, that's the kind of pain."

"So, bittersweet?"

"That's what it is. But they are still beautiful and precious to those of us who listen."

"Those memories?"

"Yup."

Pausing to review her notes, Sarah remarked, "We've got a lot of good lyrics here! Is there anything else you'd like the song to say?"

"The warmth and joy that comes from these words give my heart such peace. Why can such simple things be so powerful. And how lucky we are that they are."

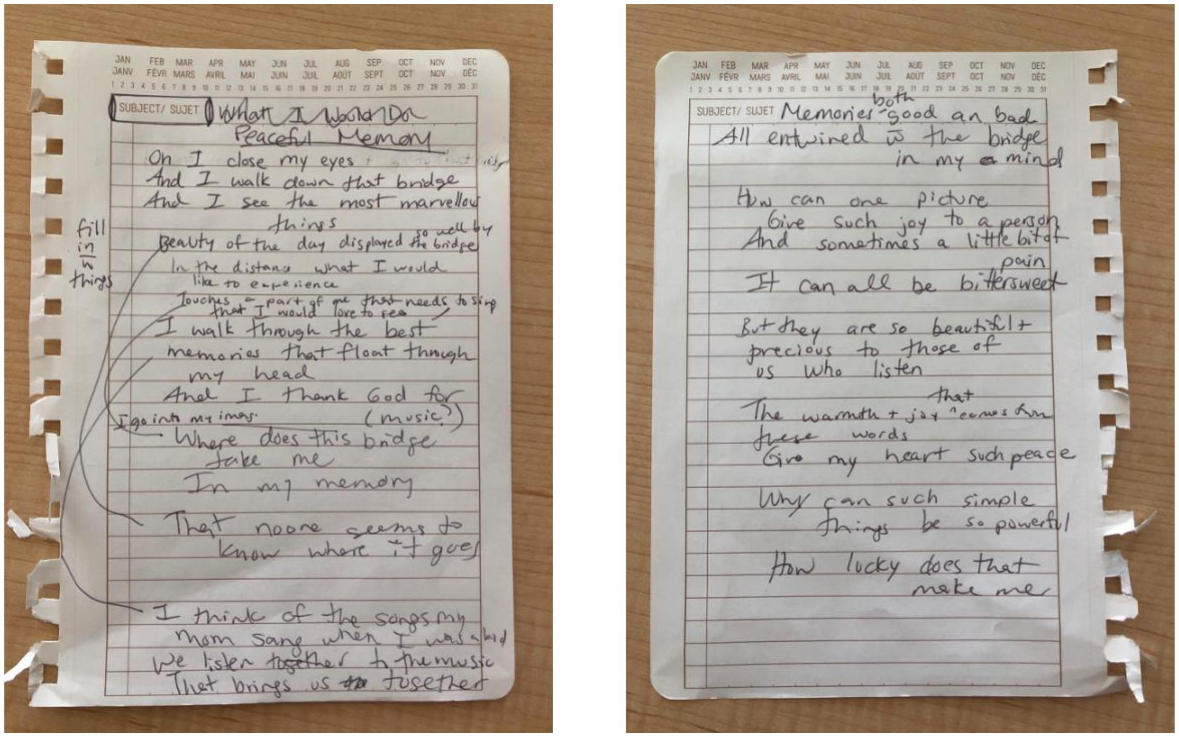

Figure 4. Peaceful Memory.

"Alright," Sarah said as she wrote down the final lines (see figure 4). "Let's see…where should I start…" Sarah murmured to herself. She strummed her guitar and began to sing, improvising a melody.

Oh I go back in my imagination
And there's a bridge that takes to me to my memories
The beauty of the day is displayed so well by the bridge
And it touches a part of me that I would love to see

Oh I close my eyes
And walk down that bridge
And I see the most marvelous things
In the distance is what I would like to experience
And I dream that one day I'll see where it goes

I think of the songs my mother played when I was young
And how we'd listen to the music that brings us together
Brings memories both good and bad
I see them intertwined through the bridge leading to the river

Oh I close my eyes
And walk down that bridge
And I see the most marvelous things
In the distance is what I would like to experience
And I dream that one day I'll see where it goes

How can one picture give so much joy to a person
And sometimes a little bit of pain
It's bittersweet
But it's beautiful and precious to me

The warmth and joy that comes from these words
Give my heart such peace
Why can simple things be so powerful
And how lucky we are to take it all in

Oh I close my eyes
And walk down that bridge
And I see the most marvelous things
In the distance is what I would like to experience
And I dream that one day I'll see where it goes

"Beautiful. It's amazing to hear those words brought to life," Margaret said.

"It's all you, you have such great lyrics! We'll play around with it a bit until we get it right. What do you think it should be called?"

After a long pause, Margaret stated somberly, "Peaceful Memory."

"Are you feeling okay? I hope it didn't make you sad to go into all the memories."

"All the beautiful memories." Margaret paused. "You see, to me there's beauty in the words and there's beauty in the pain that it brings. It's not a bad pain. It's a good pain because it brings back things that have meant so much. Instead of wanting to have everything perfect and happy, no—sometimes there has to be a bit of pain involved."

"What's that saying…to see a rainbow, there has to be a little bit of rain?"

"You can't have beauty all the time without a little bit of pain. It takes a certain amount of pain to bring out the beauty that is there. It's not a bad pain, it's a good pain. It's a pain that causes you to grow a little bit as well."

"That's a nice way to look at it."

"This has been a long, long, *long* haul. Being able to find some beauty in it after three years or more, there's nothing wrong with that. It's a growing type of pain, you feel it and if you feel it the right way then you grow some with it and then you move on from there. I always tell my husband—he finds it difficult; I can understand why—I tell him, you have to dig deep to find things that give you comfort and peace. Sometimes you can't, so then you have to find what causes the discomfort and go from there."

Margaret described feeling pain but a "good" kind of pain—what cultural theorist Sianne Ngai (2004) might call "ugly feelings." But Sarah had not included "feel pain" as a "clinical goal" for Margaret—quite the opposite. Her clinical goals included things like pain alleviation, relaxation, emotional support, and personal expression—goals that are legible to modern biomedical practice, where, since the nineteenth century, health has been about restoring "normal functioning" (Canguilhem [1943] 1998; Foucault [1963] 2012), with medicine the "key to a life free of illness, pain or suffering" (Crawford 2006, 404), and anaesthetics the means to desensitizing and relieving pain and suffering (Buck-Morss 1992). Facilitating moments of "feeling pain" does not make sense according to normative aesthetics of clinical care and therefore conflicts with the dominant aesthetic regime of the clinical sensorium. But Margaret's desire to access sensory-affective experiences through music therapy and feel feelings of pain and suffering unfold, entangled with "good memories" of the past that animate her experiences of beauty in the present, suggests that health, even within the structures

of biomedicine, can be about more than feeling "normal" or "good," or free of pain and suffering.

Sarah sang and played *with* Margaret, tailoring the tempo, timbre, dynamics, lyrics, and style of the music to support Margaret. In extra/ordinary music therapy encounters like that between Margaret and Sarah, music therapy is not only a mode of expression and meaning making, but also a process for opening up sensory-affective possibilities, where feelings are structured and felt as they unfold in the immediacy of the moment, entangled with multiple temporalities of the past, present, and future. The process of structuring and containing feelings, however, is fraught and always changing in the moment. Like Alice, Sarah was uncertain whether the feelings coming up in music therapy sessions were "good" or "bad" feelings. Margaret's insights on the entanglements of goods and bads, of pain and healing, and of life and death, gesture toward the complexities of sense and sense-making in the clinical sensorium as well as the sensory-affective openings afforded by moments in music therapy that facilitate attunments otherwise.

Conclusion

Music therapists work with aural vulnerability in the clinic, reconfiguring attunements to the clinical sensorium, redistributing what is sensed and how it is sensed. Through modulating perceptions of noise, composing atmospheres of care, and structuring feelings, they intervene in the dominant aesthetic distribution of the clinical sensorium, opening up sensory-affective possibilities that exceed the normative aesthetics of clinical care. In extra/ordinary music therapy sessions, the intimacy, immediacy, and immanence of encounters disrupts the stultifying *an*aesthetics of the clinic. The singularity of a life is instantiated, and, in moments of sensory excess, the entanglements of life, death, and nonlife are exposed. Through their

attunements in the clinic, music therapists demonstrate that aural vulnerability is a space of manoeuvrability where normative aesthetic regimes can be reconfigured.

Chapter 5. Improvising Care through Musical Gift Exchange: Connection and Attachment in the Clinic

Connection

"I don't know what you'd call 'progress' for Dorothy," Kate said as we waited for the hospital elevator. We were on our way to visit Dorothy, a resident of the long-term care facility operated by the hospital, for her weekly individual music therapy session with Kate. I had asked Kate earlier that morning about how she measured "progress" when working toward clinical goals and charting progress notes in patient charts. Elaborating on her work with Dorothy, Kate explained:

> We do a lot of improv and just being in the moment. Sometimes she goes into words and gets almost stuck in this *words-world*, trying to make sense of the words. I try to give her space to do that, but then I try to go back to the scatting, back to the syllables. Then I feel [*gasp*] she'll click back into that *connection.*
>
> I can *feel* this music connection between us that's very vibrant. It can fade when we get into talking. But when we go back into the scatting, we make eye contact, and I can *feel* that kind of groove. We're back in that space—in the pocket, the field of play[44]—whatever you want to call an improvised moment. I try to stay in it, just noticing for me what I am feeling. When we're doing the more music-based stuff, I really feel that [*snaps*] connection lock in. It makes me think, "Huh, *this* is why we use music." Let music be the thing. Words can kind of just get in the way.

What music therapists like Kate call "connection" was consistently described to me as something that is *felt* in an ephemeral way—moments of passing intensities, feelings that are fleeting—and as something that they strive to facilitate in music therapy sessions.

This chapter describes how music therapists in the clinic facilitate moments of connection through music therapy encounters and practices of improvising care. I argue that

[44] In jazz, "in the pocket" is a phrase that implies feeling the groove or the beat (Erskine 2016). In music therapy, Carolyn Kenny (2006) theorized "the field of play" as a musical space of *being* where the patient or client has a sense of security that enables an openness to experimentation and exploration through play.

affective connections and attachments are forged and sustained through musical gift exchange, while subjectivities are distributed through relationality.

Hello Dorothy

"Are you scared?" Dorothy asked, staring into my eyes. We were sitting side by side on the small couch in her private room on a locked unit of the long-term care facility. Unlike hospital patients, long term care residents could personalize their rooms with their own furniture and artwork. A handmade quilt covered Dorothy's hospital bed and colourful artwork animated the walls. We were sitting across from Kate, who was setting up the iPad and portable speaker on the music cart in the middle of the room.

"Not right now. But sometimes," I said.

"What are we doing for the unknown-as-yet?" Dorothy asked.

"I thought we could do some music!" Kate interjected, with the iPad queued and ready.

"Because?" Dorothy questioned, turning her gaze toward Kate.

"Well, because I'm a music therapist."

"Are you?"

"I am."

"Why?"

"Because I love music and I love people."

"Really?"

"Yeah! Why don't we start with a little bit of…" Kate began to play a recording of the song "Let's Call the Whole Thing Off" from the 1937 film *Shall We Dance,* sung by Ella Fitzgerald and Louis Armstrong (1957).

"This!"

"Oh. *Oh* yes!" Dorothy said enthusiastically, upon hearing the music. "Where is it?"

Over the speaker, Fitzgerald sang the melancholic introduction to the song:

Things that come to a pretty pass
Our romance is going flat
For you and this and the other
While I go for this and that

Goodness knows what the end will be
Oh I don't know where I'm at

"Oh my goodness, I'm going to be crying in a hundred billionth of a second!" Dorothy sniffed.

"That happens sometimes with the music," Kate averred reassuringly.

"I like it." Dorothy closed her eyes.

It looks as if we two will never be one
Something must be done

"I was silly enough to fall in love!" Dorothy sighed.

The song transitioned into the upbeat verse with a swinging groove, sung in Armstrong's deep baritone:

You say either and I say either
You say neither and I say neither

"Who is this?" Dorothy's brow furrowed.

"Louis Armstrong!"

Either, either, neither, neither
Let's call the whole thing off

"*Louuuu*-is!" Dorothy sang.

"Tell it to Louis!" Kate smiled. Dorothy tapped her toes along with the rhythm.

You like potato and I like potahto
You like tomato and I like tomahto
Potato, potahto, tomato, tomahto

Let's call the whole thing off

Kate stood up, "Should we get up and dance a little?"

"Not where anyone can see us!" Dorothy braced her arms, pushing down on the couch to stand up. I followed.

"Just us!" Kate reached for Dorothy's hand.

They always began their weekly music therapy session dancing to jazz standards, favourites of Dorothy's as evidenced by her collection of compact discs.

"There we go!" Kate encouraged. We stood in a circle and began to dance, swaying our bodies to the swinging groove. Dorothy led us in clapping on the off beats.

You like potato and I like potahto
You like tomato and I like tomahto
Potato, potahto, tomato, tomahto.
Let's call the whole thing off

"Potahhtas, absolutely!" Dorothy joked.

You like vanilla and I like vanella
You saspiralla, and I saspirella
Vanilla vanella chocolate strawberry
Let's call the whole thing off

"I hate vanilla, yuck!" Dorothy wrinkled her nose in disgust.

"What about chocolate?" Kate asked.

"Yeah!"

So if you go for oysters and I go for ersters
I'll order oysters and cancel the ersters
For we know we need each other so we
Better call the calling off off,
Let's call the whole thing off.

As the music faded and we stopped dancing, Dorothy asked, "Where am I going now?"

"Why don't you sit back on the couch and get comfy," Kate suggested.

"Sure!"

Dorothy and I sat back on the couch as Kate reached for her portable swivel stool.

"I brought my guitar today. Would you like to do some songs together?"

"Oh yeah, I remember 'guitar,' as soon as you say it." Dorothy said.

Kate pulled her guitar out of its case.

"I don't know how to do."

"You don't have to, I can play it for us, is that alright?"

"How would I know? '*Yes dear.*' Give it a little hoop and a boop."

Kate began to strum a C major chord rhythmically.

"*Yes, yes, yes*!"

"I always like to start by singing hello."

"Oh, imagine that!"

They began to sing, improvising vocal melodies back and forth in a call-and-response type style, as Kate strummed a simple rhythmic pattern:

Hell-oooo Doro-thy

Hell-oooo to you

Hell-oo you

Bee da da da dooo

Ah ah ah-ah ah-ahhh ahh

Humda diddle humda diddle do

Oooo oooo

Ooo-ooo

Hell-oo to you

I am Doro-thy

Hell-oo you

Hello where it i-s
Ba ba beetle dee da daaa

Ahh ahhh ah ah-ah ah-ah ah-ahhhh ahh

Humda diddle humda diddle do

Ooooo ooooo

Ooooo ooo-ooo ooo-Ooo Ooo-ooo

Hell-oo

Gotcha

Gotcha

You got me, got me, good

I gotcha

Oooo ooo

Ba dinga dina pretty diddle like you

Gotta gotta get-cha got-chaaaaa
Whatda think whatda think say nothing think

Whatda ya thinking Dot

Ain't nothing left to think

Nothing left to think

I don't feel like I wanna think
I have something else-a

Can we boop-ba-doop-a dee ba

Absolutely nooooooooot

Absolutely not

It's alright, unless it's all wrong
Keep singing the song

Singing the song

Boop boop boop-bo bo boop

Boop boop

My nose is sniffy

My nose is sniffy

My nose is sniiiii-ffy

Sniffyyyyy

How about my noseeee

How about your toes

How's about the nose
And the nose is sniffing and tripping
The nose

Nose is sniffing and sniffing
The nose

Boop boop, boop boop boooo

Boop boop ba-boop-boop bo

Boo boo boo boo ba-ba ba-be ba-baaaa-ba-be-ba boo beedily baddily diddly oddly boddly
Holy smoke you can't even smoke on a [heh!]
Oooo ooo

Ooo ooo Ooo ooo

Oooo ooo Oooo ooo
Ooo-ooo Ooo-ooo!

Oooooo

Yuck yuck yuck

Blah bleh blah bleh

Ouuuty

Ba baa Do-do doooo

Booops

Yeahhhh

Boop boop ba
Bah ba boo

Yeah

Hello helloooo

Uh-huh uh-huh uh uhhh

Boop

Baba baba baba boooo

Yeah

Mhmm mhmm

Bam boo

A tree like a willow

Oooo

Biddle diddle doooo

All gone for you

Biddle diddly doooo

Blah blah

Oh I can't endless imagine what you are thinking
About ouuuuty

Ba baa doo
Ba baa doo-ooo

Ba doo diddily diddily
Booops

Yeah ah ah ahhhhhh

Don't cry don't cry
Don't cry there's a lot less of
Boop

Yeahhh

Ooo-ooo

Uh-huh uh-huh

Ooop

Baba baba baba boooo

Yeahh

Bad boops bad boops
And all you gotsa bad boops

Mmmmmhmmm bad boops

A bamboo is in a treeeee

Oh ohhhh

Biddle dee dooo

Oooo all gone for you

Iddly biddle diddly doddly doo doops

Oh yes that's not nice

Oh yeah oh yeah

It's nice not nice

Nice not nice not nice

A little bit nice?

A little bit…

Nice

They sang the last word together, Kate singing the root of the tonic chord on C and Dorothy harmonizing a third above, holding *Nice* for eight beats.

"Did we have a little bit of fun with that one? Kate beamed.

"I don't know, you think so, too me hi-ho-hu-hey?"

Kate strummed an F chord on her guitar, easing them into Dorothy's repertoire of familiar songs.

"Hello Dolly?" Dorothy asked, referencing the song they usually sang after their "Hello" improvisation. But this week Kate had switched the order of songs, having started to play "When You're Smiling" (1928) instead. They began to sing, Kate singing the lyrics with Dorothy alternative between echoing the text, harmonizing lines, and scatting improvisational melodies:

When you're smiling

When I'm smiling

When you're smiling

Oh when I get to smile

The whole world smiles with you

Ba ba daba deba daba deba deba

When you're laughing

A ha ha ha

When you're laughing

Ha ha ha ha ha ha haaa

The sun comes shining through

Be ba diba deba dooo

But when you're crying

You're crying
You bring on the rain
Stop you sighing
Be happy again
Keep on smiling
Ba ba de ba
Cause when you're

Smiling
The whole world smiles
With you

Ba ba da ba be baaaa
Ba ba ba ba de ba bada da
Ba de ba de ba
Yeahhh
Yeahhh la da da
La deedle doodle da
Keep on smiling
When you're smiling
When you're smiling
Oh when you're smiling

The whole world
Smiles with you

"That was all absolutely, absolutely-lo!" Dorothy proclaimed, as Kate strummed her guitar, modulating chords to move smoothly into "Hello Dolly" (1964):

I said hello
Hello!
Dolly, well hello
Hello

Dolly
It's so nice to have you
Back where you belong

Ba ba de ba do ba
You're looking swell *Ba ba ba di ba*
Dolly *Ba ba*
I can tell *Ba ba ba di ba*
Dolly *Ba ba*
You're still glowing

You're still crowing
You're still
Going
Strong!

We feel that room swaying *Ba ba de ba da*
And the band playing *Yep!*
One of your old favourite songs
From way back when
Here it comes!
So Oh yeah!
Take her up fellas

Dolly'll never go away again

"Boop!" Dorothy punctuated the last line comically, making the three of us laugh. Kate then transitioned into the next songs in their weekly repertoire: "I Could Have Danced All Night" (1956), "Favourite Things" (1959), and "Singin' in the Rain" (1952). Dorothy sang, harmonized, scatted, and clapped a little less with each song over the course of the forty-five-minute session. Kate played slow versions of "Dream a Little Dream of Me" (1931) and "Fly Me to the Moon" (1954) while Dorothy listened and looked on, her hands resting in her lap.

"Very nice," Dorothy said as Kate paused. "How old are you?" Dorothy asked.

"Thirty-eight. How old are you?" Kate asked in return.

"Some kind of up-in-the-nothings. I'm just hoping to evaporate at this point. Out. Get me *out* of here. Do you care?"

"I care."

"Oh, too bad! Undo it! Don't make yourself feel yucky. Just do it because. Let it go."

"That's good advice! Would you like to do anymore songs?"

"Whatever you want to do."

"Do you want to keep singing?"

"Don't feel like it. Nothing."

"Well, we can say goodbye. How about we finish today with a song to relax."

"Really?"

"If you want, you can lean back on the couch, back as far as you can, get nice and comfy."

"And?"

"That pillow looks like it's in your way," Kate reached behind Dorothy's back to adjust the pillow.

"My father's name happens to be Ray."

"Is that so!"

"Yes, it is."

"Is that comfortable?"

"Yes."

"You can close your eyes and just listen." Kate began to play "All I have to do is Dream" (1958).

Dream, dream, dream, dream
Dream, dream, dream, dream
When I want you in my arms
When I want you and all your charms
Whenever I want you, all I have to do is
Dream, dream, dream, dream

"Nice," Dorothy said.

"It's just about time for us to say goodbye. I like to sing a song to say goodbye."

"Well, how long is the song?"

"Not long!"

Goodbye and thank you for the music
Goodbye and thank you for the music
Goodbye Dorothy

Goodbye Meredith and Kate
Goodbye Doro-thy

"Thank you," Dorothy said.

"Thank you for making music with me today," Kate smiled. Putting her guitar back in its case, Kate accompanied Dorothy back to the common lounge area, walking arm in arm.

In Kate and Dorothy's music therapy sessions, they dance and sing together, improvise lyrics and scat in a call and response format, harmonize their voices, converse in breaks between songs, share laughter and moments of silence. Their interactions in music therapy sessions can be understood as care practices constituted through exchange. Anthropologist Janelle Taylor (2008) describes care practices between herself and her mother as practices of exchange:

> Our conversations go nowhere, but it hardly matters what we say, really, or whether we said it before, or whether it is accurate or interesting or even comprehensible. The exchange itself is the point. Mom and I are playing catch with expressions, including touches, smiles, and gestures as well as words, lobbing them back and forth to each other in slow easy underhand arcs. That she drops the ball more and more often doesn't stop the game from being enjoyable. It is a way of being together. […]
>
> When I make a joke, she laughs. When I tell some small story about something that happened, she murmurs sympathetically. When I express an opinion, she agrees. When we sit together, she attends to my presence, reaches out to me, pats my hand. These communicative practices are, I believe, also practices of caring—my mother cares about smoothness of the back-and-forth flow, takes care to keep it all going, and in doing so she acts in a caring way toward me and other people around her. (J. S. Taylor 2008, 327–28)

Caring through quotidian practices of exchange that Taylor describes are central to Kate and Dorothy's music therapy sessions. In their improvisational Hello song, Kate begins by improvising a lyric and Dorothy improvises a response in turn. Kate might echo Dorothy's response or build on her answer by riffing a variation. Then Dorothy might improvise a new lyric and Kate will keep the pattern going. In familiar songs, Kate sings the lyrics and Dorothy embellishes the lines by scatting or providing harmonies. When Dorothy makes a joke, Kate

laughs with her; when Kate suggests they dance, Dorothy stands up to dance with her; when Kate tells Dorothy she cares, Dorothy cares for Kate by telling her not to feel bad and to let it go. It is a "back-and-forth flow" that hinges on both Dorothy and Kate "taking care to keep it all going" (J. S. Taylor 2008, 328). And, as it keeps going, Kate can feel what she described as a "vibrant music connection" coalesce and fade; Kate hopes that Dorothy can feel such moments of affective connection, too.

Musical Exchange

In music therapy, caring through practices of exchange are centered in and around music. According to ethnomusicologist Jim Sykes (2018), music can be best understood through the framework of gift exchange. Western liberal aesthetics, he claims, inform a ubiquitous belief that music is as an art form with the capacity to express identities of selves and communities. Sykes (2018, 55) argues that this conviction obfuscates the "sonic efficacy" of the musical gift—the capacity to not only express identity but also to make and transform worlds through relations of gift exchange, only partially transformed through commodification. The profession of music therapy hinges on an underlying understanding of sonic efficacy; music therapists know that their labour of musical giving constitutes acts of care for others and selves that can be transformative. Yet the labour of music therapists in the clinic is consistently devalued because of the widespread belief that music is merely an expressive art. While a "nice" activity for patients to enjoy—especially in instances of biomedical failure or when there is "nothing else" medicine can do—its transformative capacities are regularly overlooked in the clinic (see also chapter three).

In the clinic, music and music therapy was regularly described to me as a gift by patients and families. Music therapy is also described as a gift in the media as well as on occasion by

music therapists themselves in their literature.[45] As a profession, music therapy is a commodified service as music therapists are compensated for their labour; however, in North American hospitals there is no overt transactional exchange: patients do not pay out of pocket for music therapy services.[46] Music therapy is both a commodity and a gift, depending on the context: while perceived as a commodity for hospital administrators and insurance companies, music therapy is felt and experienced as a gift for patients and families.

In the clinic, music therapy is offered as a gift. Music therapists will gently ask patients if they are interested in receiving music therapy, for example with the question: "Would you like to do some music with me today?" While music therapy is usually welcomed by patients and families, music therapists are careful not to impose music therapy on patients, acknowledging that "not everyone likes music!" They make it clear that no one is obligated to receive music therapy. However, music therapists *want* people to want music therapy. If a patient says that they are not interested in or do not want music therapy, music therapists as caregivers in the clinic will follow the "logic of care" where "you do what you can, you try and try again" (Mol 2008, 78) in the hope of improving the situation of a patient.

Alice, for example, was not dissuaded by Elaine's daughter who said her mother "wouldn't be able to enjoy the music" that morning because of the pain she was experiencing. Alice suggested that she could check back at a later time. She went to see other patients on the

[45] See, for example, academic scholarship referring to music therapy as a gift (Lane 2006; Altenmüller and Schlaug 2015; Whittall 1991; Situmorang, Mulawarman, and Wibowo 2018) and a documentary film on the gift of music therapy (Rondeau 2010).

[46] In the United States, the average salary for music therapists in 2020 was $56,715 USD according to survey data (AMTA 2020a). No similar data exists for Canada; however, in 2015 salaries were estimated to range from $25,000 to $85,000 CAD (Lindzon 2015). In Canadian hospitals, the salaries of music therapists are typically funded by foundations or discretionary operational budgets. In American hospitals, this is also typically the case; however, some states like New York have recently approved music therapy as a billable service and this has become an additional source of funding for hospital music therapy programs (music therapy is billable for patients with private insurance as part of overall hospital charges).

palliative care unit and, when she checked in with Elaine an hour or so later and asked if Elaine felt like "doing some music together," Elaine told her, "That would be heavenly!" While music therapists like Alice are respectful of people's desires not to have music therapy, they also know that it often means patients do not want music therapy in that very moment but could be open to it at another time.

On occasions, music therapy is refused altogether—sometimes because people think they cannot receive the gift of music adequately, for example by being a "good" engaged audience; other times because they don't feel well enough or simply don't feel like it in that moment; at times because they don't want to interact with a new person; and, on occasion, because they don't like music altogether. Refusals of music therapy can feel defeating for music therapists like Rachel, who said:

> There are so many things that happen when I walk into a room. There's a power dynamic. And there's a relationship development element. I can be triggering for people for various reasons; people might associate with me or not for different reasons that are completely out of my control. It could be because of my age or my gender, or there's something about me that reminds them of someone. Or they might connect with me immediately because there's some kind of positive vibe going on. A lot of this is out of my control. A lot of it is in my control, in how I approach people.
>
> But people can put up barriers and immediately make assumptions like, "No, that's fine. I have YouTube, I have Spotify. I have my phone. I'm fine." [*laughs*]. They're sort of missing that relationship element. That's hard. Or if people are like, "That's not really my thing..." Whereas I feel like music is everyone's thing! That's my bias.
>
> I'm very careful. I don't push it on anyone. But I feel disappointed if people aren't willing to try. However, in moments when I feel unwell, I don't necessarily want music! So, I never push it on anyone, ever. But there is a little bit of a disappointment if someone isn't willing to try.

The disappointment Rachel and other music therapists expressed when people refused music therapy services in hospital was not because it impacted their job or income in any way (wait

lists for music therapy in hospitals are long and demand is high) but because their gift of music was rejected.

As a gift, music therapy in the clinic is presented within the imaginary ideological framework of a pure or genuine gift, one that is not solicited and where there is no overt expectation to receive or return the gift (Parry 1986); yet, as anthropologist Marcel Mauss ([1950] 2002) established, free gifts are impossible, since gift offerings produce relationships of debt and obligation that are fulfilled through reciprocity. Social relations and interdependence are established through practices of reciprocal gift-giving (Mauss [1950] 2002; Strathern 1988). According to Mauss, refusing to receive a gift amounts to a rejection of social relations and suggests that a person who refuses a gift is "afraid of having to reciprocate" ([1950] 2002, 52).

For music therapists, reciprocity can take many forms—anyone is understood as capable of showing up and participating in music. "I don't put any expectations on them," Matthew explained. It was okay for someone to arrive late to a session, to leave early, and to participate in any capacity—from what the music therapy literature refers to as "active music therapy," such as singing or playing an instrument, to "passive music therapy," such as listening (Wigram, Pedersen, and Bonde 2002). Like other music therapists I spoke to, Matthew wanted patients to show up to music therapy sessions and to be present but tried his best to made it clear that—unlike many other aspects of medical institutionalization—no one was obligated to participate or do anything they didn't want to do.

Reciprocity is felt by music therapists in the relations that are forged in collective music making and the moments of affective connection that unfold in musical exchange. They appreciated peoples' gratitude but were never looking for applause; Kate, for instance, even felt a little uneasy at times when patients applauded after a song. She was not performing *for* people

and was not seeking approval or praise. She was making music *with* people. Through musical exchange, they were "making music together," whatever that looked or sounded like. What she and other music therapists wanted—for patients and for themselves—were moments of connection. These moments are considered transformative for patients and rewarding for themselves. Similarly, for Brian, feeling connection with patients affirmed he had chosen the right career path—"it's what fills my sails, what feeds my soul," he said.

Showing up, being present, and being together—in relation, open to the possibility of feeling a connection—constitutes reciprocity through musical gift exchange. In the act of giving, receiving, and reciprocating through "making music together" as musical exchange, music therapists and patients build and sustain relations of care where sensory-affective possibilities open up (chapter four) and moments of affective connection can be felt.

Moments of Connection

While relations are established and sustained through the act of musical giving, music therapy sessions build toward moments of affective connection. Kate, for instance, had a therapeutic relationship with Dorothy while she could feel moments connection come and go during their musical exchange. The distinction between relations and connections is delineated by anthropologist Gregory Feldman, who suggests that "connections involve direct, immediate contact between people while relations involve indirect, mediated contact" (2011, 379). While relations can be entangled with connections, anthropologist Marilyn Strathern argues that relations can exist without connections; relations "open up the capacities of properties in unexpected ways and capacities come into existence through new relations" (2020, 15). Through the exchange of the musical gift, relations open up the possibility for connection.

Music was understood as a "way in" to the connection music therapists were looking for. Matthew told me, "I'm always saying I'm lucky I have music. I can knock on doors and bypass the defence mechanisms of the head. That's how I see my music. I go directly into the action, to the emotion, to the connection. I don't have to battle with the defences." Similarly, Rachel described music as "the secret highway to the heart" that people are "sideswiped by, but in a good way." For Sam, making music together in music therapy—as a "shared aesthetic experience"—facilitated "intimate, emotional connection." He explained:

> There is an implicit trust when you're working together toward a common goal. In traditional talk therapy or other modalities, you do have a common goal which is the client's wellbeing and health. But when you're making music together, the therapist benefits just as much from the aesthetic experience as the client does. So, I have more stakeholder-ship. I commit myself. I'm able to fully be authentic in the music, and fully express myself in an honest and authentic way. I think that's something that people pick up on. I don't know if it's something you can quantify. But it's something that draws you together. And just being able to look back at an experience and say "Wow, that was really cool, we did that, we made that together." It draws people together. Meredith, you've played music with people before. When you have that kind of experience, you're rehearsing and you get to a point where it's together, it sounds good, there's that moment, that *communitas* that builds. It's a really special moment.

As relations with patients are forged through musical exchange, "special" moments—moments of affective connection—become possible. Such moments are difficult for music therapists to measure, as Sam suggests, and are difficult to describe; it is tacit embodied knowledge to know what moments of connection feel like, particularly if "you've played music with people before." Although music therapists regularly refer to connection, few attempted to define the term; Matthew, however, offered a definition of connection as feelings and emotions predicated on the quality of relationships, saying that:

> We like to be with certain people because of the connections we have with them. What is the connection if it's not feelings and emotions? When you're with patients in the musical interaction, you're having fun, it's getting intense, but you feel you're on the same page, or it's getting sad but you're there and you sustain it. It's exactly what we're

> talking about, it's the quality of relationships, that with music therapy you can easily get if you're good and if the person wants it.

Like Sam, Matthew implied that feeling connection in music therapy was something implicitly known—like feeling connections in other relationships, often referred to colloquially as "chemistry" or "positive vibes" with others. Music is again referred to as facilitating those moments of connection, yet Matthew points out that the connections they're looking for will not happen if the person doesn't want that connection. Rachel articulated the necessity for desiring connection in terms of "openness," explaining that moments of connection in music therapy require "some openness on my part and on their part. Just a willingness to kind of…they're there. I'm here. And if we can somehow meet, whatever that looks like, sometimes in music, sometimes in words, sometimes with no words." This meeting is a felt relation of contact—a visceral, affective, bodily sensation of immediacy, and a feeling in common. Although moments of connection are not always easy to describe or define, these moments are understood as transformative. It is in those moments that "something that feels like *some*thing" (Kathleen Stewart 2007, 2) happens. Lachy explained, "Music therapy is more than just playing music for people. It's about the connection, that human connection. It's about reading the energy, responding to the energy. It's what the connection does. The change it makes for patients." For Kate, moments of connection are what music therapy is "all about."

In describing her gratitude for group music therapy sessions on her unit, Esther told me, "I feel like a part of what Alice is doing. She's a part of us, too. We're answering her, she's answering us. I feel that I don't want her to stop. You can close your eyes and be with her, be with the music. I'm grateful that she is sharing her gift with us." Esther compared the group music therapy session to the concerts put on by volunteer musicians in the hospital, saying that, "I don't like the hospital concerts. Because you're sitting there and there is no connection at all.

Or the film screenings…there's nobody there. You're sitting there watching something, but there was nobody to…no connection."

Moments of connection are not only interpersonal as the quality of felt relation between a music therapist and a patient; connections in music therapy are plural and multiple. Connections can be felt not only with people but also with music, particular songs, instruments, memories, feelings, ideas, objects, voices, movements, and so on. Music therapists described many forms of connection that could unfold for patients during music therapy sessions. Kate explained:

> There's connection with me, which is good socially. They're also possibly having some cognitive stimulation. Perhaps they're having an involuntary or voluntary movement along with the music. There could be connection spirituality or culturally, which is also important in a holistic sense. And then emotions. Connecting with all these domains could be happening in one moment with one song.

Sophie talked about the importance of connecting with the music; sometimes she saw herself as a facilitator of the relationship between a patient and the music. In other instances, she understood social connections between a patient and herself, or between patients within a group, to be facilitated by the music. Similarly, Rachel described music as her "co-therapist." Barbara spoke of the connections she felt parents make with their babies in the NICU when singing "songs of kin" or lullabies. Sam told me that "cultural connections" could be facilitated by the use of specific musical genres, while "spiritual connections" could unfold in the use of religious songs. Mary said it was important for patients to connect with their memories in music therapy and that it was "powerful" that so many different connections could happen in one musical experience. Rachel described everyday moments of connection in the hospital:

> It's a win if I can connect with another human being. That might be just introducing myself and having a quick chat about something that's meaningful for that person. There are special moments when people say, "Sure, you can play, whatever," and then they just start sobbing out of nowhere. And they say, "I didn't know I had to feel those things."

> There's that breakthrough moment. It can happen quickly in music, and that's very special when people just realize, process, open-up, or discover something about themselves. Or the look on someone's face when we talk about legacy work, song writing, or funeral playlists and they get so excited, so relieved at the thought of having someone there to help them with it. Or that moment when a young man with down syndrome, nonverbal, the first time he smiled at the hospital was when he saw the instruments. So, it can look like anything, but it's all about relationship and connection.

As Rachel suggests, moments of connection are not always "feel good" moments; they are often difficult moments characterized by "ugly feelings" (Ngai 2004). Connections, as Rachel said, can "look like anything."

One particularly memorable music therapy session between Dorothy and Kate was marked by a difficult moment of connection. The session began with their regular "Hello" improvisation. It quickly intensified as Dorothy improvised lyrics including "run, running away" and "I wanna go home," which she sang loudly and forcefully, her eyes closed. Kate supported Dorothy by echoing her lyrics in a call and response-type style; this intense back-and-forth improvisation continued for nearly fifteen minutes. After this moving musical exchange came to a close, we sat together in a heavy and poignant collective silence. Later, I asked Kate if she thought that Dorothy was expressing her desire to go home and run away from institutional confinement; Kate was unsure. These moments of connection—in music, sound, words, and silence—were not necessarily about "meaning" just as they were not necessarily about "progress." They were about being together, in the moment.

Caring through facilitating moments of affective connection in music therapy recalls a kind of care that anthropologists Janelle Taylor describes as "a way of being together" (2008, 327) and Lisa Stevenson (2014, 163) characterizes through "song" as a mode of "company" and "presence." In music therapy, musical exchange is "a way of being together" often literally

through "song" but also through conversation or silence. Rachel explained that being "alongside someone"—with or without music—was the most rewarding part of her work:

> That's the most rewarding thing, just to be alongside someone. That's a gift. I'm not a believer that we can always relieve suffering. I think there's some suffering we can't relieve. It's that space that I'm interested in, if I can just be with someone in their experience with music, with words, with my presence. It's hugely rewarding.

Similarly, Lucy described being present with patients as both rewarding and humbling:

> Being in the hospital is probably one of the worst things that will ever happen in your life. And you want *me* to be there? For me, it is an incredibly humbling and rewarding space to be in. I'm always mind blown that people invite me into that space. I don't take it lightly. Just to be able to support them in any capacity that I can, if it's with my presence, if it's with a guitar strum or my voice singing, whatever they need.
>
> I've tried to name it, and I can't. There's something that happens in the music where we're holding that space for people to just be. It's enhancing quality of life, whatever that might mean in the moment. It's enhancing those meaningful interactions. Making connections. A lot of people do experience it as a spiritual transcendental experience, but it can also be like… I am just present.

Care through moments of connection in music therapy as moments marked by togetherness, company, and presence, are constituted through exchange as a mutual process of reciprocity. It is not the kind of care that is done to a patient but rather the kind of care that patients are understood as actively participating in, regardless of ability. "There's an accessibility element to it," Kate told me.

> You don't need verbal communication. You don't need cognitive wellness or ability. You don't need physical ability. Music can still foster a relationship, a conversation, an experience, a connection. Even with limited hearing, you can *feel* the music. That's connection, still.

Participation in music therapy, building relations through musical exchange, and feeling connection do not hinge on ability. Kate and other music therapists consistently thank all the patients they work with at the hospital and affiliated long-term care facilities for making music

with them each day, from people like Dorothy who would sing and dance along to the music to others who would close their eyes and sleep. Rachel explained:

> There is a gift in trusting the music, to be your co-therapist, to do part of the work, or to access things you can't access. When people are in their last minutes of life. When I'm playing for someone and they're taking their last breaths, I don't know what their body is experiencing. There's this Indigenous idea of traveling after you die—that you have to go on a journey. I like to think music is going with them, even for a little, wherever they go, in a way that I physically can't. Because energy doesn't die. Their energy is still in the room and the music's energy is still in the room.

Connections, as Rachel suggests, are not limited to the living and can extend into death and nonlife as lingering energies. Acts of musical giving in music therapy open up possibilities for affective connection; relations established in musical exchange intensify in moments of affective connection and are felt as feelings, emotions, special moments, togetherness, communitas, and energies in the room. "I feel like I have this gift," Rachel continued, gesturing to her instruments, "Not me personally but I carry it with me, you know? So that keeps me waking up in the morning and coming to work every day."

Although it is unclear what, exactly, connection does, it does *some*thing—offers an opening, a feeling, a moment—that is collectively understood as important and potentially transformative. Musical exchange and associated moments of connection are immersed in what philosopher Henri Bergson ([1896] 1991) calls the duration of the present, where the immediate past is perceived as sensation and the immediate future is determined as action—philosophers Deleuze and Guattari (1987) call this qualitative multiplicity. The immediacy of contact as the mixture of bodies (Serres 1985, 28) is felt and sensed through touch. Through the mutual articulation of gift-giving, moments of connection are openings toward perpetual becoming. In the multiplicity of becoming, a moment of affective connection in musical exchange as the

intensification of relation "produces nothing other than itself" through symbioses, assemblage, and alliance (Deleuze and Guattari 1987, 238).

Getting to Know You

When musical exchange fails, connections in music therapy can be thwarted. Kate and Dorothy regularly sang "Getting to Know You" (1951) from the Broadway musical *The King and I* in their weekly sessions. But one week, Dorothy didn't feel like singing this particular song.

Getting to know you	
	Blech.
Getting to know all about you	
	Really?
Do you want to do this song?	
	No. I don't want to ever see it again.
Well, let's not do it then.	
	Let's leave it. Garbage.
We will leave it!	

Although music therapists begin their sessions with a plan, music therapy, as Kate put it, "always changes in the moment." When Kate began to sing "Getting to Know You," Dorothy indicated immediately that she did not want to hear or sing that song. "Blech," she uttered, wrinkling her nose to the same song that in previous weeks she had seemed to enjoy. Kate stopped singing and, after verbally confirming with Dorothy that she didn't feel like hearing or singing that song, Kate quickly pivoted by trying another song. She did not insist on singing "Getting to Know You." She also did not try to remind Dorothy that it was a song that she usually likes to sing—what mattered was that Dorothy didn't like that song in that very moment. Dorothy's refusal to participate in musical exchange indicated to Kate that the connections she was hoping to cultivate were unlikely to occur. Kate moved onto other songs that she thought Dorothy would like and where she hoped they could "click back into that *connection.*"

I argue that an improvisational approach to care through musical exchange, with the intention of fostering connection, exceeds the intervention that music therapists call clinical improvisation. In music therapy, "clinical improvisation" refers to musical improvisation as a therapeutic method of intervention. Music therapists distinguish between clinical improvisation and music improvisation in terms of intentionality; suggesting that while clinical improvisation is intended for therapeutic purposes, music improvisation is intended for the purpose of creating music for its own sake (Hiller 2009). These definitions of improvisation, as music therapy scholars have pointed out, often overlap (Aigen 2014). Yet, in both instances, improvisation is limited to experimental and spontaneous music-making, distinguished from other music activities and music therapy interventions; namely, receptive music listening, recreating precomposed music, and composing new music (Bruscia [1989] 2014). In draw from music scholarship on improvisation and medical anthropology, I approach improvisation through a broader lens to argue that care practices in music therapy are improvised through musical gift exchange.

According to music scholar George Lewis (1996, 107), defining improvisation "in terms of a pure spontaneity, unmediated by memory" is derived from what he calls a Eurological perspective. Lewis identifies how Eurological perspectives on improvisation, perpetuated by influential white American composers like John Cage, worked to dismiss Black musical forms like jazz, since "'real' improvisation is often described in terms of eliminating reference to 'known' styles" (107). While Cage's approach to experimental music aimed to produce unique performances that could not be repeated, Lewis references the numerous recordings of saxophonist John Coltrane's "Giant Steps" (1959) to demonstrate how jazz—an Afrological approach to improvisation—results from "careful preparation" while "each

improvisation, taken as a whole, maintains its character as unique and spontaneous" (108). While an Afrological perspective on improvisation accounts for memory and history, a Eurological perspective on improvisation as pure spontaneity is ahistorical and maintains what Lewis (2004, 16) refers to as a "composition/improvisation binary." He writes:

> It should be axiomatic that, both in our musical and in our human, everyday-life improvisations, we interact with our environment, navigating through time, place, and situation, both creating and discovering form. On the face of it, this interactive, form-giving process appears to take root and flower freely, in many kinds of music, both with and with-out preexisting rules and regulations (Lewis 1996, 117).

Improvisation, as Lewis suggests, is a constitutive element of everyday musical life and social life. Bourdieu (1977) identifies practice as improvisational, as actors negotiate interactions in the moment of their unfolding. This art of strategizing was identified by Bourdieu in his analysis of the temporality of the gift, where "the counter-gift must be *deferred* and *different*" (5). Bourdieu articulates how power dynamics unfold through the temporality of the gift, as actors improvise strategy by determining the tempo of giving and receiving. For Bourdieu, the improvisation of practice in response to the temporality of the gift exposes the limitations of prescriptive models and structures. Improvisation, then, can be understood as not only a specific method deployed by music therapists but also characteristic of music therapists' care practices more broadly. By trying different ways of exchanging the musical gift—such as singing or playing music together, dancing, listening to music, talking about music, writing music, as well as trying different songs, tempos, keys, styles, genres, and so on—music therapists are always changing, adapting, and adjusting in the moment.

An improvisational approach to clinical care is in line with the care praxis that medical anthropologists Annemarie Mol, Ingunn Moser, and Jeanette Pols (2015, 13–15) characterize not as "improvisational" but rather as "embodied practices" of "tinkering" or "attentive

experimentation." Persevering through improvising, adapting, and tinkering is in line with Mol's "logic of care." In her study of people's experiences living with and treating diabetes in the Netherlands, Mol (2008, 56) situates the "logic of care" as both a practice and a process. She describes how medical staff experiment when caring for patients with diabetes, for example with physicians adjusting insulin doses and nurses offering different styles of blood sugar monitors, until they find what works. In the logic of care, it is imperative to persevere through experimentation, since "there is always something to improve." For Mol, "good" clinical care persists in its efforts while "bad" care neglects. In striving to initiate and negotiate musical exchange through improvisation—experimenting, trying and trying again to find what will work—music therapists practice "good" care according to Mol's logic of care by persevering and adapting in their efforts to find what will work and, hopefully, improve the situation of a patient by offering them moments of connection.

The work of medical anthropologists Claire Wendland (2010) and Julie Livingston (2012) illustrates that, while the logic of "good" clinical care may rely on improvisational efforts, finding what works through an improvisational approach to care is not inherently "good." Wendland (2010) documents how medical students in Malawi learn how to improvise responses to a lack of material and human resources by, for example, reusing items for medical interventions and delegating conventional nursing tasks to family caregivers or students. She notes that while some medical students were pleased that they could care for patients through the spontaneous solutions they crafted in the moment, most were also saddened by the experience, disenchanted by medicine, and burnt out from the work. Similarly, in her work Livingston (2012, 181) illustrates how practices of "improvising medicine," like substituting

codeine for morphine and mixing chemo drugs themselves, are a "daily imperative" in response to scarcity for medical staff on a Botswana cancer ward.

In the medical anthropology literature, improvisation is characterized as "a defining feature of biomedicine in Africa" where, in under-resourced clinics and hospitals, "clinical improvisation is accentuated" (Livingston 2012, 6). Meanwhile, clinical care in well-resourced European contexts is characterized as experimental—not improvisational (Mol 2008; Mol, Moser, and Pols 2015). Like in music, improvisation in clinical care is defined by medical anthropologists in terms of pure spontaneity, ascribing to what Lewis (1996) deems to be a Eurological perspective. Following Lewis' (1996) broader conceptualization of musical improvisation—accounting for memory and history, and informed by an Afrological perspective—we can understand clinical experimentation in care as improvisatory, as illustrated in music therapy. Music therapists improvise both musically and clinically as they compose care with patients.

Familiar Music

When introducing themselves to new patients and attempting to initiate musical exchange, music therapists ask what kind of music a patient likes. It is assumed that patients are more likely to engage in music therapy as a process of musical exchange if they like the music and that moments of connection are more likely to unfold. Using musical styles, genres, instruments, recordings, and so on that patients like is what music therapists call using "patient-preferred music" (Silverman, Letwin, and Nuehring 2016). When patients are not able to verbally articulate the kind of music they like, music therapists attempt to learn about their musical preferences from family and friends or make informed assumptions about what music

might be familiar for them (for example, based on their age) and modify based on their responses.

Learning a patient's musical preferences, however, is not only a way for music therapists to find out what kind of music might help to catalyze musical exchange and connection. Musical preferences help music therapists get to know their patients. Brian explained:

> Music is a viable entry point into understanding who someone is in the world. The songs they like, the songs they don't like, the styles they might want to hear. Their receptiveness to music or any art form says a lot about who someone is in the world. We're musical beings. At the same time, learning who someone is can be channelled into the music we choose and the way we create music.

Music therapy, as a profession deeply intertwined with Western epistemologies of music (see chapter two), is entangled with the liberal logic of what Sykes calls the music identity episteme—"a belief that music is intimately associated with what it means to be a person" (2018, 3). A belief that music expresses personhood is reflected by music therapists like Brian, who understand getting to know the kind of music a patient likes as a way of getting to know the singularity of a person's life. While Sykes critiques the liberal identity episteme for denying sonic efficacy—the capacity for music to not only express an innate state of being but to make worlds as a technology of care—and argues that an ontological understanding of music as a gift helps us to move away from the liberal identity episteme, I argue that music therapists mobilize the liberal identity episteme to facilitate musical gift exchange.

The question "What kind of music do you like?" can be juxtaposed with the standard medical questions outlined by philosopher Michel Foucault ([1963] 2012)—"What's the matter with you?" that assessed health in the eighteenth century and "Where does it hurt?" that began to search for disease in the nineteenth century modern clinic. According to Foucault ([1963] 2012), the clinical gaze objectifies patients through a focus on disease. The patient becomes

"the accident of his disease" (Foucault [1963] 2012, 59) as the focus of medicine shifted to physiology. In shifting the focus to the person through music, Alex explained how music therapy intervenes in this dominant clinical paradigm:

> In hospitals, it's all about the diagnosis. The focus is the disease and not the person. Patients feel like they get lost. They think, "I'm just here because of this, they keep poking me because of this thing, they just care about if I can go home without this thing, they don't really care about *me*." That's where we can come in. Music therapy is a way of bringing back their humanity into the space. Like, "I'm talking to *you.* You may be here for this, but I'm talking to *you*, I'm making music with *you.*"

In setting disease and diagnosis aside, music therapists, as Alex indicates, move away from the "anonymous care" of the clinic (Stevenson 2014) to approach hospital patients first and foremost as people through approaches they often describe as holistic, humanistic, person-centered, personalized, or individualized. Yet, as a gift, music therapy is unlike therapeutic regimes centered around what Foucault (1986, 101) calls a "health practice" or "*hygieinē pragmateia* or *technē*" that focuses attention on the cultivation of one's self through discipline, exercise, and confession. In the care of the self, one confesses or appeals to another for guidance and advice; like the musical gift, this too is a system of reciprocal exchange (Foucault 1986, 53–54). Instead, in music therapy, the self is displaced through an attention to musical exchange and attention is focused on cultivating moments of connection. Music therapists learn about the singularity of a life in and around the liberal paradigm of music-as-expression; yet, unlike physiological and psychological medical therapeutics that strive to return the patient to the norm from which they have deviated (Canguilhem [1943] 1998; Foucault 1978; 2003a), music therapists strive to cultivate meaningful moments of connection for patients in the clinic that are transformative for patients as a mode of care as presence and togetherness.

In promoting and justifying their profession, music therapists mobilize the liberal identity paradigm that music expresses personhood and identity, as well as the belief that music

is inherently human (Aigen 2014) and inherently good (Edwards 2011). Brian's statement, for instance, that "we're musical beings" suggests that music has an essential, innate, and biologically human quality. Access to music, I was told, should be a human right—one that music therapists could help to facilitate. Although narratives of music's essentially human quality and inherent goodness are often reiterated by music therapists, their work depends on sonic efficacy—the capacity of music to be mobilized as a technology of care. They are simultaneously aware of music's capacity to be mobilized as a technology of violence; for example, the way in which it is mobilized for torture and warfare (Cusick 2008; 2020; Friedson 2019; Cloonan and Johnson 2002; Pieslak 2009; Daughtry 2015; Goodman 2010). They are careful in their use of music not to "trigger" or cause patients' distress. By getting to know a patient—their musical preferences as well as what kinds of music, sounds, lyrics, and so on could potentially cause distress—music therapists mobilize the liberal identity paradigm in order to operationalize music as a technology of care through the musical gift.

The problem, according to Sykes, of understanding music through the liberal identity paradigm is that "uses of music aimed at rehumanization tend to occur through the belief that music simply *is* about the expression of one's personal emotions and/or music's ability to project one's communal identity […]. This way of thinking is only capable of humanizing those within one group and dehumanizing those outside" (2018, 186). While music therapists mobilize this liberal identity paradigm otherwise for music therapy as a technology of care through musical exchange, the ways in which participation in music and music therapy is broadly understood are constrained by the liberal identity paradigm, perhaps most overtly when participation in music or music therapy is interpreted as expressing a patient's humanity. Non-music therapy staff, families, and broader publics often interpret participation in music and

music therapy as humanizing people who are otherwise dehumanized, excluded from the realm of the social, and condemned to "social death" and abandonment (Biehl 2004; 2013; Patterson 1982; Goffman 1961; J. S. Taylor 2008). When commenting on the hospital music therapy program, a nurse told me:

> I think music therapists have the best job ever. Especially working with the Alzheimer's patients, to watch them snap back to that time where they can sing a song and know every word. It's powerful. It activates a totally different part of your brain. It just wakes it up. It kind of helps you see them as a person. Not that you don't see them as a person. But, you know… if they have severe dementia and can't make sense of much around them, and then you find out, "Wow, they had full capacity before, they knew all the lyrics of this song, and this is what they enjoyed." You see them in a different way.

Although the nurse I spoke with was quick to qualify her comment by stating "not that you don't see them as a person," her suggestive "But, you know…" implies a shared understanding that they are not perceived as the *same* kind of people—not quite as full a person as someone with "full capacity" whose "brain" is "awake." The notion that music can "awaken" people with cognitive disabilities is popular; so popular, in fact, that video clips of people with dementia and autistic people singing, playing instruments, or dancing to music are widely circulated, garnering millions of views on platforms like YouTube (e.g., CTV News 2017; Music & Memory 2011; Talent Recap 2019). Seeing patients who participate in music therapy, particularly by reacting in a physical way such as singing, dancing, or playing an instrument, as persons depends, as Sykes suggests, on dehumanizing those same patients and other patients who do not participate in music in that same way. As anthropologist Andrés Romero (Forthcoming) demonstrates, it is not only processes of dehumanization that constitute violence in the clinic but also efforts at humanization through practices of care.

In mobilizing musical exchange as a technology of care, music therapists strive to "humanize" patients to medical staff in particular; they sympathize with overworked, burnt-out

medical and support staff, who they perceive as having to do the difficult work of care. As Matthew explained, "I get to be the good guy. They like me, I'm not telling them to take their pills or giving court orders!" He and other music therapists rationalize the dehumanization of patients by staff as a coping mechanism of "compartmentalization." Music therapy, he said, helps to mitigate this problem by "bringing some humanity" onto the unit. As Kate explained, "if seeing these moments can influence medical staff's opinion of that person and remind them of their humanity, their beauty, their creativity, and their uniqueness, that is an incredible thing." Music therapists like Kate and Alex hope that if medical staff can recognize patients' humanity by witnessing music therapy—to not just make sense of them as people instead of patients but to *feel* and *sense* their humanity—medical staff's care practices and interactions with patients could change for the better. While working to mitigate the violence of the clinic, "humanizing" patients who respond to music in particular ways also perpetuates the violence of the clinic, since recognizing the humanity of some patients is contingent on foreclosing the recognition of the humanity of those same patients and others.

Talk to God

Lachy, Sarah, and I arrived at an empty lounge on the inpatient psychiatry unit. Several patients had been recently discharged. The unit was quiet, other than some muffled conversation and laughter in the staff room behind the nurses' station. As Lachy and Sarah unpacked their guitars at a table near the window, Donald walked around the corner into the lounge, fiddle in hand. After tuning their instruments together, Lachy suggested to Donald that they play "Make and Break Harbour" (1977) by Stan Rogers. Lachy sang the song slowly, quietly accompanying himself on guitar. In between the first and second verse, Donald joined in on the fiddle, echoing

the vocal melody in a higher register. He carried the fiddle into the third verse, accompanying and embellishing Lachy's vocal line:

Well in Make and Break Harbour the boats are so few
Too many are held up and rotten
Houses now stand empty, old nets hung to dry
Are blown away, lost and forgotten

In the instrumental break before the fourth verse, Donald's fiddle melody and Lachy's harmonic progression on guitar were ever so slightly discordant.[47] Although this dissonance was very subtle, Donald apologized profusely after the song concluded.

"Nice Lachy, I'm sorry I didn't follow your chord pattern," Donald said.

"Well, I think I had us…" Lachy began.

"I just did a piece of music I was wrong this time I was wrong." Donald insisted.

"I messed up the chords actually!" Lachy told him.

"I knew that song for a long time and I should have known the chords better right?" Donald insisted.

"No, no, I was giving you wrong ones!" Lachy said again.

"No, geeze!" Donald shook his head.

"I was messing up my chords!" Lachy repeated.

"Lachy, don't take the fall for me Lachy please!" Donald laughed. "There's enough of me around, I'm going to be doing hard time here! I'm already doing my time, being kept on track! Yeah, I think we all are in here, I think just abandoned souls. No, I shouldn't say that, no, some people have tragedies and likely can't handle them like there's so many triggers eh. People have disabilities, disorders, nerve troubles, there's so many triggers like stress or they get lost in the

[47] Donald played a melody up to a C-sharp, thinking Lachy was moving from IV on G major to V on A major but instead Lachy went back to a I chord on D major, so his playing the C-sharp over D major sounded dissonant.

family and stuff sometimes, sometimes they just can't handle it, when you take the pressures of life, you really gotta be discipline, you know it helps to have a good job, nice things, it defines your happiness in life, a good paying job, a career, a nice car, a home, a nice family, if you're married or if you're single whatever, but just keep in step number one though, there's a lot that goes into your health like your happiness, you work hard you know take vacations, have a real organized routine, life, yeah."

"Donald, last week you said you had a couple poems that you started?" Lachy asked.

"Yeah!" Donald's eyes brightened. "Plenty! I was just talking about that one day I brought it up to somebody at the detox, they gave me the poem out of it, I went blah blah blah, it was like a prayer, I thought somebody could do something with it like a song or a hymn."

"I'd still be up for working on that with you, if you wanted," Lachy suggested.

"Oh okay Lachy, yeah! Like today, you could just put it on the computer and just tap it in maybe."

"I could do that too." Lachy opened his laptop.

"I thought it could make a nice hymn if somebody maybe sung it the right way, if it got in the right hands like yourself, someone who is good at music."

"Can you remember it off the top of your head?"

"Oh yeah. It's—you can put your own twist on it kinda too Lachy. I'll just give you the words."

"Sure."

"It's just something I thought maybe might be a good hymn. I thought, it's like four…four verses, five verses with the last two, it's only two lines, they're all four lines."

"Alright."

"And you rhyme the second sentence, the last word rhymes…the title is 'Talk to God.' It was '97 '98 I sat at the table and just…anyway. I never wrote much over the years, a few things."

"Whenever you're ready," Lachy said gently. In a slow and steady voice, Donald recited while Lachy typed.

Talk to God, say every word
He'll always listen to your prayer
Put all your faith and trust in him
And he'll always bring you peace within

Just ask for favours anytime of the day
And he'll always bring help your way
So, pray, pray, wherever you may be
Cause God's above, someday you'll see

It may take a while to get your answer that's true
But he'll never leave or forsake you
He's with you morning noon and night
So just talk to God and everything will be alright

God is powerful, consumed with wisdom and love
And he's looking down on us from heaven up above

"Man are you good on that, the best I ever saw!" Donald said, admiring Lachy's typing skills. "Best typer I ever saw!"

"I bet these two can type a heck of a lot faster than I can," Lachy said, looking over at Sarah and me.

"Are you ever quick! All eight fingers, you probably get your thumb in there, yeah for the spacer, I took typing one time but I never, because the course, we had to type, it was associated with a course, I forget what kind of material, but I was sitting in the back of the class, I was asking a lot of questions, I think I got forty-five, it was an honours class, they were all honours students but they had no need to ask questions, they could understand the teacher really good."

"What kind of music do you think you'd like for this? What style?" Lachy asked.

"Oh, maybe… Lachy I'll tell you, it's in your ballpark! It's more your song, or as much your song as it is mine, since you're going to be the one singing it! If you do, gospel or country maybe? I don't know, maybe it's almost next to impossible to turn it into a song…"

"No, no, it's not impossible! I just want to make it good. I want you to like it!"

"Oh, I'm sure I will Lachy."

Lachy strummed a simple chord progression in the key of G major. "I'm loving this guitar," he said.

"I know, it's nice, it's really bright, the strings!" Donald agreed,

Lachy repeated the chord progression. "Here's where I could go with it," Lachy said. He began to sing Donald's words.

Talk to God he's everywhere – no, I don't like that [melody].
Talk to God, he's everywhere
He's always listening to your – to your prayers
Put all your faith and trust in him
And he'll always bring you peace with you
Yeah he'll always bring you peace within

"Something like that?"

"Nice, I like it! Yeah, I like that, it's really nice Lachy! It's kinda cool. The young ones can relate to it, put in a recording."

"Do you want me to tag that last line? Maybe we can do that for all the ending lines." Lachy asked, referring to the repetition of the last line of the verse.

"Yeah I like that!" Donald smiled

Just ask for favours anytime of the day
He'll always bring help your way
So, pray, pray, wherever you may be
Cause God is above, someday you'll see
Oh God is above, someday you'll see

It may take a while to get your answer that's true
But he'll never leave or forsaken you
Cause he's with you morning noon and night
So just talk to God, everything will be alright
Just talk to God, everything will be alright

"Nice, I like it! Lachy, you got it right there, the whole song after finishing the last line!" Donald beamed.

"These last two lines, maybe they could be like a bridge to the song? God is powerful, consumed with wisdom and love / And he's looking down on us from heaven up above."

"Yeah!"

"It could be revisited a couple times…" Lachy hummed a possible melody for the bridge over different chords.

"Whatever you think Lachy, you've made it your own, it's your song now."

"No!" Lachy and Donald laughed. "This is *your* song! You're the producer! You have to tell me what you like and what you don't like."

"Ah, Lachy, no, no, Lachy, you're very humble but please don't go overboard!" Donald said, chuckling. "No Lachy you're so good, you know what's best! All these ideas, I would never think of them in a million years, you know what's good, whatever you feel is comfortable, what you think is best for the song go for it, because if I put my input into it…I don't have any ideas other than the words, no, no, now it's in your hands. Thank you. No really Lachy, you're the master. Interpreter and philanthropist! Is that the word for anthropology?" Donald turned to me.

"What's that?" I asked.

"No, anthropology. So, what is a philanthropist?"

"Oh, someone who donates money to charity."

"Oh! I've heard the word a few times before but I never looked it up in the dictionary. Obviously. But yeah I never knew! So anthropology I never knew. I heard the word a few times."

"Alright, I'll make you a deal," Lachy said to Donald. "Fifty-fifty. This song is ours. Fifty percent you, fifty percent me."

"Okay! Okay. Alright Lachy, that means the profits too, if you record it!" Donald laughed. "No, no, I shouldn't say that, all the profits go to you! Whatever you want to do with them!"

We all laughed along with Donald.

"Here's what I think now," Lachy sang the first verse again.

"Oh, is it ever nice. Is that ever good." Donald beamed.

"We need your touch on the fiddle Donald," Lachy said. "How about this, I'll sing the first verse and then we'll do some fiddle,"

"A solo?"

"Yeah, a solo, then I'll sing the second verse, solo, third verse…you know what I might do, those last two lines, I might take them and copy them and put them right after the second verse. Let's try it again," Lachy started to sing from the top:

Talk to God, he's everywhere
Always listening to your prayers
Put all your faith and trust in him
And he'll always bring you peace within
He'll always bring you peace within

"Here we go," Lachy called out, as Donald adjusted his fiddle in the crook of his neck in preparation to play. "Fiddle, one-two-three-four."

Donald improvised a fiddle solo, echoing and embellishing the vocal melody Lachy had sang in the previous verse.

"That sounds great Donald! Right on."

Lachy sang the next verse; this time Sarah added her voice, harmonizing a third above Lachy's melody:

Just ask for favours any time of day
He'll always bring help your way
So, pray, pray, wherever you may be
Because God is above someday, you'll see
Oh God is above someday you'll see

"I'm going to try to do the bridge here," Lachy said. Improvising a melody, he sang:

God is powerful consumed with love
He's looking down from heaven above—I missed the line there, one sec
*God—God is powerful consumed with love…*okay, gotta break that up, how about, hmm…

Lachy paused, thinking over the melodic and harmonic structure for the bridge.

"You brought it right to life Lachy." Donald said in awe. "And the harmonies," referring to Sarah's vocals. "Just hearing it right there is enough for me to...it just came to me, Talk to God…they say just write it down on a piece of paper, just one thought write around it, personal experience, yup. But those harmonies, geeze, really top notch, really world class."

"Here's what I think for the bridge. Let me know what you think, we can change it." Lachy said. He sang the lines again, ascending the vocal line into a higher register:

God is powerful, consumed with wisdom and love
And he's looking down at us from heaven above

"Something like that?" Lachy paused.

"Right on," Donald said.

"You think those chords work?" Lachy asked again.

"Oh, right on Lachy, oh god, yes."

Lachy moved back into the song, singing the final verse:

It may take a while to get your answers that's true

But he'll never leave or forsaken you
Cause he's with you morning noon and night
So just talk to God and everything will be alright
So just talk to God and everything will be alright

"One two three four!" Lachy said, counting in Donald's fiddle solo. "Keep 'er going," Lachy encouraged, strumming accompanying chords on his guitar.

"Alright, we just wrote a song!" Lachy exclaimed, chuckling.

"Yes! Geeze!" Donald beamed.

"It's a good song, good lyrics!" Lachy complimented Donald.

"Thanks a lot Lachy, I would have never thought of that myself, putting music to it, I thought it'd be tricky but geeze you work wonders with words" he said. "Does that ever make me feel a special feeling inside! Geeze."

"Maybe what I'll do is bring my computer in tomorrow, and my mic, and we can just record it live off the floor," Lachy suggested.

"No way!"

"That way we can record it and I can send it to you by email," Lachy said.

"Oh I don't have a computer Lachy but the flip phones, I don't know if they would play it?" Donald wondered.

"Maybe I could burn it on a disk?" Lachy suggested.

"Yeah! That'd be awesome, like a compact disk? I had a disk one time, I did a recording, the guy put it on a DVD disk, it was pretty cool, he was a real expert with computers, everything sounded like an auditorium but still it was really good, played it on a DVD player, the song came up whatever song you wanted, I had a DVD player at the time, would you have that Lachy? I don't have a DVD player right now but it would be a compact disk Lachy?"

"Yeah, there'd be a way to burn it on a compact disk. That'd be great. And I'll print the lyrics off too, so you can have the lyrics, I'll put what key it is, maybe I'll put the chords above the lyrics too."

"Lachy you never cease to amaze me with your musical abilities!"

"The feeling is mutual!"

"Oh, Lachy you make me want to go practice for ten hours a day to live up to your compliments!" Donald laughed. "You're my best fan, one of my only fans! I can't let you down!"

"Everyone enjoys your playing," Lachy assured.

"Thanks a lot Lachy. I've got to get back out there, get on the circuit."

"That would be great."

"After all these years, I'm on a hiatus right now."

"People would enjoy it."

"I mostly played just backing people up."

"When I'm playing with you there's a lot more emotion in the playing, we feed off each other with the emotion, when I play with other players—not that they're bad—but it's just…you can't influence them with your energy or vice versa," Lachy said.

"Yeah I know what you're talking about, the emotions, being passionate about it, you feed off each other, you know what I mean? That's what makes a great player, I always say that. They bring out the best in you. It's chemistry," Donald nodded.

Figure 5. Recording.

The next day, Lachy brought his recording equipment onto the unit (see figure 5). As we recorded our temperatures in the staff room as a COVID-19 precaution, a nurse told us that Donald had been talking to all of the staff on the unit about their upcoming recording session.

“Hi guys!” Donald walked into the lounge excitedly.

“How’re you doing?” Lachy asked while setting up the equipment.

“Oh nice Lachy, that looks pretty high tech! Wow, what a microphone! Gee,” Donald commented.

“It’s a Shure SM7B,” Lachy told him.

“SM7B? Now the mics we used to use over the years with different bands the most popular vocal mic was the, you would’ve heard of the SM57 eh? A Shure mic is really top of the line. But that’s a new kind, higher tech no doubt.”

"If we're set up like this it should pick us up alright."

"It's a studio mic, is it?"

"Yeah, it's really good for podcasts and stuff like that, it should pick us up alright too. And we're just doing it for fun you know? I typed up the lyrics but I forgot to put the chords in, I'll put the chords into it later," Lachy said, handing him a sheet of paper with the typed lyrics.

"That's alright Lachy, you're a busy man! It'll be nice to sing it myself just for pastime or to give it to someone else to show them how it goes. But I can't imagine anyone singing it as good as you!"

They played through the song together; midway, a nurse came into the lounge to listen.

"So, this is a song you wrote Donald?" the nurse asked, after they had paused.

"Yeah, a poem, I asked if Lachy would turn it into a hymn, maybe if he could, he had no problems with it at all, geeze, he brought it right to life!"

"Next stop, the concert hall!" Lachy announced.

"Next up, the radio!" Donald laughed. "I'll give Lachy all the credit, he's the real creator."

"I think what we should do is, I'll count us in, you should take a little intro solo, then I'll sing two verses, you can do your own colouring, decorating, whatever you feel like—it's your song, so you do whatever you want. I'll do two verses, I wonder if I should do two verses, then fiddle solo, or two verses, bridge, then fiddle solo…" Lachy deliberated.

"Oh yeah, I never thought about it, what part is the bridge? The bridge always goes up a little," Donald said.

"It's the one that goes…" Lachy sang the ascending melody, "*God is powerful consumed with wisdom and love and he's looking down at us from heaven above,* then it goes back."

“It goes up, the bridge, yeah!” Donald affirmed.

“So, what do you think, solo then bridge or bridge then solo?”

Donald didn’t answer. After a brief silence, I added, “Last time you did two solos. You did two verses, fiddle solo, bridge, third verse, then another fiddle solo.”

“Right,” Lachy said, thinking.

“I have no idea what you’re talking about!” The nurse exclaimed, to everyone’s amusement.

“They’re talking music language!” Donald laughed.

“I guess I’ll just cue you, Donald?” Lachy proposed.

“Okay! Yeah, I’m just playing around with it, I’m really am not… the last time I played it, I played around G major, I started with that and finished with it. That’s the first chord you start with isn’t it Lachy?”

“That’s right.”

“I kinda just, yeah.”

“I’ll count us in, one two, one two three four…” Lachy began to strum his guitar. Donald played a fiddle solo for the intro, followed by Lachy singing the two verses, the bridge, and the third verse before cueing Donald into another solo. “Giv’er!” Lachy said. Donald leaned into a lengthy solo, first echoing Lachy’s vocal melody. Lachy urged Donald to continue; “Keep going!” he encouraged. Donald ascended into a high register before embellishing a dramatic descending line, sliding from one note to the next using a portamento technique. “Good!” Lachy remarked, before transitioning back into the bridge a second time, followed by a quiet recapitulation of the first verse. “Giv’er, Donald!” Lachy instructed one last time, cheering Donald into one last fiddle solo. They ended together, on G major.

“Nice Lachy! Brought it right to life,” Donald grinned.

“What do you think about that take?” Lachy asked.

“Nice, I like it.”

“Good? What do you guys think?” Lachy turned to Sarah and me.

“It’s good!” Sarah said.

“Nice harmony, geeze,” Donald said, referring to Sarah’s vocals.

“Do you want to listen to it?” Lachy asked.

“Okay Lachy, yeah! Cool!” Donald said with enthusiasm.

“Oh you know what…oh god, we weren’t even using that mic, we’ve got to do it again!” Lachy laughed, shaking his head.

“Well, we’ve practiced!” Donald chuckled, reassuringly. “But you’re changing your chords Lachy, I tried to stick to mostly G, C, and D. That’s the way it is usually.”

“Oh yeah, I played an A minor in there actually,” Lachy recalled.

“Yeah, I know, yeah, that’s nice, an A7 minor?” Donald asked.

“No, I think they’re all triads.”

“Triads? I’ve never heard that word before.” Donald raised his eyebrows.

“There’s no sevens or anything like that,” Lachy explained.

“Oh okay. Yeah, I’ve got so much to learn about chords. I know a lot but I don’t know the names and I don’t understand fully,” Donald said with a frown.

“I think you’ve got it Donald!” Sarah chuckled, referencing his expertise on both the fiddle and guitar, improvising and playing by ear.

“Thanks a lot,” Donald smiled.

They tried recording the song again; each version was different. This time, Lachy led them in a crescendo in the last verse, encouraging Donald into a vociferous solo. Stomping his feet to the beat, Donald played them into a big finish.

"Woo! Right on," Lachy cheered. "Good work, let's try to listen to that!"

Lachy played the recording on his computer for all of us to hear.

"Cool! It sounds really cool, makes me look cool when I don't feel so cool! Temperature is about 104!" Donald joked.

"I think I still made some minor mistakes but…" Lachy commented.

"Like Fred Flintstone with steam coming out of his ears!" Donald continued, laughing. "No, not too bad right now I just don't want to overdo it, but with you guys it's so easy just to lay back, I don't dare go near the fiddle when I hear your harmonies," he told Sarah.

"We want to hear the fiddle!" Sarah insisted.

"I've heard a lot of fiddle but I haven't heard harmonies like yours. With really good players, even the first time, as much as I love to play I just want to take everything in you know? I like to listen first. Your attention when you're playing, people are listening they're getting the whole picture, when you're playing you're focused on your instrument but after I play with people that are really good sometimes the second or third time, like a festival or something, I like to step back and listen, not play at all, just after playing, yeah my god you guys really compliment each other, real chemistry there," Donald admired.

"Ah I might have screwed up again!" Lachy's brow furrowed. The recording was barely audible.

"What's that called Lachy?" Donald asked, looking at the equipment on the table.

"This is an interface," Lachy said.

"Cool. Nice stand too, really state of the art."

"Oh dear. It picked up but it's really low, I'll try this…well it's picking up…" Lachy adjusted the microphone input levels.

"But you've got yours, I bet that picks up good!" Donald said, looking at me.

"My little recorder? Yeah, I'm recording the recording here!" I laughed.

"Yeah, it's so low," Lachy sighed. "I've got to find a way to make it louder. Sounds good though." We listened to the recording quietly play back over Lachy's computer speakers.

"Oh yeah, geeze," Donald said.

"You've got your foot going!" Lachy remarked. Donald's stomping feet were audible in the recorded track.

"Mine eh?" Donald asked.

"Sounds like a metronome!" Lachy said, over Donald's fiddle solo. "Great line there Donald, wow!"

"Thanks a lot Lachy, I started off trying to improvise and then I felt more into it, like I tried to start on G and then go to like C and D and come back to G, the in between chords that you do, you know what chord you're in, you have an idea, though you don't or I don't really know the name of it, but it started on G and ended on G, Lachy, so I was just trying to keep it simple, just something that someone can remember to hum back. Play to the chords but it's kinda tricky Lachy, I felt that I was a little out there a bit, like improvising too much because I didn't know the chords to be honest with you," Donald paused.

"Sounds good though," Lachy said.

"As long as it comes together like first and last chords!" Donald laughed. "You never know where it's gonna take you."

"It's almost like a gravitational pull, you foresee it in milliseconds," Lachy agreed.

"All of a sudden it just comes to you, so spontaneous, the chemistry has got to be there. When you're really satisfied with your music..." Donald trailed off. "Don't spend too much time on it Lachy…what's your name again?" Donald looked over at me.

"Meredith."

"Oh yes, like the actor Meredith Baxter, I forgot. But I was saying, usually almost everybody shows up," Donald noted for the benefit of my research, referencing the near-empty patient lounge on the locked unit. The nurse had left, and it was just Donald, Lachy, Sarah, and me in the space. It just happened that the unit was quiet that day. It had given Lachy the opportunity to initiate the song writing session with Donald.

"Sometimes there's a quieter bunch," Lachy confirmed. The playback stopped.

"Had no problem picking up my fiddle, what a nice mic, geeze. Have you ever recorded Lachy? It's nice to hear yourself. You're so focused on your music that sometimes you don't realize how good you are, until you hear yourself on a recording. I don't think you realize the full potential because you're so focused on playing, I don't know, maybe that's just me, but I know one thing, of all the people you see in your life who's the one person you see the least of?"

"I dunno Donald," Lachy said.

"It's a statistic, somebody said that to me thirty years ago, he said who's the one person you see the least, it's yourself!"

"Oh!"

"Yup, in the morning you see yourself in the mirror a bit, but your family and friends and coworkers…I always thought it was a statistic that he got out of a book or a program or something."

Lachy suggested they attempt one final recording of the song, strumming his guitar gently before prompting, "One two three four." At the end of this rendition, Lachy praised Donald's playing, "Good! Right on, good ending."

"Thanks a lot Lachy. You made my poem...you made it just…I could see it as a hit someday!" Donald laughed, "No really, there's a lot of people, I sit back and listen, I mean I always did, we went over, it's great, it's just I dunno there's something about it, every song is different, but the chords you put to it, the changes, there's so much to appreciate there."

"Yeah, it's an energy thing, right? Isn't it?" Lachy said.

"God, the harmonies, I never thought this song had this kind of potential, but you guys are good," Donald said, admiring Lachy and Sarah.

Lachy played back the final recording.

"Well maybe someday, you know Lachy, I might be able to connect with somebody with that song and maybe help somebody out," Donald said.

"I think so," Lachy nodded.

"They'll hear that song and think geeze, that reminds me to just say a little prayer and just have a little talk with God and move onwards, nothing formal, you know. Maybe it could be a single someday, on the market, if any money comes from it, it'll be for you guys. Or put it here to the hospital, then the whole world will know I have a history of being here for what, nineteen years!" Donald chuckled.

"We'll get all the money we can out of those record companies," Lachy joked.

“Yeah!” Donald laughed. “Lachy you made something of that song. You made a lot of it, I never knew, I suppose there are quite a few people who take a poem and turn it into a song,” Donald said.

“Yeah!” Lachy affirmed. An older woman named Beth walked into the lounge, guided by the social worker who helped her into a seat at one of the tables. “Hi Beth, are there any songs you’d like to hear today?”

Beth shook her head, “No.”

“If you think of anything you’d like to hear, just let us know,” Lachy said.

“Do you like fiddle music? Scottish or French or Irish?” Donald asked. “Do you like the fiddle? Any certain tune I might be able to play for you on the fiddle?”

Beth shrugged, averting her eyes, refusing Donald’s offer.

“I think Sarah’s got something for us,” Lachy said.

“What about some Hank Williams, I could do ‘You’re Cheating Heart’ or ‘I Saw the Light’? Your choice.” Sarah asked.

“Ohhh, ‘I Saw the Light,’ *No more darkness, no more night…*I was just singing that last night! *I’m so happy no sorrow in sight, Praise the lord, I saw the light.* Yeah he was a genius, he had to be, no education nothing, he was definitely up there…” Donald mused.

Sarah began to sing “I Saw the Light” (1948). This time Lachy harmonized a third below Sarah, with Donald accompanying them on the fiddle.

“What a voice, million-dollar voice, can’t put a prize on a voice like that, wow!” Donald said after the song concluded. “Same as you Lachy,” he smiled.

Lachy smiled back at Donald.

Distributed Subjectivities

In writing their song "Talk to God," Donald and Lachy's musical exchange was marked by reciprocity. Donald provided the text of his poem and Lachy set the text to a harmonic and melodic structure. While Lachy sang the lyrics and accompanied with a harmonic chord progression on guitar, Donald improvised virtuosic fiddle solos. Donald was so amazed by Lachy setting his poem to music that he insisted the song was now Lachy's. Lachy, in turn, insisted that it was Donald's song. After numerous attempts to gift each other authorship and ownership over the song, they agreed to share it "fifty-fifty." Donald would not dream of taking individual or sole authorship over the song; Lachy would not imagine doing so either. The back and forth of musical exchange was a co-compositional process; their song was co-authored through relationality.

In musical exchange, it is not only songs and music that are distributed, shared, and emergent but also selves. As a gift, music is inalienable—it cannot be fully separated from the giver. This is what Annette Weiner calls "keeping while giving" (1985, 223). Mauss describes this inalienable attachment between the gift and the giver using the Māori term *hau* or "the spirit of the thing given" ([1950] 2002, 13). The spirit of the gift, Mauss writes, creates "a tie occurring through things" and implores reciprocity such that "one must give back to another person what is really part and parcel of his nature and substance, because to accept something from somebody is to accept some part of his spiritual essence, of his soul" ([1950] 2002, 16). The inalienable quality of the gift can be felt in musical exchange, apparent in Donald's insistence the song was Lachy's and Lachy's insistence the song was Donald's. According to Mauss, "to make a gift of something to someone is to make a present of some part of oneself" ([1950] 2002, 16). Through gift-giving, the spirits, souls, and selves of givers and receivers of

gifts become entangled. Gifts "circulate as part of persons" (Strathern 1988, 192) and, through gift-giving, a person "becomes more than she or he is" as gifts "stand as the means through which individual mortality is transcended" (Weiner 1985, 212). Donald and Lachy both shared and gifted a part of themselves in their contributions to their song, entangling and extending themselves into the musical exchange.

The entangled composition of musical gifts exposes the fiction of a contained, autonomous, and stable subject, showing it's an impossibility. Gift-giving demonstrates what philosopher Michael Serres (1985, 26) writes, that "two mingled bodies do not form a separate subject and object" and instead constitute mixtures, blends, meetings, and hybrids through the back and forth of musical exchange. Selfhood, as Taylor (2008, 326) suggests, "is distributed among networks, sustained by supportive environments, emergent within practices of care." The distribution of selves is apparent in musical exchange, where the sharing of music is the sharing and distribution of selves. Musical exchange unfolds as "direct experience" that "takes place not in the subject or the object, but in the relation itself" (Manning 2013, 3). In writing and recording "Talk to God," the focus of music therapy was on the song-writing process, the musical elements, and the musical exchange. Participating in that musical exchange with Lachy made Donald "feel a special feeling inside." Through a focus on musical exchange, music therapy displaces a therapeutic fixation on an imagined individual self to attend to relation and, in doing so, creates meaningful moments for people that make them feel seen, heard, and recognized otherwise.

The stakes of musical exchange are heightened in clinical institutions like hospitals and long-term care facilities where people are interpellated as patients, the subjects of medical care, objectified and dehumanized by the clinical gaze. In these spaces, musical exchange is a way to

forge relations and connection as well as to acknowledge and recognize another without fixing them as particular kinds of clinical subjects. As Lucy explained:

> In hospitals, patients and families have to listen to the doctors and the nurses, ask questions, make decisions about care. It's very cerebral stuff. Then I'll come in, slowly strum a chord, and sing: "*Hello, Welcome to Music*." And it's tears right away. Because it gives them that permission to just be. To not have to worry about the next medical decision they're going to have to make or how they're going to do something, but to just be.

In music therapy, patients and families could "just be," beyond the roles of patient, caregiver, or decision-maker. Similarly, Matthew explained that music therapy can create a space where patients can "just be" while also feeling a sense of autonomy over their lives:

> On the unit you have this heavy hospital feeling. Patients don't have control. Patients have to do what doctors tell them to do, what nurses tell them to do. And with the pandemic it feels like a jail now more than ever. They can't go outside; they can't have visitors. But when they come to music therapy, *they* choose the music. Music puts people at ease, it offers them a way to feel part of something and not have to talk. They can play, they can sing, they can just be there listening, and they can feel like they are a part of something.

Creating space in the clinic through music therapy where patients can "just be" is, as previously discussed in this chapter, a mode of care that Taylor describes as "being together" and Stevenson describes as "song." Both Taylor and Stevenson attend to the ways in which such modes of care can move beyond fixing the subject-position of another through recognition or interpellation.

Recognizing someone's capacity for showing up without attempting to "render an other intelligible" (Stevenson 2014, 165) in musical exchange unhinges people from the subject-positions they are otherwise asked to occupy in the clinic and in the world—instead they can "just be" in music, without being rendered sensible. The kind of recognition that acknowledges someone's capacity for showing up and being present without fixing them into a subject position is not the kind of recognition that depends on identifying the other through language. In

depicting her mutual caring relationship with her mother, who "lights up" upon seeing her regardless of not being able to name her, Taylor (2008, 326) illustrates ethnographically what Serres theorizes: that recognition works through touch and "unfolds across space, above individuals, like melody" (1985, 137). In musical exchange, moments of connection as touch is a mode of recognition that acknowledges another as company, "as loveable kinds of beings capable of showing up" (Stevenson 2014, 163) in and around music, where togetherness and relationality is animated through song. Donald and Lachy, for instance, recognize each other's presence through musical exchange and in moments of connection. In their musical exchange, Donald recognizes Lachy and Lachy recognizes Donald—not "as human" but in their singularity, specificity, and incommensurability, across different *genres* of being human (Wynter 2006).

Attachments

Through the affective connection and relationality of musical gift exchange, attachments form and linger in music therapy. Music therapists formed various attachments, not only to the people they work with, the relationships they develop, and the connections they forge, but also to the idea of, responsibility for, and dedication to caring for patients through creating connections that exceed the linear, curative, progress-driven and cause-effect logics of therapy and therapeutic progress. Affective attachments to patients were often described to me with the psychoanalytic term of "countertransference," when music therapists recognized that they were relating "too" closely to the patients' experiences and feelings, getting too emotionally entangled, and getting too attached. In order to avoid countertransference and burnout as a result, they were taught to maintain adequate "boundaries."

In one of the last hospital music therapy group sessions I attended, Mary had to tell the group that it was the last time they would be allowed to meet, since lockdown measures were increasing due to another wave of the COVID-19 pandemic. The hospital's long-term care facility was restricting in-person groups like theirs that convened people from different units. It was a sad and sombre session, with one of the group's participants commenting how Fridays had been the "best days of the week" for her, because of the group, and she "hoped they could sing together again." After the session came to a close and the last patient returned to their room, a tearful and grief-stricken Mary talked about how tough the year has been. Her colleagues told her not to cry, to have stronger boundaries, to not be so invested in or attached to her patients, to not *care* so much about them, and to cultivate a detached mode of care and concern. Mary's lack of rigid boundaries was emotionally draining and exhausting for her, but she told me that she couldn't help but care and feel connected to the people she worked with and couldn't help but feel deeply sad for all the losses they are facing.

A few days earlier, I had accompanied Mary to her individual music therapy session with Mr. Crawford. In the music therapy studio, Mr. Crawford sat in his wheelchair beside Mary, who sat in a chair. Mary boasted about how Mr. Crawford was a guest speaker in one of her group music therapy sessions the previous week, sharing his love of colliery bands, brass bands in the United Kingdom made up of coal mine workers. Mary beamed, "The group loved your visit, you did a wonderful job talking to them!" Mr. Crawford chuckled and shrugged. "As long as it pleased you," he offered. "You made everybody happy, so thank you," Mary said. Mr. Crawford smiled, "It gets me, so I expect it from these people when they hear it in such a way." Mary nodded. She asked, "Should we listen to a piece?" Opening up YouTube on her iPad,

Mary played the Grimpethorpe Colliery Band's fast-paced rendition of Rossini's "William Tell Overture" (1829).

"It's a fine band," Mr. Crawford remarked after the final cadence. "They play with heart. Work and pleasure…" Mr. Crawford paused, searching for his words, "working *together*."

Mary nodded.

Mr. Crawford continued, "The beauty is that they're all playing together. There's nobody out for glory or anything like that. All summer there's a band. The music touches my heart. I love it."

The following week, Mary was alarmed to see that Mr. Crawford's chart indicated he was confused, depressed, feels like a burden to staff, and had expressed wishes that he were dead.

She began their weekly session asking how he was feeling that day.

"Things are rushing by," Mr. Crawford said somberly.

"That's tough," Mary said softly.

"It's part of life. In the past…could appear to be keeping up. As long as you can keep…" Mr. Crawford paused. "Presentable. Because that period when you're healthy, you can use the moments to appear healthy and do well. You never smoked or drank."

"I remember you told me that you never smoked or drank," Mary affirmed.

"The knowledge that you abstained does you good, gives you a bit of a lift," Mr. Crawford said, forming a fist with his hand.

"That motion of strength," Mary made a fist with her hand like Mr. Crawford, "that's the same motion you use when you talk about brass bands."

"You understand a little better," Mr. Crawford nodded.

"I think I understand. I think it's good that you tell people when you're having a hard time. You don't always have to be—"

"In charge. You can do a lot of good. Just looking after…it all helps."

"These days, when you have a tough day, is there something that you tell yourself to help or is there a certain way you cope?" Mary asked.

"I give priority to anything physical."

"Physical activity is very important to you, you used to box."

"Boxing, I really like it at the time, not quite as much now."

"Have you thought of using music to help?

"I would like to but I don't know, I don't think I'm…I feel I would be nothing myself. Not a high standard."

"We've been making a list of your favourite music. I wonder if we put that music on a CD, you could go to your room and listen to the music?"

"I'm not sure the cost."

"Maybe I could help you with that."

Together they spent time choosing additional songs, mostly brass band music, for Mr. Crawford's list.

"Some of that music is…it's hard to say no when people ask you, 'Would you like to hear the music?'" Mr. Crawford laughed. "It's wonderfully really what music can do, when it's moulding in such a way. Gets the best of you."

"Yes, I think you said before that it motivates you."

"Yes. We haven't yet touched, how can I say, all that's there…"

"We've touched the tip of the iceberg!" Mary exclaimed.

"It's a good thing, the music…I got lost. But the music's got to be touched," Mr. Crawford said.

"It has to touch you in a certain way, yes, I agree," Mary nodded again.

"When it gets you on the right track it can do wonders," he nodded.

"Yes. Thank you for sharing."

"It's a pleasure!" Mr. Crawford turned to me, asking, "Did you enjoy it?"

I nodded, saying I enjoyed the songs they chose.

"We tried our best, this list, we're making up a list. Just listening to it gives you strength…I can't describe it."

"I think you described it well," Mary affirmed. "It gives you strength."

Mary felt deeply empathetic to experiences of Mr. Crawford and others who she worked with. She was viscerally overcome by sadness, pain, and loss. Attachment, however, can be read as another part of caring through the musical gift—another side of connection, of being profoundly moved and affected by another. Inside the clinic, where detached concern is the standard of care, attachment is understood as something to be avoided. But attachments are a necessary element of forging deep connections in music therapy through musical gift exchange. Mary was not the only music therapist who spoke openly about their empathetic and overwhelming response to patients' feelings and experiences; many music therapists shared their experiences feeling affected by their attachments to patients.

Lachy, for instance, would source second-hand instruments from the community to give to patients like Donald after they had been discharged from the hospital so that they could continue playing music at home. While Donald had a fiddle, he had mentioned in passing that

he no longer had a guitar; so, Lachy found a guitar for Donald, restrung it, and delivered it to Donald at home after he had been discharged.

During their music therapy sessions, Donald would talk about how he should "get back out there" and play music professionally again. One day Lachy asked Donald if he would consider busking at the market; Donald responded, "Oh yeah…" Supportively, Lachy told him, "I'd try to accompany you, but I don't know if I have the chops!" Donald replied, "Oh, they wouldn't pay attention to me!" Lachy laughed, affirming to him, "I assure you it'd be the other way around!" But back in the office Lachy wasn't smiling or laughing; he seemed defeated. Despite Donald's exceptional musical skills and in spite of his certainty that Donald would surely make lots of money busking, Lachy knew that Donald was unlikely to ever follow through on the idea of playing at the market, or elsewhere for that matter. He could sense Donald's hesitation, his shyness, his insecurity. Like Stevenson (2014), who desired lives and futures for the Inuit youth with whom she worked, Lachy desired more for Donald. He wanted Donald to have his musical skills be recognized, appreciated, and validated by others. The impossibility to make this happen for Donald weighed on Lachy.

In post-industrial America, cultural theorist Lauren Berlant (2011) describes the impact of what she calls post-Fordist affective attachment, a normative aspirational desire for the promise of "the good life" that shapes felt imaginaries and everyday lives yet "is for so many a bad life" (27) of what she deems "slow death" (114) under capitalist exploitation. In the affective atmosphere of what she calls the impasse of the "historical present" (196), Berlant maps an emergent sense of the unravelling of the good life fantasy in the wake of the recession where alienation, shame, anxiety, and precarity maintain the cruelty of aspirational attachments that are momentarily disrupted through refusal. Lachy's desires for Donald could be read as

cruel aspirational attachments for "a good life." Yet they can also be read in another way, as wanting something else for Donald, for him to be recognized differently than the normative ways in which he is read by others. Lachy could offer fleeting moments of recognition otherwise for Donald in music therapy sessions, but it never felt like enough.

This feeling of never being able to do enough for patients also haunts Alice as she cultivates attachments with patients in palliative care. I was with Alice when she knocked on Deborah's door. Deborah's daughter told Alice that her mother, who was tired and in a lot of pain, "wouldn't be able to enjoy the music today." Alice told them that she'd check back again later, knowing that music therapy could potentially alleviate some of Deborah's pain. Just a half hour later we returned to Deborah's room. Alice asks Deborah if she would like some music. "That would be heavenly," Deborah said. Knowing Deborah to be a devote Catholic, Alice sang a soft rendition of the hymn "Here I am Lord." Once Alice started singing, Deborah mouthed the words softly. After the song ended, Deborah launched into an emotional speech about the importance of faith and her memories of going to church. She says she was worried earlier that she didn't think she'd be able to participate because she was having a hard day but was so grateful that Alice came back to share the "beautiful music" with her.

The following Monday morning, Alice texted to let me know that Deborah and another of her palliative patients had passed away. "Morning! Heads up – both palliative patients have died. No sessions this morning, so if you haven't already left for the hospital, you can take your time! Meet in my office around noon?"

Music therapists like Alice, who is only on the palliative unit one morning each week, do not always get notified when patients pass away. When I met her in the office she told me it's a good thing she checked their charts, otherwise she would have prepared for the sessions

and shown up to their rooms only to find their beds empty—this has happened to her in the past. She commented dryly, “I’m telling you, it’s the holidays! Lots of people die at this time of year.” Alice loves working in palliative care; she considers it a “privilege” to support and care for people in their final days. But Alice, like other music therapists and so many health workers and care givers, have to detach from their attachments in order to avoid being consumed with sadness and loss. There are limits to care in the clinic.

Conclusion

Hospital music therapists prioritize music therapy for patients who are socially isolated within the normative structures of the clinic. Attuned to the limits of clinical care, music therapists intervene in the normative aesthetics of clinical care by facilitating moments of connection through musical gift exchange. This back-and-forth exchange affords opportunities for building and sustaining relationships, processing complex feelings, experiences, memories, and situations, and for recognition otherwise. By co-composing practices of care in musical gift exchange, personhood beyond normative liberal subjectivity is valued and affirmed.

Through musical gift exchange, affective connections and attachments are forged and sustained, while subjectivities are distributed through relationality. This illustrates how care is co-composed by patients and practitioners, who enter relations through practices of exchange; music therapy offers opportunities reciprocal relationships of giving something and getting something in return. Musical gift exchange is not only about giving and receiving but also building relational spaces and moments of connection in care. The sensibility of musical gift exchange as moments of connection are sustained, enabled, and worked through in and despite sites of social abandonment.

Chapter 6. Conclusion

> Sometimes I see patients in the street. They'll say, "Hi man! Ten years ago, I was in the hospital, and you really helped me! It was so cool!" So that's nice when that happens.
>
> At the same time, I've lost my illusions about what's recovery, what's curing. I hate when people say, "Music cures, music heals." [*scoffs*]. If it helps in the moment, great, and if it helps you understand things so you can go onto the next chapter of your life, great. For me it's just a way to get in touch with people, I dunno, trying to enjoy life. I see people that come back, who are readmitted on the unit every year. It's okay. We're all going to end up in the same place eventually. After a few years I realized even the doctors with their pills, they can't figure it out. They're just doing their best.
>
> – Matthew

This dissertation traces the entanglements of music therapy and the clinic, arguing that music therapy is made into a health profession through its relation to the clinic while, at the same time, music therapists intervene in the clinic by composing care otherwise.

In chapter one I detail the history of North American music therapy's relationship with the clinic and argue that the clinic makes music therapists into clinicians and music therapy a mode of clinical care. Chapter two demonstrates that the professionalization of music therapy is grounded in university-level classical music training that is implicated in colonial histories and continues to be exclusionary. Through analysis of the field's foundation in classical music, I argue that music therapy becomes sensible as a care practice that is ostensibly neutral, objective, and universal in application—a practice commensurate with normative clinical aesthetics and therefore one that can be made sense of as clinical care. In chapter three, I follow music therapists into the clinic, where music therapists care for patients on the margins of biomedical systems and struggle to have their work taken seriously by other health professionals. I contend that making music therapy sensible as clinical care happens through processes of clinical

recognition that unfold through everyday interactions in the clinic, as music therapists strive to have their work sensed and made sense of by medical staff as patient care and not "just music."

Although music therapists strive for clinical recognition and want their work perceived as clinical care, I argue that the aesthetics of music therapy as a care practice exceed the normative aesthetics of clinical care—where detached concern and relieving pain and suffering is common sense. Chapters four and five exemplify how the care practices of music therapists work to compose clinical care otherwise, beyond what is typically sensible as clinical care. In chapter four, I argue that music therapists intervene in the clinical sensorium by opening up possibilities for affective-sensory experiences that thwart normative clinical *an*aesthetics. Instead of anaesthetizing pain and suffering, music therapists stage extra/ordinary encounters that support patients to feel their feelings and that instantiate the singularity of a life. Such encounters, I claim, facilitate perceiving, sensing, and feeling the clinical space otherwise. In chapter five, I contend that music therapists' care practices are characterized by musical gift exchange and grounded in reciprocity. In striving to create moments of connection for patients, I argue that music therapists improvise and co-compose care with patients through giving and receiving musical gifts. I consider how attachments to patients—as afterlives of moments of connection—linger and affect music therapists.

This dissertation documents the work of music therapists who—like the doctors Matthew references in this chapter's epigraph—are doing their best to care for patients in the clinic. But after years of working as a music therapist in the clinic, Matthew is disenchanted by the fantasies of progress that either music or medicine might "cure" or "heal" a person. Such normative progress narratives of clinical care can be understood as predicated on what Rancière

(2009) calls a conditional aesthetic belief, "as if" a return to a normal state of health through curing and healing disease is possible.

In this dissertation I have shown that the care practices of music therapists are both commensurate and incommensurate with the normative aesthetics of clinical care—their work as and in support of clinical care is predicated on this conditional as if, while they simultaneously stage moments of dissensus through practices of care that exceed linear progress narratives. Such moments of caring otherwise offer political potential for constructing new aesthetic beliefs about care and open up possibilities for redistributing how we sense and make sense of care in the clinic.

The Politics and Aesthetics of Care

As feminist science scholars have demonstrated, practices of care are fraught (Duclos and Criado 2020; M. Murphy 2015; de La Bellacasa 2011; de la Bellacasa 2012; de La Bellacasa 2017). Michelle Murphy (2015, 719) urges "caution against the conflation of care with affection, happiness, attachment, and positive feeling as political goods." She warns against interpreting care as a purely liberatory practice, reminding readers that care can enable and/or sustain hegemonic oppressive structures. In her analysis of the 1970s feminist self-help movement in Los Angeles, Murphy shows how the practices of care afforded by the movement were non-innocent—while a subversive clinical reconstitution of women's health, she argues that this movement also glossed over structural inequities and histories, specifically those of race, class, and colonialism. In her analysis of the feminist self-help movement as not purely liberatory, Murphy argues for an unsettling of what is often taken to be self-evident in care.

For managers and other hospital staff I spoke with, it was self-evident that music therapy is a positive—if non-essential—addition to clinical care, especially for patients for whom there

is “nothing else” medicine can do. Indeed, this dissertation describes many moments that imply that music therapy is a positive addition to the clinic. Yet, as medical anthropologists have documented, practices of care are entangled with regimes of governmentality as techniques of disciplinary and biopower (Stevenson 2014; Sufrin 2017). Like other clinical care practices, music therapy is conscripted into regimes of governmentality as a technique of disciplinary and biopower in institutions like hospitals and long-term care facilities. By soothing and calming people, music therapists make patients easier for medical staff to manage in the clinic. In bringing moments of “beauty,” “warmth,” and “connection,” they soften clinical spaces like hospitals and long-term care facilities for patients, families, staff, and broader publics, making them seem like gentler, kinder, and less violent institutions in which to live and die. And, in giving people something to look forward to, music therapy is entangled in the biopolitical project of extending and managing life in the clinic.

Moments of music therapy, while implicated in regimes of governmentality, simultaneously make life more liveable in the clinic. Liz’s “code xylophone” with Charles, described in chapter three, is exemplary of music therapy’s entanglements with discipline; while Liz’s music therapy intervention can be understood as a disciplinary technique—in calming Charles with music, Liz assisted the security guards who were forcibly fencing in Charles so that a nurse could administer an injection—it was also a moment that mitigated the violence of life in the clinic. Similarly, in chapter five, Mary’s efforts to support Mr. Crawford through finding music that “motivated” him when he was not feeling a desire to live can also be understood as a technique of biopower, as a mode of prolonging his life. At the same time, music therapy offers meaningful moments that can make life more liveable for people like Mr. Crawford.

Music therapists, while striving to ameliorate, support, and assimilate within the normative biomedical model of care, simultaneously work against the normative aesthetics of the clinic. In reconfiguring clinical aesthetics and the aesthetics of clinical care, the care practices of music therapists are reparative, as they imagine the clinic and clinical care otherwise. Their care practices can be identified as quasi-events (Povinelli 2016) that sustain endurance and are often facilitated through improvisation, offering moments of reprieve and maneuverability, as demonstrated in chapters four and five. Through musical exchange, practices of music therapy in the clinic affirm personhood by calling patients and practitioners into relational becomings.

The role of music therapists in making life more liveable within the clinic has been thrown into relief by the COVID-19 pandemic. In Canadian long-term care facilities, staff, residents, and families of residents have described music therapists as care practitioners who offer a "lifeline" during the pandemic (Merali 2020)—a "beacon of light, hope, and healing for seniors" (Connor 2021; see also Baird 2020; CBC News 2020; CBC Radio 2021; Krewen 2020; Riches 2020). Yet the suspension of visitors and therapeutic programs like music therapy during the pandemic highlights how conceptions of essential and standard care within institutional facilities are overdetermined by medical and physical care, including assistance with activities of daily living (i.e., eating, bathing, toileting). Notions of what constitutes good, standard, and essential care have significant implications for understanding the clinic and broader healthcare systems. Although implemented to mitigate COVID-19 infection risk, limitations on visitors as well as on therapeutic, recreation, and volunteer programs have also been detrimental to the quality of institutional care, amplifying social isolation and rates of depression (CIHI 2021; Flint, Bingham, and Iaboni 2020).

When I resumed my in-person fieldwork six months after the beginning of the COVID-19 pandemic, I found that music therapists' care practices—creatively reimagined in response to restrictions on indoor group activities and singing (M. Evans et al. Forthcoming)—mitigated social isolation for hospital patients in these otherwise alienating institutions by offering moments of connection and togetherness. The ongoing presence of music therapists helped to make persistent COVID-19 lockdowns bearable for hospital patients and long-term care residents, confined within these institutions and isolated from kinship networks. Music therapy affords hospital patients and long-term care residents—too often subject to social death through isolation and abandonment (Biehl 2013; 2004; Buch 2014; 2015; Goffman 1961; Patterson 1982; Povinelli 2011; J. S. Taylor 2008)—moments of connection, recognition otherwise, feelings of togetherness, and affirmations of personhood.

This dissertation contributes to a recent turn toward an anthropology of care (Buch 2014; 2015; 2018; Kleinman 2013; Kleinman and Geest 2009; Garcia 2010; Livingston 2012; Meyers 2013; Mol 2008; Mol, Moser, and Pols 2015; Stevenson 2014; J. S. Taylor 2008; 2017). Through ethnographic attention to the care practices of music therapists in the clinic, I use the aesthetics of care as an analytic to document the ways in which the composition of care is unstable, improvised, and relational—not something done *to* others but, as music therapists demonstrate, always *with* others. As I have shown, an attention to the politics of aesthetics attunes us to the complexities of care and the normative sensory regimes in which care is co-composed. The care practices of music therapists described in this dissertation intervene in the normative aesthetics of the clinic and the broader aesthetics and politics of care. Through practices of recognition otherwise, music therapists hold others in music and sound; we would all do well to listen.

Holding Music

Sitting in his office, Alex told me it had been a heavy week. One of his patients with whom he had a particularly close attachment had died on Monday. He had been present, providing music to support their final moments. Music therapy, he explained, is particularly apt at supporting "moments of transition" like dying. After his patient passed, Alex returned to his small, windowless office. A small desk, guitars, and percussion instruments filled the cramped space. "I turned off the lights and listened to music," he told me as he closed his eyes, leaned back in his desk chair, and folded his hands in his lap, demonstrating his movements from days prior. Listening to what he called "holding music" was what helped Alex "process." That day, he told me he had listened to Colin Hay's "I Just Don't Think I'll Get Over You" (1998). A slow, pop-rock ballad, the song's lyrical content focuses on loss. "*I still find pieces of your presence here, even after all these years,*" Hay sings in a low husky voice over acoustic guitar. While supporting his dying patient, Alex had sung and played songs meaningful to them—music that would hold them in their final moments. In processing his own feelings of grief, Alex plays recordings of songs that acted as holding music for himself and, in the act of listening and remembrance, continues to hold the patients he has lost.

References

Abbate, Carolyn. 2004. “Music—Drastic or Gnostic?” *Critical Inquiry* 30 (3): 505–36.

Adams, Vincanne. 2016. *Metrics: What Counts in Global Health*. Durham: Duke University Press.

AFMT. 2011. “About WFMT.” World Federation of Music Therapy. 2011. http://wfmt.info/wfmt-new-home/about-wfmt/.

Agawu, Victor Kofi. 2003. *Representing African Music: Postcolonial Notes, Queries, Positions*. New York: Routledge.

Aigen, Kenneth. 1998. *Paths of Development in Nordoff-Robbins Music Therapy*. Gilsum, NH: Barcelona.

———. 2005. *Being in Music: Foundations of Nordoff-Robbins Music Therapy*. Gilsum, NH: Barcelona Publishers.

———. 2007. “In Defense of Beauty: A Role for the Aesthetic in Music Therapy Theory: Part I: The Development of Aesthetic Theory in Music Therapy.” *Nordic Journal of Music Therapy* 16 (2): 112–28.

———. 2014. *The Study of Music Therapy: Current Issues and Concepts*. New York: Routledge.

Ainlay, George W. 1948. “The Place of Music in Military Hospitals.” In *Music and Medicine*, edited by Dorothy Schullian and Max Schoen, 322–51. New York: Henry Schuman, Inc.

Alper, Garth. 2007. “Towards the Acceptance of a Bachelor of Music Degree in Popular Music Studies.” *College Music Symposium* 47: 156–66.

Altenmüller, Eckart, and Gottfried Schlaug. 2015. “Apollo’s Gift.” In *Progress in Brain Research*, edited by Eckart Altenmüller, Stanley Finger, and François Boller, 217:237–52. Elsevier.

Amaral, Mayra Alves Soares do, Mansueto Gomes Neto, Jessica Gonçalves de Queiroz, Paulo Ricardo Saquete Martins-Filho, Micheli Bernardone Saquetto, and Vitor Oliveira Carvalho. 2016. “Effect of Music Therapy on Blood Pressure of Individuals with Hypertension: A Systematic Review and Meta-Analysis.” *International Journal of Cardiology* 214 (July): 461–64.

AMTA. 2005. “What Is Music Therapy?” American Music Therapy Association (AMTA). 2005. https://www.musictherapy.org/.

———. 2013. “Professional Competencies.” American Music Therapy Association. 2013. https://www.musictherapy.org/.

———. 2017a. “2017 AMTA Member Survey and Workforce Analysis.” American Music Therapy Association. https://www.musictherapy.org/assets/1/7/17WorkforceAnalysis.pdf.

———. 2017b. “Advanced Competencies.” American Music Therapy Association. 2017. https://www.musictherapy.org/.

———. 2017c. “National Roster Internship Guidelines.” American Music Therapy Association. 2017. https://www.musictherapy.org/.

———. 2020a. “The American Music Therapy Association 2020 Workforce Analysis.”

———. 2020b. “The Commission on the Education and Clinical Training of 21st Century Music Therapists.” American Music Therapy Association. 2020. https://www.musictherapy.org/.

———. 2021a. “FAQ’s.” American Music Therapy Association (AMTA). 2021. https://www.musictherapy.org/.

———. 2021b. “History of Music Therapy.” American Music Therapy Association (AMTA). 2021. https://www.musictherapy.org/.

———. 2021c. “Standards for Education and Clinical Training.” American Music Therapy Association (AMTA). 2021. https://www.musictherapy.org/.

———. 2021d. “What Is Music Therapy?” American Music Therapy Association (AMTA). 2021. https://www.musictherapy.org/.

———. 2021e. “What Music Therapy Is...and Is Not.” American Music Therapy Association (AMTA). 2021. https://www.musictherapy.org/.

———. 2021f. “What You Need to Be a Music Therapist.” American Music Therapy Association. 2021. https://www.musictherapy.org/.

Anderson, John M., E. Thayer Gaston, and Roy Underwood. 1953. “Education Committee Report.” In *Music Therapy 1952: Second Book of Proceedings of the National Association for Music Therapy*, edited by Esther Goetz Gilliland.

Ansdell, Gary. 1995. *Music for Life: Aspects of Creative Music Therapy with Adult Clients*. London: J. Kingsley Publishers.

Ansdell, Gary, and Tia DeNora. 2016. *Musical Pathways in Recovery: Community Music Therapy and Mental Wellbeing*. New York: Routledge.

Aronson, Naomi. 1982. “Nutrition as a Social Problem: A Case Study of Entrepreneurial Strategy in Science.” *Social Problems* 29 (5): 474–87.

Assagioli, Roberto. (1933) 1956. “Music as a Cause of Disease and Healing Agent.” Colorado State University Libraries: American Music Therapy Association Records.

Atiwannapat, Penchaya, Papan Thaipisuttikul, Patchawan Poopityastaporn, and Wanwisa Katekaew. 2016. “Active versus Receptive Group Music Therapy for Major Depressive Disorder—A Pilot Study.” *Complementary Therapies in Medicine* 26 (June): 141–45.

Austin, Diane. 2009. *The Theory and Practice of Vocal Psychotherapy: Songs of the Self*. London: Jessica Kingsley Publishers.

Backer, Jos De, and Julie Sutton. 2014. *The Music in Music Therapy: Psychodynamic Music Therapy in Europe: Clinical, Theoretical and Research Approaches*. London: Jessica Kingsley Publishers.

Baird, Corey. 2020. “Music Therapy Brings Joy to Isolated Seniors during COVID-19 Outbreak.” Toronto. June 4, 2020. https://toronto.ctvnews.ca/music-therapy-brings-joy-to-isolated-seniors-during-covid-19-outbreak-1.4970026.

Baker, Felicity, Jeanette Tamplin, and Jeanette Kennelly. 2006. *Music Therapy Methods in Neurorehabilitation: A Clinician’s Manual*. London: Jessica Kingsley Publishers.

BAMT. 2020. “BAMT Diversity Report.” British Association for Music Therapy. https://www.bamt.org/resources/diversity-report.

Beer, Laura E, and Kathrine Lee. 2017. “Music Therapy and Procedural Support: Defining and Identifying Areas of Practice.” *Music and Medicine* 9 (4): 261–67.

Bellacasa, María Puig de la. 2012. “‘Nothing Comes without Its World’: Thinking with Care.” *The Sociological Review* 60 (2): 197–216.

Benjamin, Walter. (1935) 2007. “The Work of Art in the Age of Mechanical Reproduction.” In *Illuminations*, edited by Hannah Arendt, translated by Harry Zohn. New York: Schocken Books.

Bergson, Henri. (1896) 1991. *Matter and Memory*. Translated by Nancy Margaret Paul and W. Scott Palmer. New York: Zone Books.

Berlant, Lauren. 2011. *Cruel Optimism*. Durham: Duke University Press.

Berne, Eric. 1949. “The Nature of Intuition.” *Psychiatric Quarterly* 23: 203–26.

Biehl, João. 2004. “Life of the Mind: The Interface of Psychopharmaceuticals, Domestic Economies, and Social Abandonment.” *American Ethnologist* 31 (4): 475–96.

———. 2013. *Vita: Life in a Zone of Social Abandonment*. Berkeley and Los Angeles: University of California Press.

Biehl, João, and Peter Locke. 2017. *Unfinished: The Anthropology of Becoming*. Durham: Duke University Press.

Biruk, Crystal. 2018. *Cooking Data: Culture and Politics in an African Research World*. Durham: Duke University Press.

Black, SarahRose. 2020. "That's How the Light Gets in: Music and Assisted Dying." *Journal of Psychosocial Oncology* 38 (1): 1–3.

Bloechl, Olivia. 2018. "The Vulnerability of the Ear, or Listening with Levinas." *Cahiers d'études Lévinassiennes* 16: 122–35.

BMTN. 2021. "The Black Music Therapy Network, Inc." Black Music Therapy Network. 2021. https://www.blackmtnetwork.org.

Bonny, Helen L. 1989. "Sound as Symbol: Guided Imagery and Music in Clinical Practice." *Music Therapy Perspectives* 6 (1): 7–10.

———. 2002. *Music & Consciousness: The Evolution of Guided Imagery and Music*. Gilsum, NH: Barcelona Publishers.

Boothby, Dawn Michele, and Steven J. Robbins. 2011. "The Effects of Music Listening and Art Production on Negative Mood: A Randomized, Controlled Trial." *The Arts in Psychotherapy* 38 (3): 204–8.

Born, Georgina. 2005. "On Musical Mediation: Ontology, Technology and Creativity." *Twentieth-Century Music* 2 (1): 7–36.

———. 2010. "For a Relational Musicology: Music and Interdisciplinarity, Beyond the Practice Turn: The 2007 Dent Medal Address." *Journal of the Royal Musical Association* 135 (2): 205–43.

Born, Georgina, and David Hesmondhalgh, eds. 2000. *Western Music and Its Others: Difference, Representation, and Appropriation in Music*. Berkeley: University of California Press.

Bourdieu, Pierre. 1977. *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.

———. 1984. *Distinction: A Social Critique of the Judgement of Taste*. Cambridge, Mass: Harvard University Press.

Bowling, Ann M., Rhonda Cooper, Ashley Kellish, Laura Kubin, and Tedra Smith. 2018. "No Evidence to Support Number of Clinical Hours Necessary for Nursing Competency." *Journal of Pediatric Nursing* 39 (March): 27–36.

Boyer, Dominic. 2008. "Thinking through the Anthropology of Experts." *Anthropology in Action* 15 (2): 38–46.

Bradley Palmer, Jaclyn, Deforia Lane, Diane Mayo, Mark Schluchter, and Rosemary Leeming. 2015. “Effects of Music Therapy on Anesthesia Requirements and Anxiety in Women Undergoing Ambulatory Breast Surgery for Cancer Diagnosis and Treatment: A Randomized Controlled Trial.” *Journal of Clinical Oncology* 33 (28): 3162–68.

Bradt, Joke, Wendy L. Magee, Cheryl Dileo, Barbara L. Wheeler, and Emer McGilloway. 2010. “Music Therapy for Acquired Brain Injury.” In *Cochrane Database of Systematic Reviews*, edited by The Cochrane Collaboration, CD006787.pub2. Chichester, UK: John Wiley & Sons, Ltd. http://doi.wiley.com/10.1002/14651858.CD006787.pub2.

Brett, Philip, Elizabeth Wood, and Gary C. Thomas, eds. 2006. *Queering the Pitch: The New Gay and Lesbian Musicology*. 2nd ed. New York: Routledge.

Briggs, Charles L. 2016. “The Meaning of Nonsense, the Poetics of Embodiment, and the Production of Power in Warao Healing.” In *The Performance of Healing*, edited by Carol Laderman and Marina Roseman, 185–232. New York and London: Routledge.

Brooks, Daphne A. 2006. *Bodies in Dissent: Spectacular Performances of Race and Freedom, 1850–1910*. Durham: Duke University Press.

Bruscia, Kenneth E. 1998. *The Dynamics of Music Psychotherapy*. Gilsum, NH: Barcelona.

———. (1989) 2014. *Defining Music Therapy*. 3rd ed. Gilsum, NH: Barcelona.

Buch, Elana D. 2014. “Troubling Gifts of Care: Vulnerable Persons and Threatening Exchanges in Chicago’s Home Care Industry.” *Medical Anthropology Quarterly* 28 (4): 599–615.

———. 2015. “Anthropology of Aging and Care.” *Annual Review of Anthropology* 44 (1): 277–93.

———. 2018. *Inequalities of Aging: Paradoxes of Independence in American Home Care*. New York: New York University Press.

Buck-Morss, Susan. 1992. “Aesthetics and Anaesthetics: Walter Benjamin’s Artwork Essay Reconsidered.” *October* 62: 3.

Bull, Anna. 2019. *Class, Control, and Classical Music*. Oxford: Oxford University Press.

Busch-Vishniac, Ilene J., James E. West, Colin Barnhill, Tyrone Hunter, Douglas Orellana, and Ram Chivukula. 2005. “Noise Levels in Johns Hopkins Hospital.” *The Journal of the Acoustical Society of America* 118 (6): 3629–45.

Butler, Judith. (1990) 1999. *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge.

———. (1993) 2011. *Bodies That Matter: On the Discursive Limits of Sex*. New York: Routledge.

Campbell, Don. 1997. *The Mozart Effect: Tapping the Power of Music to Heal the Body, Strengthen the Mind, and Unlock the Creative Spirit.* New York: Avon Books.

CAMT. 2016a. "Annual Report 2015-16." Canadian Association of Music Therapists. https://www.musictherapy.ca/wp-content/uploads/2016/07/Annual-Report-2015-2016-FINAL-EN.pdf.

———. 2016b. "Recommended Competency Areas." Canadian Association of Music Therapists. 2016. https://www.musictherapy.ca/wp-content/uploads/2016/04/Competencies.pdf.

———. 2017. "Annual Report 2016-17." Canadian Association of Music Therapists. https://www.musictherapy.ca/wp-content/uploads/2018/05/Annual-Report-2016-2017-Final.pdf.

———. 2018. "CAMT Internship Guidelines." Canadian Association of Music Therapists (CAMT).

———. 2020a. "About Music Therapy." Canadian Association of Music Therapists. 2020. https://www.musictherapy.ca/about-camt-music-therapy/about-music-therapy/.

———. 2020b. "Annual Report 2019-2020." Canadian Association of Music Therapists. https://www.musictherapy.ca/wp-content/uploads/2020/08/CAMT-ANNUAL-REPORT-2019-2020-final-3.pdf.

———. 2021a. "About CAMT." Canadian Association of Music Therapists (CAMT). 2021. https://www.musictherapy.ca/about-camt-music-therapy/about-camt/.

———. 2021b. "Canadian Music Therapy Education Programs." Canadian Association of Music Therapists. 2021. https://www.musictherapy.ca/about-camt-music-therapy/canadian-music-therapy-education-programs/.

———. 2021c. "MTA Credentials & Members." Canadian Association of Music Therapists. 2021. https://www.musictherapy.ca/about-camt-music-therapy/mta-credentials-members/.

Canga, Bernardo, Ronit Azoulay, Jonathan Raskin, and Joanne Loewy. 2015. "AIR: Advances in Respiration – Music Therapy in the Treatment of Chronic Pulmonary Disease." *Respiratory Medicine* 109 (12): 1532–39.

Canga, Bernardo, Cho Long Hahm, David Lucido, Michael L. Grossbard, and Joanne V. Loewy. 2012. "Environmental Music Therapy: A Pilot Study on the Effects of Music Therapy in a Chemotherapy Infusion Suite." *Music and Medicine* 4 (4): 221–30.

Canguilhem, Georges. (1943) 1998. *On the Normal and the Pathological*. Translated by Carolyn R. Fawcett and Robert S. Cohen. New York: Zone Books.

Cann, Hayley Frances, and Priya Shah. 2020. “Resources for Everyday Anti-Oppressive Practices.” https://mtahayley.com/blogs/view-all/anti-oppressive-practice-resources.

Carr, Catherine, Patricia d’Ardenne, Ann Sloboda, Carleen Scott, Duolao Wang, and Stefan Priebe. 2012. “Group Music Therapy for Patients with Persistent Post-Traumatic Stress Disorder - an Exploratory Randomized Controlled Trial with Mixed Methods Evaluation: Group Music Therapy for Post-Traumatic Stress Disorder.” *Psychology and Psychotherapy: Theory, Research and Practice* 85 (2): 179–202.

Carr, E. Summerson. 2010. “Enactments of Expertise.” *Annual Review of Anthropology* 39 (1): 17–32.

———. 2011. *Scripting Addiction: The Politics of Therapeutic Talk and American Sobriety*. Princeton: Princeton University Press.

CBC News. 2020. “Surrey Elders’ Christmas Music Album a ‘bright Spot’ during a Difficult Holiday Season.” CBC News. December 19, 2020. https://www.cbc.ca/news/canada/british-columbia/pandemic-party-album-kinsmen-lodge-1.5845697.

CBC Radio. 2021. “Pioneer Manor in Sudbury Is Using a Music Program to Help Reduce Isolation and Loneliness.” *Morning North with Markus Schwabe*. https://www.cbc.ca/listen/live-radio/1-41-morning-north/clip/15845408-pioneer-manor-sudbury-using-music-program-help-reduce.

CBMT. 2021. “Home.” Certification Board for Music Therapists. 2021. https://www.cbmt.org/home/.

Cepeda, MS, DB Carr, J Lau, and H Alvarez. 2006. “Music for Pain Relief.” *Cochrane Database of Systematic Reviews*, no. 2. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004843.pub2/references.

Chan, Moon Fai. 2007. “Effects of Music on Patients Undergoing a C-Clamp Procedure after Percutaneous Coronary Interventions: A Randomized Controlled Trial.” *Heart & Lung* 36 (6): 431–39.

Chan, Moon Fai, Zi Yang Wong, and N.V. Thayala. 2011. “The Effectiveness of Music Listening in Reducing Depressive Symptoms in Adults: A Systematic Review.” *Complementary Therapies in Medicine* 19 (6): 332–48.

Chang, Mei-Yueh, Chung-Hey Chen, and Kuo-Feng Huang. 2008. “Effects of Music Therapy on Psychological Health of Women during Pregnancy.” *Journal of Clinical Nursing* 17 (19): 2580–87.

Choiniere, Denise B. 2010. “The Effects of Hospital Noise.” *Nursing Administration Quarterly* 34 (4): 327–33.

CIHI. 2021. “The Impact of COVID-19 on Long-Term Care in Canada: Focus on the First 6 Months.” Ottawa, ON: Canadian Institute for Health Information.

Cimini, Amy, and Jairo Moreno. 2016. “Inexhaustible Sound and Fiduciary Aurality.” *Boundary 2* 43 (1): 5–41.

Citron, Marcia J. 1993. *Gender and the Musical Canon*. Cambridge: Cambridge University Press.

CJMT. 2021. “About the Journal.” Canadian Journal of Music Therapy. 2021. https://www.cjmt-rcm.musictherapy.ca/index.php/cjmt-rcm/about.

Classen, Constance. 1997. “Foundations for an Anthropology of the Senses.” *International Social Science Journal* 49 (153): 401–12.

Cloonan, Martin, and Bruce Johnson. 2002. “Killing Me Softly with His Song: An Initial Investigation into the Use of Popular Music as a Tool of Oppression.” *Popular Music* 21 (1): 27–39.

CNO. 2021. “RN Applicants: Evidence of Practice.” College of Nurses of Ontario. 2021. https://www.cno.org/en/become-a-nurse/registration-requirements/evidence-of-practice/evidence-of-practice-rns-and-rpns/.

Cohen, Lawrence. 2020. “The Culling: Pandemic, Gerocide, Generational Affect.” *Medical Anthropology Quarterly* 34 (4): 542–60.

Cole, Linda C., and Geri LoBiondo-Wood. 2014. “Music as an Adjuvant Therapy in Control of Pain and Symptoms in Hospitalized Adults: A Systematic Review.” *Pain Management Nursing* 15 (1): 406–25.

Collins, H.M., and Robert Evans. 2002. “The Third Wave of Science Studies: Studies of Expertise and Experience.” *Social Studies of Science* 32 (2): 235–96.

Coltrane, Scott. 2000. “Research on Household Labor: Modeling and Measuring the Social Embeddedness of Routine Family Work.” *Journal of Marriage and Family* 62 (4): 1208–33.

Colwell, Cynthia M., Robin Edwards, Emily Hernandez, and Kristine Brees. 2013. “Impact of Music Therapy Interventions (Listening, Composition, Orff-Based) on the Physiological and Psychosocial Behaviors of Hospitalized Children: A Feasibility Study.” *Journal of Pediatric Nursing* 28 (3): 249–57.

Connor, Kevin. 2021. “Helping Seniors Endure the Pandemic with Music.” Toronto Sun. July 11, 2021. https://torontosun.com/news/local-news/helping-seniors-endure-the-pandemic-with-music.

Cook, Nicholas. 2000. *Music: A Very Short Introduction*. Oxford: Oxford University Press.

Cooke, Marie, Wendy Moyle, David Shum, Scott Harrison, and Jenny Murfield. 2010. "A Randomized Controlled Trial Exploring the Effect of Music on Quality of Life and Depression in Older People with Dementia." *Journal of Health Psychology* 15 (5): 765–76.

Costa, Andrea, Luigi Maria Montalbano, Ambrogio Orlando, Carlo Ingoglia, Cristina Linea, Marco Giunta, Andrea Mancuso, et al. 2010. "Music for Colonoscopy: A Single-Blind Randomized Controlled Trial." *Digestive and Liver Disease* 42 (12): 871–76.

Coulthard, Glen Sean. 2014. *Red Skin, White Masks: Rejecting the Colonial Politics of Recognition*. Minneapolis: University of Minnesota Press.

Crawford, Robert. 2006. "Health as a Meaningful Social Practice." *Health* 10 (4): 401–20.

CTV News. 2017. "Magic of Music: 102-Year-Old's Memory Triggered by Piano." Youtube. 2017. https://www.youtube.com/watch?v=7Zwrta7SjtM&ab_channel=CTVNews.

Cusick, Suzanne G. 2008. "'You Are in a Place That Is out of the World. . .': Music in the Detention Camps of the 'Global War on Terror.'" *Journal of the Society for American Music* 2 (1): 1–26.

———. 2020. "Music as Torture / Music as Weapon." In *The Auditory Culture Reader*, edited by Michael Bull and Les Back, 1st ed., 379–91. New York: Routledge.

Cvetkovich, Ann. 2003. *An Archive of Feelings: Trauma, Sexuality, and Lesbian Public Cultures*. Durham: Duke University Press.

———. 2012. *Depression: A Public Feeling*. Durham, NC: Duke University Press.

Das, Veena. 2007. *Life and Words: Violence and the Descent Into the Ordinary*. Berkeley: University of California Press.

Daughtry, J. Martin. 2015. *Listening to War: Sound, Music, Trauma, and Survival in Wartime Iraq*. Oxford: Oxford University Press.

Davis, William. 1997. "Music Therapy Practice in New York City: A Report From a Panel of Experts, March 17, 1937." *Journal of Music Therapy* 34 (1): 68–81.

Davis, William B. 1987. "Music Therapy in 19th Century America." *Journal of Music Therapy* 24 (2): 76–87.

Davis, William, and Susan Hadley. 2015. "A History of Music Therapy." In *Music Therapy Handbook*, edited by Barbara L. Wheeler, 17–28. New York: Guilford Publications.

Deleuze, Gilles, and Félix Guattari. 1987. *A Thousand Plateaus: Capitalism and Schizophrenia*. Translated by Brian Massumi. Minneapolis and London: University of Minnesota Press.

DeLoach Walworth, Darcy. 2005. “Procedural-Support Music Therapy in the Healthcare Setting: A Cost–Effectiveness Analysis.” *Journal of Pediatric Nursing* 20 (4): 276–84.

DeNora, Tia, and Gary Ansdell. 2014. “What Can’t Music Do?” *Psychology of Well-Being* 4 (1): 23.

———. 2017. “Music in Action: Tinkering, Testing and Tracing over Time.” *Qualitative Research* 17 (2): 231–45.

Desjarlais, Robert R. 1992. *Body and Emotion: The Aesthetics of Illness and Healing in the Nepal Himalayas*. Philadelphia: University of Pennsylvania Press.

Donner, Lorraine Long, Edwin E Kopytko, Sandra Day McFolling, Diane Cronin-Stubbs, Susan G Szczesny, Kate Mayton, and Sandra Kawczynski Pasch. 1990. “Increasing Psychiatric Inpatients’ Community Adjustment Through Therapeutic Passes.” *Archives of Psychiatric Nursing* 4 (2): 93–98.

Duclos, Vincent, and Tomás Sánchez Criado. 2020. “Care in Trouble: Ecologies of Support from Below and Beyond.” *Medical Anthropology Quarterly* 34 (2): 153–73.

Dumit, Joseph. 2012. *Drugs for Life: How Pharmaceutical Companies Define Our Health*. Durham: Duke University Press.

Edwards, Jane. 2011. “A Music and Health Perspective on Music’s Perceived ‘Goodness.’” *Nordic Journal of Music Therapy* 20 (1): 90–101.

Eidsheim, Nina Sun. 2011. “Marian Anderson and ‘Sonic Blackness’ in American Opera.” *American Quarterly* 63 (3): 641–71.

———. 2012. “Voice as Action: Towards a Model for Analyzing the Dynamic Construction of Racialized Voice.” *Current Musicology* 93 (1): 7–31.

———. 2015. *Sensing Sound: Singing and Listening as Vibrational Practice*. Durham: Duke University Press.

———. 2019. *The Race of Sound: Listening, Timbre, and Vocality in African American Music*. Durham: Duke University Press.

Engwall, Margaretha, and Gill Sörensen Duppils. 2009. “Music as a Nursing Intervention for Postoperative Pain: A Systematic Review.” *Journal of PeriAnesthesia Nursing* 24 (6): 370–83.

Epstein, Steven. 1995. “The Construction of Lay Expertise: AIDS Activism and the Forging of Credibility in the Reform of Clinical Trials.” *Science, Technology & Human Values* 20 (4): 408–37.

Erskine, Peter. 2016. “In the Pocket: How a Drum Set Player Grooves.” In *The Cambridge Companion to Percussion*, edited by Russell Hartenberger, 187–200. Cambridge: Cambridge University Press.

Evans, David. 2002. “The Effectiveness of Music as an Intervention for Hospital Patients: A Systematic Review.” *Journal of Advanced Nursing* 37 (1): 8–18.

Evans, Meredith, Priya Shah, Chrissy Pearson, Dany Bouchard, and Tom Curry. Forthcoming. “Providing Music Therapy on Inpatient Mental Health Units in Canada: Reflections on Practice During the COVID-19 Pandemic.” *Canadian Journal of Music Therapy*.

Eyal, Gil. 2013. “For a Sociology of Expertise: The Social Origins of the Autism Epidemic.” *American Journal of Sociology* 118 (4): 863–907.

Falk, Stephen A., and Nancy F. Woods. 1973. “Hospital Noise — Levels and Potential Health Hazards.” *New England Journal of Medicine*, no. 289: 774–81.

Fanon, Frantz. 2007. *A Dying Colonialism*. Translated by Haakon Chevalier. New York: Grove Press.

———. (1952) 2008. *Black Skin, White Masks*. New York: Grove Press.

Fassin, Didier. 2008. “The Elementary Forms of Care.” *Social Science & Medicine* 67 (2): 262–70.

Feld, Steve, and Donald Brenneis. 2004. “Doing Anthropology in Sound.” *American Ethnologist* 31 (4): 461–74.

Feld, Steven. 1982. *Sound and Sentiment: Birds, Weeping, Poetics, and Song in Kaluli Expression*. Philadelphia: University of Pennsylvania Press.

Feldman, Gregory. 2011. “If Ethnography Is More than Participant-Observation, Then Relations Are More than Connections: The Case for Nonlocal Ethnography in a World of Apparatuses.” *Anthropological Theory* 11 (4): 375–95.

Flint, Alastair J., Kathleen S. Bingham, and Andrea Iaboni. 2020. “Effect of COVID-19 on the Mental Health Care of Older People in Canada.” *International Psychogeriatrics* 32 (10): 1113–16.

Foucault, Michel. 1978. *The History of Sexuality: An Introduction*. Translated by Robert Hurley. New York: Pantheon Books.

———. 1986. *The History of Sexuality: The Care of the Self*. Translated by Robert Hurley. New York: Pantheon Books.

———. 2003a. *Abnormal: Lectures at the Collège de France 1974 - 1975*. Edited by Valerio Marchetti and Antonella Salomoni. Translated by Graham Burchell. London: Verso.

———. 2003b. *Society Must Be Defended: Lectures at the Collège de France, 1975-76*. Edited by Mauro Bertani, Alessandro Fontana, François Ewald, and David Macey. Translated by David Macey. 1st ed. New York: Picador.

———. 2005. *The Hermeneutics of the Subject: Lectures at the Collège de France 1981–82*. Edited by Frédéric Gros, François Ewald, and Alessandro Fontana. New York: Palgrave Macmillan.

———. 2006. *Psychiatric Power: Lectures at the Collège de France, 1973–74*. New York: Palgrave MacMillan.

———. (1963) 2012. *The Birth of the Clinic*. New York: Routledge.

Fox, Renee C. 1988. *Essays in Medical Sociology: Journeys Into the Field*. Transaction Books.

Fraser, Nancy, and Axel Honneth. 2003. *Redistribution or Recognition? A Political-Philosophical Exchange*. London; New York: Verso.

Friedson. 2019. "The Music Box: Songs of Futility in a Time of Torture." *Ethnomusicology* 63 (2): 222.

Friedson, Steven M. 1996. *Dancing Prophets: Musical Experience in Tumbuka Healing*. Chicago: University of Chicago Press.

Garcia, Angela. 2010. *The Pastoral Clinic: Addiction and Dispossession Along the Rio Grande*. Berkeley: University of California Press.

Gaston, E. Thayer. 1948. "Conference for Hospital Musicians." Lawrence, Kansas: Department of Music Education, University of Kansas.

Geertz, Clifford. (1973) 2000. *The Interpretation of Cultures*. New York: Basic Books.

Geest, Sjaak van der, and Kaja Finkler. 2004. "Hospital Ethnography: Introduction." *Social Science & Medicine* 59 (10): 1995–2001.

Geest, Sjaak van der, and Susan Reynolds Whyte. 1989. "The Charm of Medicines: Metaphors and Metonyms." *Medical Anthropology Quarterly* 3 (4): 345–67.

Geretsegger, Monika, Cochavit Elefant, Karin A Mössler, and Christian Gold. 2014. "Music Therapy for People with Autism Spectrum Disorder." Edited by Cochrane Developmental, Psychosocial and Learning Problems Group. *Cochrane Database of Systematic Reviews*, June. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004381.pub3/full.

Ghetti, C. M. 2013. "Effect of Music Therapy with Emotional-Approach Coping on Preprocedural Anxiety in Cardiac Catheterization: A Randomized Controlled Trial." *Journal of Music Therapy* 50 (2): 93–122.

Ghetti, Claire M. 2012. “Music Therapy as Procedural Support for Invasive Medical Procedures: Toward the Development of Music Therapy Theory.” *Nordic Journal of Music Therapy* 21 (1): 3–35.

Gibson, James. 1979. *The Ecological Approach to Visual Perception*. Boston, MA: Houghton Mifflin.

Gilliland, Esther Goetz. 1951. “Present Status and Needs in Music Therapy.” *The American Music Teacher* 1 (3).

———, ed. 1952. *Music Therapy 1951: Book of Proceedings of the National Association for Music Therapy*. Chicago, Illinois: National Association for Music Therapy.

Goffman, Erving. 1961. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York: Anchor Books.

Gold, Christian, Hans Petter Solli, Viggo Krüger, and Stein Atle Lie. 2009. “Dose–Response Relationship in Music Therapy for People with Serious Mental Disorders: Systematic Review and Meta-Analysis.” *Clinical Psychology Review* 29 (3): 193–207.

Good, Byron. 1994. *Medicine, Rationality, and Experience: An Anthropological Perspective*. Cambridge: Cambridge University Press.

Gooding, Lori F, and Diane G Langston. 2019. “Music Therapy With Military Populations: A Scoping Review.” *Journal of Music Therapy* 56 (4): 315–47.

Goodman, Steve. 2010. *Sonic Warfare: Sound, Affect, and the Ecology of Fear*. Cambridge, Mass: MIT Press.

Gouk, Penelope, ed. 2000. *Musical Healing in Cultural Contexts*. Aldershot; Brookfield, USA: Ashgate.

Green, Ray. 1948. “Hospitals Employing Full-Time Music Specialists.” *Hospital Music Newsletter* 1 (1): 1–4.

———, ed. 1950. “National Association for Music Therapy.” *Hospital Music Newsletter* 3 (1): 1–2.

Guétin, S., E. Coudeyre, M.C. Picot, P. Ginies, B. Graber-Duvernay, D. Ratsimba, W. Vanbiervliet, J.P. Blayac, and C. Hérisson. 2005. “Intérêt de la musicothérapie dans la prise en charge de la lombalgie chronique en milieu hospitalier (Étude contrôlée, randomisée sur 65 patients).” *Annales de Réadaptation et de Médecine Physique* 48 (5): 217–24.

Gutgsell, Kathy Jo, Mark Schluchter, Seunghee Margevicius, Peter A. DeGolia, Beth McLaughlin, Mariel Harris, Janice Mecklenburg, and Clareen Wiencek. 2013. “Music Therapy Reduces Pain in Palliative Care Patients: A Randomized Controlled Trial.” *Journal of Pain and Symptom Management* 45 (5): 822–31.

Hadley, Susan. 2003. *Psychodynamic Music Therapy: Case Studies*. Gilsum, NH: Barcelona.

Hall, Stuart. 1980. “Cultural Studies: Two Paradigms.” *Media, Culture & Society* 2 (1): 57–72.

Hamilton, Samuel W., and Willem van de Wall. 1944. “The Use of Music in Hospitals for Mental and Nervous Diseases.” New York: National Music Council.

Hanser, Suzanne B. 2015. “Cognitive-Behavioral Approaches.” In *Music Therapy Handbook*, edited by Barbara L. Wheeler. New York, NY: Guilford Publications.

Haraway, Donna. 1988. “Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective.” *Feminist Studies* 14 (3): 575.

Hardt, Michael. 1999. “Affective Labor.” *Boundary 2* 26 (2): 89–100.

Hayes, Ann, Martha Buffum, Elaine Lanier, Elaine Rodahl, and Colleen Sasso. 2003. “A Music Intervention to Reduce Anxiety Prior to Gastrointestinal Procedures:” *Gastroenterology Nursing* 26 (4): 145–49.

Hegel, Georg Wilhelm Fredrich. (1807) 2018. *The Phenomenology of Spirit*. Edited by Terry Pinkard and Michael Baur. 1st ed. Cambridge: Cambridge University Press.

Helmreich, Stefan. 2007. “An Anthropologist Underwater: Immersive Soundscapes, Submarine Cyborgs, and Transductive Ethnography.” *American Ethnologist* 34 (4): 621–41.

———. 2009. *Alien Ocean: Anthropological Voyages in Microbial Seas*. Berkeley: University of California Press.

Hesser, B. 1992. “AAMT, Coming of Age.” *Music Therapy* 11 (1): 13–27.

Hiller, James. 2009. “Use Of and Instruction In Clinical Improvisation.” *Music Therapy Perspectives* 27 (1): 25–32.

Hisama, Ellie M. 2006. *Gendering Musical Modernism: The Music of Ruth Crawford, Marion Bauer, and Miriam Gideon*. Cambridge: Cambridge University Press.

Hjørnevik, Kjetil, and Leif Waage. 2019. “The Prison as a Therapeutic Music Scene: Exploring Musical Identities in Music Therapy and Everyday Life in a Prison Setting.” *Punishment & Society* 21 (4): 454–72.

Hochschild, Arlie Russell. (1983) 2012. *The Managed Heart: Commercialization of Human Feeling*. Berkeley: University of California Press.

Hochschild, Arlie Russell, and Anne Machung. 2012. *The Second Shift: Working Families and the Revolution at Home*. Penguin.

Holmes, Jessica A. 2017. “Expert Listening beyond the Limits of Hearing: Music and Deafness.” *Journal of the American Musicological Society* 70 (1): 171–220.

Horden, Peregrine, ed. 2000. *Music as Medicine: The History of Music Therapy since Antiquity*. Aldershot; Brookfield, USA: Ashgate.

Howes, David. 2003. *Sensual Relations: Engaging the Senses in Culture and Social Theory*. Ann Arbor: University of Michigan Press.

Hsu, Kuo-Cheng, Li Fen Chen, and Pi Hsia Hsiep. 2016. "Effect of Music Intervention on Burn Patients' Pain and Anxiety during Dressing Changes." *Burns* 42 (8): 1789–96.

Huang, Shih-Tzu, Marion Good, and Jaclene A. Zauszniewski. 2010. "The Effectiveness of Music in Relieving Pain in Cancer Patients: A Randomized Controlled Trial." *International Journal of Nursing Studies* 47 (11): 1354–62.

I'Etoile, Shannon de. 2000. "The History of the Undergraduate Curriculum in Music Therapy." *Journal of Music Therapy* 1: 51–71.

Ingold, Tim. 2007. *Lines: A Brief History*. London: Routledge.

Jain, S. Lochlann. 2013. *Malignant: How Cancer Becomes Us*. Berkeley: University of California Press.

JMT. 2021. "About the Journal." The Journal of Music Therapy. 2021. http://academic.oup.com/jmt/pages/About.

Jobson, Ryan Cecil. 2020. "The Case for Letting Anthropology Burn: Sociocultural Anthropology in 2019." *American Anthropologist* 122 (2): 259–71.

Johnson, Julian. 2011. *Who Needs Classical Music?: Cultural Choice and Musical Value*. Oxford: Oxford University Press.

Kant, Immanuel. (1790) 2007. *Critique of Judgement*. Edited by Nicholas Walker. Oxford; New York: Oxford University Press.

Kapferer, Bruce. 1983. *A Celebration of Demons: Exorcism and the Aesthetics of Healing in Sri Lanka*. 1st Midland Book ed. Bloomington: Indiana University Press.

Kaufman, Sharon R. 2015. *Ordinary Medicine: Extraordinary Treatments, Longer Lives, and Where to Draw the Line*. Durham: Duke University Press.

Kenny, Carolyn. 1982. *The Mythic Artery: The Magic of Music Therapy*. Atascadero, CA: Ridgeview Publishing Company.

———. 2006. *Music & Life in the Field of Play: An Anthology*. Gilsum, NH: Barcelona Publishers.

Kittay, Eva Feder. 2013. *Love's Labor: Essays on Women, Equality and Dependency*. New York: Routledge.

Klassen, Jeffrey A, Yuanyuan Liang, Lisa Tjosvold, Terry P Klassen, and Lisa Hartling. 2008. "Music for Pain and Anxiety in Children Undergoing Medical Procedures: A Systematic Review of Randomized Controlled Trials." *Ambulatory Pediatrics* 8: 117–28.

Kleinman, Arthur. 1988. *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic books.

———. 2013. "From Illness as Culture to Caregiving as Moral Experience." *New England Journal of Medicine* 368 (15): 1376–77.

Kleinman, Arthur, and Sjaak van der Geest. 2009. "'Care' in Health Care. Remaking the Moral World of Medicine." *Medische Antropologie* 21 (1): 159–68.

Koen, Benjamin, Gregory Barz, and Kenneth Brummel-Smith. 2008. "Introduction: Confluence of Consciousness in Music, Medicine, and Culture." In *The Oxford Handbook of Medical Ethnomusicology*, edited by Benjamin Koen, Jacqueline Lloyd, Gregory Barz, and Karen Brummel-Smith, 2–17. Oxford: Oxford University Press.

Korenjak, Andrea. 2018. "From Moral Treatment to Modern Music Therapy: On the History of Music Therapy in Vienna (c. 1820–1960)." *Nordic Journal of Music Therapy* 27 (5): 341–59.

Kramer, Lawrence. 1990. *Music as Cultural Practice, 1800-1900*. Berkeley: University of California Press.

———. 1996. *Classical Music and Postmodern Knowledge*. Berkeley: University of California Press.

———. 2007. *Why Classical Music Still Matters*. Berkeley: University of California Press.

Krewen, Nick. 2020. "Music Therapist's Siren Song Draws Seniors and Others out of Their Shell." The Star. June 2, 2020. https://www.thestar.com/entertainment/music/2020/06/01/music-therapists-siren-song-draws-seniors-and-others-out-of-their-shell.html.

Kunikullaya, Kirthana Ubrangala, Jaisri Goturu, Vijayadas Muradi, Preethi Avinash Hukkeri, Radhika Kunnavil, Venkatesh Doreswamy, Vadagenahalli S. Prakash, and Nandagudi Srinivasa Murthy. 2015. "Music versus Lifestyle on the Autonomic Nervous System of Prehypertensives and Hypertensives—a Randomized Control Trial." *Complementary Therapies in Medicine* 23 (5): 733–40.

La Bellacasa, Maria Puig de. 2011. "Matters of Care in Technoscience: Assembling Neglected Things." *Social Studies of Science* 41 (1): 85–106.

———. 2017. *Matters of Care: Speculative Ethics in More than Human Worlds*. Minneapolis: University of Minnesota Press.

Lai, Hui-Ling, Chia-Jung Chen, Tai-Chu Peng, Fwu-Mei Chang, Mei-Lin Hsieh, Hsiao-Yen Huang, and Shu-Chuan Chang. 2006. "Randomized Controlled Trial of Music during Kangaroo Care on Maternal State Anxiety and Preterm Infants' Responses." *International Journal of Nursing Studies* 43 (2): 139–46.

Lane, Deforia. 2006. "Music Therapy: A Gift beyond Measure." *Oncology Nursing Forum* 33 (4): 863–67.

Latour, Bruno, and Steve Woolgar. 1986. *Laboratory Life: The Construction of Scientific Facts*. Princeton, N.J: Princeton University Press.

Lee, Colin. 2003. *The Architecture of Aesthetic Music Therapy*. Gilsum, NH: Barcelona Publishers.

———. (1996) 2016. *Music at the Edge: The Music Therapy Experiences of a Musician with AIDS*. New York: Routledge.

Lee, Danny W.H., Kin-Wing Chan, Chi-Ming Poon, Chi-Wah Ko, Kam-Hon Chan, Kwok-Sang Sin, Tak-Suen Sze, and Angus C.W. Chan. 2002. "Relaxation Music Decreases the Dose of Patient-Controlled Sedation during Colonoscopy: A Prospective Randomized Controlled Trial." *Gastrointestinal Endoscopy* 55 (1): 33–36.

Levine, Lawrence W. 1988. *Highbrow/Lowbrow: The Emergence of Cultural Hierarchy in America*. Cambridge, Mass: Harvard University Press.

Lewis, George E. 1996. "Improvised Music after 1950: Afrological and Eurological Perspectives." *Black Music Research Journal* 16 (1): 91–122.

———. 2004. "Gittin' To Know Y'all: Improvised Music, Interculturalism, and the Racial Imagination" 1 (1): 33.

Li, Xiao-Mei, Hong Yan, Kai-Na Zhou, Shao-Nong Dang, Duo-Lao Wang, and Yin-Ping Zhang. 2011. "Effects of Music Therapy on Pain among Female Breast Cancer Patients after Radical Mastectomy: Results from a Randomized Controlled Trial." *Breast Cancer Research and Treatment* 128 (2): 411–19.

Licht, Sidney. (1946) 2015. *Music in Medicine*. Mass., New England Conservatory of Music.

Lindzon, Jared. 2015. "I Want to Be a Music Therapist. What Will My Salary Be?" *The Globe and Mail*, 2015. https://www.theglobeandmail.com/report-on-business/careers/career-advice/i-want-to-be-a-music-therapist-what-will-my-salary-be/article23878223/.

Little, Kenneth. 2010. "Paradise from the Other Side of Nowhere: Troubling a Troubled Scene of Tourist Encounter in Belize." *Journal of Tourism and Cultural Change* 8 (1–2): 1–14.

———. 2014. "Mr. Richie and the Tourists." *Emotion, Space and Society* 12 (August): 92–100.

———. 2020. *On the Nervous Edge of an Impossible Paradise: Affect, Tourism, Belize*. First edition. New York: Berghahn Books.

Livingston, Julie. 2012. *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic*. Durham: Duke University Press.

Loewy, J., K. Stewart, A.-M. Dassler, A. Telsey, and P. Homel. 2013. "The Effects of Music Therapy on Vital Signs, Feeding, and Sleep in Premature Infants." *Pediatrics* 131 (5): 902–18.

Loewy, Joanne. 2009. "Musical Sedation: Mechanisms of Breathing Entrainment." In *Music, the Breath and Health: Advances in Integrative Music Therapy*, edited by R Azoulay and JV Loewy. New York: Satchnote Press.

———. 2015. "NICU Music Therapy: Song of Kin as Critical Lullaby in Research and Practice: Rhythm, Breath, and Lullaby NICU Music Therapy." *Annals of the New York Academy of Sciences* 1337 (1): 178–85.

———. 2020. "Music Therapy as a Potential Intervention for Sleep Improvement." *Nature and Science of Sleep* 12 (January): 1–9.

Long, Debbi, Cynthia Hunter, and Sjaak van der Geest. 2008. "When the Field Is a Ward or a Clinic: Hospital Ethnography." *Anthropology & Medicine* 15 (2): 71–78.

Low, Ming Yuan, Sheen Tse Kuek Ser, and Gurpreet Kaur Kalsi. 2020. "Rojak: An Ethnographic Exploration of Pluralism and Music Therapy in Post-British-Colonial Malaysia." *Music Therapy Perspectives* 38 (2): 119–25.

MacDonald, Margaret. 2008. *At Work in the Field of Birth: Midwifery Narratives of Nature, Tradition, and Home*. Nashville: Vanderbilt University Press.

———. 2018. "The Making of Informed Choice in Midwifery: A Feminist Experiment in Care." *Culture, Medicine, and Psychiatry* 42 (2): 278–94.

Madsen, Clifford K. 1981. *Music Therapy: A Behavioral Guide for the Mentally Retarded*. National Association for Music Therapy.

Manning, Erin. 2013. *Always More Than One: Individuation's Dance*. Durham: Duke University Press.

Maratos, Anna, Christian Gold, Xu Wang, and Mike Crawford. 2008. "Music Therapy for Depression." Edited by Cochrane Common Mental Disorders Group. *Cochrane Database of Systematic Reviews*, January. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004517.pub2/abstract.

Marks-Tarlow, Terry. 2012. *Clinical Intuition in Psychotherapy: The Neurobiology of Embodied Response*. New York and London: WW Norton & Company.

Martin, Aryn, Natasha Myers, and Ana Viseu. 2015. “The Politics of Care in Technoscience.” *Social Studies of Science* 45 (5): 625–41.

Martin, Emily. 1994. *Flexible Bodies: Tracking Immunity in American Culture from the Days of Polio to the Age of AIDS*. Boston: Beacon Press.

———. 2013. “The Potentiality of Ethnography and the Limits of Affect Theory.” *Current Anthropology* 54 (S7): S149–58.

Marx, Karl. (1867) 2019. *Capital: Volume One*. Mineola, New York: Dover.

Massumi, Brian. 2002. *Parables for the Virtual: Movement, Affect, Sensation*. Durham: Duke University Press.

Mattingly, Cheryl. 2017. “Autism and the Ethics of Care: A Phenomenological Investigation into the Contagion of Nothing.” *Ethos* 45 (2): 250–70.

Mauss, Marcel. (1935) 1973. “Techniques of the Body.” Translated by Ben Brewster. *Economy and Society* 2 (1): 70–88.

———. (1950) 2002. *The Gift*. London; New York: Routledge.

Maysaud, Nebal. 2019. “It’s Time to Let Classical Music Die.” NewMusicBox. 2019. https://nmbx.newmusicusa.org/its-time-to-let-classical-music-die/.

Mazer, Susan E. 2012. “Creating a Culture of Safety: Reducing Hospital Noise.” *Biomedical Instrumentation & Technology* 46 (5): 350–55.

Mazzarella, William. 2009. “Affect: What Is It Good For?” In *Enchantments of Modernity: Empire, Nation, Globalization*, edited by S. Dube, 291–309. New Delhi; Abingdon: Routledge.

McClary, Susan. 2000. *Conventional Wisdom: The Content of Musical Form*. Berkeley: University of California Press.

———. (1991) 2002. *Feminine Endings: Music, Gender, and Sexuality*. Minneapolis: University of Minnesota Press.

McConnell, Tracey, David Scott, and Sam Porter. 2016. “Music Therapy for End-of-Life Care: An Updated Systematic Review.” *Palliative Medicine* 30 (9): 877–83.

McDermott, Orii, Nadia Crellin, Hanne Mette Ridder, and Martin Orrell. 2013. “Music Therapy in Dementia: A Narrative Synthesis Systematic Review: Music Therapy in Dementia.” *International Journal of Geriatric Psychiatry* 28 (8): 781–94.

McKay, Ramah. 2018. *Medicine in the Meantime: The Work of Care in Mozambique*. Duke University Press: Durham.

McLean, Stuart. 2011. “Black Goo: Forceful Encounters with Matter in Europe’s Muddy Margins.” *Cultural Anthropology* 26 (4): 589–619.

———. 2017. *Fictionalizing Anthropology: Encounters and Fabulations at the Edges of the Human*. Minneapolis: University of Minnesota Press.

Merali, Farrah. 2020. “Music Therapy Offering Lifeline to GTA Seniors during COVID.” CBC News. December 28, 2020. https://www.cbc.ca/news/canada/toronto/music-therapy-seniors-gta-ocivd-1.5825707.

Messingher, Gabriel, Erica Ryherd, and Jeremy Ackerman. 2012. “Hospital Noise and Staff Performance.” *The Journal of the Acoustical Society of America* 132 (3): 2031–2031.

Meyers, Todd. 2013. *The Clinic and Elsewhere: Addiction, Adolescents, and the Afterlife of Therapy*. Seattle and London: University of Washington Press.

Mol, Annemarie. 2002. *The Body Multiple: Ontology in Medical Practice*. Durham: Duke University Press.

———. 2008. *The Logic of Care: Health and the Problem of Patient Choice*. New York: Routledge.

Mol, Annemarie, Ingunn Moser, and Jeannette Pols. 2015. *Care in Practice: On Tinkering in Clinics, Homes and Farms*. Bielefeld: transcript.

Mondanaro, John. 2020. “Sustainability Strategies for Music Therapy in Medicine: A Study of the Louis Armstrong Center for Music and Medicine.” PhD Thesis, New York: New York University.

Mondanaro, John F., Gabriel A. Sara, Roshni Thachil, Marija Pranjić, Andrew Rossetti, Grace EunHye Sim, Bernardo Canga, Ilene Brodoff Harrison, and Joanne V. Loewy. 2021. “The Effects of Clinical Music Therapy on Resiliency in Adults Undergoing Infusion: A Randomized, Controlled Trial.” *Journal of Pain and Symptom Management* 61 (6): 1099–1108.

Moreno, Jairo. 2019. “Antenatal Aurality in Pacific Afro-Colombian Midwifery.” In *Remapping Sound Studies*, edited by Gavin Steingo and Jim Sykes, 109–34. Durham: Duke University Press.

Morrison, Wynne E., Ellen C. Haas, Donald H. Shaffner, Elizabeth S. Garrett, and James C. Fackler. 2003. “Noise, Stress, and Annoyance in a Pediatric Intensive Care Unit.” *Critical Care Medicine* 31 (1): 113–19.

Moten, Fred. 2003. *In the Break: The Aesthetics of the Black Radical Tradition*. Minneapolis: University of Minnesota Press.

MTP. 2021. “About the Journal.” Music Therapy Perspectives. 2021. http://academic.oup.com/mtp/pages/About.

Murphy, Daniel. 1994. “Jazz Studies in American Schools and Colleges: A Brief History.” *Jazz Educators Journal* 26 (3): 34–38.

Murphy, Michelle. 2012. *Seizing the Means of Reproduction: Entanglements of Feminism, Health, and Technoscience*. Durham: Duke University Press.

———. 2015. “Unsettling Care: Troubling Transnational Itineraries of Care in Feminist Health Practices.” *Social Studies of Science* 45 (5): 717–37.

Music & Memory. 2011. “Man In Nursing Home Reacts To Hearing Music From His Era.” Youtube. 2011. https://www.youtube.com/watch?v=fyZQf0p73QM&t=43s&ab_channel=Music%26Memory.

Myers, Natasha. 2015. *Rendering Life Molecular: Models, Modelers, and Excitable Matter*. Durham: Duke University Press.

Myers, Natasha, and Joe Dumit. 2011. “Haptics: Haptic Creativity and the Mid-Embodiments of Experimental Life.” In *A Companion to the Anthropology of the Body and Embodiment*, edited by Frances E. Mascia-Lees, 239–61. Oxford, UK: Wiley-Blackwell.

Ngai, Sianne. 2004. *Ugly Feelings*. Cambridge, Mass: Harvard University Press.

Nilsson, U., M. Unosson, and N. Rawal. 2005. “Stress Reduction and Analgesia in Patients Exposed to Calming Music Postoperatively: A Randomized Controlled Trial.” *European Journal of Anaesthesiology* 22 (2): 96–102.

Nilsson, Ulrica. 2008. “The Anxiety- and Pain-Reducing Effects of Music Interventions: A Systematic Review.” *AORN Journal* 87 (4): 780–807.

———. 2009. “The Effect of Music Intervention in Stress Response to Cardiac Surgery in a Randomized Clinical Trial.” *Heart & Lung* 38 (3): 201–7.

Nordoff, Paul, and Clive Robbins. 1971. *Music Therapy in Special Education*. New York: The John Day Company.

———. 1985. *Therapy in Music for Handicapped Children*. London: Gollancz.

Nordoff, Paul, Clive Robbins, and David Marcus. 2007. *Creative Music Therapy: A Guide to Fostering Clinical Musicianship*. Gilsum, NH: Barcelona.

Norris, Marisol S. 2019. “Between Lines: A Critical Multimodal Discourse Analysis of Black Aesthetics in a Vocal Music Therapy Group for Chronic Pain.” PhD Thesis, Drexel University.

———. 2020. “A Call for Radical Imagining: Exploring Anti-Blackness in the Music Therapy Profession.” *Voices: A World Forum for Music Therapy* 20 (3): 6.

Novak, David. 2015. “Noise.” In *Keywords in Sound*, edited by David Novak and Matt Sakakeeny, 125–38. Durham; London: Duke University Press.

Ochoa Gautier, Ana María. 2014. *Aurality: Listening and Knowledge in Nineteenth-Century Colombia*. Durham: Duke University Press.

Ochoa, Todd Ramón. 2007. “Versions of the Dead: Kalunga, Cuban-Kongo Materiality, and Ethnography.” *Cultural Anthropology* 22 (4): 473–500.

O’Flynn-Magee, Kathy, Wendy Hall, Cheryl Segaric, and Jessica Peart. 2021. “The Impact of Covid-19 on Clinical Practice Hours in Pre-Licensure Registered Nurse Programs.” *Teaching and Learning in Nursing* 16 (1): 3–4.

Okin, Susan Moller. 1989. *Justice, Gender, and the Family*. New York: Basic Books.

Parry, Jonathan. 1986. “The Gift, the Indian Gift and the ‘Indian Gift.’” *Man* 21 (3): 453.

Patterson, Orlando. 1982. *Slavery and Social Death: A Comparative Study*. Cambridge, Mass: Harvard University Press.

Pavlicevic, Mercedes, and Gary Ansdell. 2004. *Community Music Therapy*. London: Jessica Kingsley Publishers.

Peterson, Marina. 2021. *Atmospheric Noise: The Indefinite Urbanism of Los Angeles*. Durham: Duke University Press.

Piekut, Benjamin. 2014. “Actor-Networks in Music History: Clarifications and Critiques.” *Twentieth-Century Music* 11 (2): 191–215.

Pieslak, Jonathan R. 2009. *Sound Targets: American Soldiers and Music in the Iraq War*. Bloomington: Indiana University Press.

Pink, Sarah. 2011. “Multimodality, Multisensoriality and Ethnographic Knowing: Social Semiotics and the Phenomenology of Perception.” *Qualitative Research* 11 (3): 261–76.

Polanyi, Michael. (1958) 2015. *Personal Knowledge: Towards a Post-Critical Philosophy*. Chicago: University of Chicago Press.

Povinelli, Elizabeth A. 2002. *The Cunning of Recognition: Indigenous Alterities and the Making of Australian Multiculturalism*. Durham: Duke University Press.

———. 2011. *Economies of Abandonment: Social Belonging and Endurance in Late Liberalism*. Durham: Duke University Press.

———. 2016. *Geontologies: A Requiem to Late Liberalism*. Durham: Duke University Press.

Priestley, Mary. 1994. *Essays on Analytical Music Therapy*. Gilsum, NH: Barcelona Publishers.

———. 2012. *Music Therapy in Action.* Gilsum, NH: Barcelona Publishers.

Procter, Simon. 2011. “Reparative Musicing: Thinking on the Usefulness of Social Capital Theory within Music Therapy.” *Nordic Journal of Music Therapy* 20 (3): 242–62.

———. 2013. “Music Therapy: What Is It for Whom? An Ethnography of Music Therapy in a Community Mental Health Resource Centre.” PhD Thesis, University of Exeter.

Raglio, Alfredo, Osmano Oasi, Marta Gianotti, Agnese Rossi, Karine Goulene, and Marco Stramba-Badiale. 2016. “Improvement of Spontaneous Language in Stroke Patients with Chronic Aphasia Treated with Music Therapy: A Randomized Controlled Trial.” *International Journal of Neuroscience* 126 (3): 235–42.

Ramsey, Jr., Guthrie P. 2003. *Race Music: Black Cultures from Bebop to Hip-Hop*. Berkeley: University of California Press.

Rancière, Jacques. 2006. *The Politics of Aesthetics: The Distribution of the Sensible*. London; New York: Continuum.

———. 2009. “The Aesthetic Dimension: Aesthetics, Politics, Knowledge.” *Critical Inquiry* 36 (1): 1–19.

RCM. 2015. “Piano Syllabus.” Royal Conservatory of Music. https://rcmusic-kentico-cdn.s3.amazonaws.com/rcm/media/main/documents/examinations/syllabi/s41_pianosyllabus_2016_online_f.pdf.

———. 2016. “Theory Syllabus.” Royal Conservatory of Music.

———. 2021a. “Examinations.” The Royal Conservatory of Music. 2021. https://rcmusic.com/learning/examinations.

———. 2021b. “RCM Syllabi.” The Royal Conservatory of Music. 2021. https://rcmusic.com/learning/examinations/academic-resources-and-policies/syllabi-look-for-any-syllabus-below.

Rice, Tom. 2003. “Soundselves: An Acoustemology of Sound and Self in the Edinburgh Royal Infirmary.” *Anthropology Today* 19 (4): 4–9.

———. 2008. “‘Beautiful Murmurs’: Stethoscopic Listening and Acoustic Objectification.” *The Senses and Society* 3 (3): 293–306.

———. 2010. “Learning to Listen: Auscultation and the Transmission of Auditory Knowledge.” *Journal of the Royal Anthropological Institute*, 21.

Riches, Samuel. 2020. “Months after One of the Worst COVID-19 Outbreaks in Canada, Bobcaygeon Is Learning to Heal through Music.” National Post. August 29, 2020. https://nationalpost.com/news/months-after-one-of-the-worst-covid-19-outbreaks-in-canada-bobcaygeon-is-learning-to-heal-through-music.

Ridder, Hanne Mette O., Brynjulf Stige, Liv Gunnhild Qvale, and Christian Gold. 2013. "Individual Music Therapy for Agitation in Dementia: An Exploratory Randomized Controlled Trial." *Aging & Mental Health* 17 (6): 667–78.

Ritchey, Marianna. 2019. *Composing Capital: Classical Music in the Neoliberal Era*. Chicago: University of Chicago Press.

Robb, Sheri L., Alicia A. Clair, Masayo Watanabe, Patrick O. Monahan, Faouzi Azzouz, Janice W. Stouffer, Allison Ebberts, et al. 2008. "Randomized Controlled Trial of the Active Music Engagement (AME) Intervention on Children with Cancer." *Psycho-Oncology* 17 (7): 699–708.

Robbins, Clive. 2005. *A Journey Into Creative Music Therapy*. Gilsum, NH: Barcelona Publishers.

Rolvsjord, Randi. 2010. *Resource-Oriented Music Therapy in Mental Health Care*. Gilsum, NH: Barcelona Publishers.

Romero, Andrés. Forthcoming. "LA OLLA Y LOS PATIOS: An Ethnography of Place, Selfhood, Violence, and Rehabilitation in Bogotá." PhD Thesis, Detroit: Wayne State University.

Rondeau, Scott. 2010. *The Gift of Music Trailer for Documentary*. https://vimeo.com/17262063.

Rose, Nikolas. 2009. *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton: Princeton University Press.

Roseman, Marina. 1991. *Healing Sounds from the Malaysian Rainforest: Temiar Music and Medicine*. Berkeley: University of California Press.

Ross, Alex. 2007. *The Rest Is Noise: Listening to the Twentieth Century*. New York: Farrar, Straus and Giroux.

———. 2010. *Listen to This*. New York: Farrar, Straus and Giroux.

Rossetti, Andrew. 2020. "Environmental Music Therapy (EMT): Music's Contribution to Changing Hospital Atmospheres and Perceptions of Environments." *Music and Medicine* 12 (2): 130–41.

Ruckenstein, Minna, and Natasha Dow Schüll. 2017. "The Datafication of Health." *Annual Review of Anthropology* 46: 261–78.

Ruud, Even. 2020. *Toward a Sociology of Music Therapy: Musicking as a Cultural Immunogen*. Gilsum, NH: Barcelona Publishers.

Ryherd, Erica E., Selen Okcu, Jeremy Ackerman, Craig Zimring, and Kerstin Persson Waye. 2012. "Noise Pollution in Hospitals: Impacts on Staff." *Journal of Clinical Outcomes Management* 19 (11): 491–500.

Schieffelin, Edward. (1976) 2005. *The Sorrow of the Lonely and the Burning of the Dancers*. New York: Palgrave MacMillan.

———. 2016. “On Failure and Performance: Throwing the Medium Out of the Seance.” In *The Performance of Healing*, edited by Carol Laderman and Marina Roseman, 59–90. New York: Routledge.

Schneider, S. 2005. “Environmental Music Therapy, Life, Death and the ICU.” In *Music Therapy at the End of Life*, edited by C. Dileo and J. Loewy, 219–25. Cherry Hill, NJ: Jeffrey Books.

Serres, Michel. 1985. *The Five Senses: A Philosophy of Mingled Bodies*. Translated by Margaret Sankey and Peter Cowley. London; New York: Continuum.

Sharpe, Norma. 1960. “Music Therapy in Hospitals in Canada.” In *Music Therapy 1960: Tenth Book of Proceedings of the National Association for Music Therapy*, edited by Erwin H. Schneider, Ruth Boxberger, and William W. Sears, 227. Lawrence, Kansas: National Association for Music Therapy.

———. 1973. “Preface.” *Canadian Music Therapy Bulletin* 1 (1): 1–18.

Silverman, Michael J. 2015. *Music Therapy in Mental Health for Illness Management and Recovery*. Oxford: Oxford University Press.

Silverman, Michael J., Lorissa Letwin, and Louisa Nuehring. 2016. “Patient Preferred Live Music with Adult Medical Patients: A Systematic Review to Determine Implications for Clinical Practice and Future Research.” *The Arts in Psychotherapy* 49 (July): 1–7.

Simpson, Audra. 2014. *Mohawk Interruptus: Political Life Across the Borders of Settler States*. Durham: Duke University Press.

Situmorang, Dominikus David Biondi, Mulawarman Mulawarman, and Mungin Eddy Wibowo. 2018. “Comparison of the Effectiveness of CBT Group Counseling with Passive vs Active Music Therapy to Reduce Millennials Academic Anxiety.” *International Journal of Psychology and Educational Studies* 5 (3): 51–62.

Solie, Ruth A., ed. 1995. *Musicology and Difference: Gender and Sexuality in Music Scholarship*. Berkeley: University of California Press.

Spinoza, Benedictus de. (1677) 2000. *Ethics*. Edited and translated by G. R. H. Parkinson. Oxford: Oxford University Press.

Stainova, Yana. 2021. *Sonorous Worlds: Musical Enchantment in Venezuela*. Ann Arbor: University of Michigan Press.

Star, Susan Leigh, and James R. Griesemer. 1989. “Institutional Ecology, ‘Translations’ and Boundary Objects: Amateurs and Professionals in Berkeley’s Museum of Vertebrate Zoology, 1907-39.” *Social Studies of Science* 19 (3): 387–420.

Stegemöller, E.L., P. Hibbing, H. Radig, and J. Wingate. 2017. “Therapeutic Singing as an Early Intervention for Swallowing in Persons with Parkinson’s Disease.” *Complementary Therapies in Medicine* 31 (April): 127–33.

Steingo, Gavin. 2019. “Listening as Life: Sounding Fetal Personhood in South Africa.” *Sound Studies* 5 (2): 155–74.

Sterne, Jonathan. 2003. *The Audible Past: Cultural Origins of Sound Reproduction*. Durham: Duke University Press.

Stevenson, Lisa. 2014. *Life beside Itself: Imagining Care in the Canadian Arctic*. Oakland: University of California Press.

Stewart, K., and S. Schneider. 2000. “The Effect of Music Therapy on the Sound Environment in the Neonatal Intensive Care Unit: A Pilot Study.” In *Music Therapy in the Neonatal Intensive Care Unit*, edited by J. Loewy, 85–100. New York: Satchnote Press, The Louis Armstrong Center for Music and Medicine.

Stewart, Kathleen. 1996. *A Space on the Side of the Road: Cultural Poetics in an “Other” America*. Princeton: Princeton University Press.

———. 2003. “The Perfectly Ordinary Life.” Edited by Ann Cvetkovich and Ann Pelegrini. *Scholar and Feminist On Line*, Public Sentiments: Memory, Trauma, History, Action, 2 (1).

———. 2007. *Ordinary Affects*. Durham: Duke University Press.

Stige, Brynjulf. 1998. “Aesthetic Practices in Music Therapy.” *Nordic Journal of Music Therapy* 7 (2): 121–34.

———. 2001. “Writing Music Therapy: Clinical Research as Ethnography.” In *Music Therapy in Europe*, edited by David Aldridge, Ginaluigi Di Franco, Even Ruud, and Tony Wigram, 129–48. Rome: ISMEZ.

———. 2002. *Culture-Centered Music Therapy*. Gilsum, NH: Barcelona Publishers.

———. 2005. “Ethnography and Ethnographically Informed Research.” In *Music Therapy Research*, edited by Barbara L. Wheeler, 2nd ed., 392–403. Gilsum, NH: Barcelona.

———. 2008. “The Aesthetic or Multiple Aesthetics?: A Response to Kenneth Aigen.” *Nordic Journal of Music Therapy* 17 (1): 25–29.

Stoever, Jennifer Lynn. 2016. *The Sonic Color Line: Race and the Cultural Politics of Listening*. New York: New York University Press.

Stoller, Paul. 2016. “Sound and Things: Pulsations of Power in Songhay.” In *The Performance of Healing*, edited by Carol Laderman and Marina Roseman, 165–85. New York: Routledge.

Strathern, Marilyn. 1988. *The Gender of the Gift: Problems with Women and Problems with Society in Melanesia*. Berkeley: University of California Press.

———. 2020. *Relations: An Anthropological Account*. Durham: Duke University Press.

Street, Alice. 2014. *Biomedicine in an Unstable Place: Infrastructure and Personhood in a Papua New Guinean Hospital*. Durham: Duke University Press.

Sufrin, Carolyn. 2017. *Jailcare*. Oakland: University of California Press.

Sykes, Jim. 2018. *The Musical Gift: Sonic Generosity in Post-War Sri Lanka*. Oxford; New York: Oxford University Press.

Talent Recap. 2019. "Kodi Lee: Blind Autistic Singer SHOCKS The World Again In The Live Show! | America's Got Talent 2019." Youtube. 2019. https://www.youtube.com/watch?v=AIXgLR4wFuU&ab_channel=TalentRecap.

TallBear, Kim. 2019. "Caretaking Relations, Not American Dreaming." *Kalfou* 6 (1): 24–41.

Tamplin, Jeanette, Felicity A. Baker, Denise Grocke, Danny J. Brazzale, Jeffrey J. Pretto, Warren R. Ruehland, Mary Buttifant, Douglas J. Brown, and David J. Berlowitz. 2013. "Effect of Singing on Respiratory Function, Voice, and Mood After Quadriplegia: A Randomized Controlled Trial." *Archives of Physical Medicine and Rehabilitation* 94 (3): 426–34.

Taussig, Michael. 2018. *Mimesis and Alterity: A Particular History of the Senses*. New York: Routledge.

Taussig, Michael T. 1992. "Reification and the Consciousness of the Patient." In *The Nervous System*, 83–109. New York: Routledge.

Taylor, Charles. 1992. "The Politics of Recognition." In *Multiculturalism: Examining the Politics of Recognition*, edited by A. Gutmann, 25–73. Princeton: Princeton University Press.

Taylor, Janelle S. 2008. "On Recognition, Caring, and Dementia." *Medical Anthropology Quarterly* 22 (4): 313–35.

———. 2017. "Engaging with Dementia: Moral Experiments in Art and Friendship." *Culture, Medicine, and Psychiatry* 41 (2): 284–303.

Taylor, Timothy. 2007. *Beyond Exoticism: Western Music and the World*. Durham: Duke University Press.

Taylor, Timothy D. 2016. *Music and Capitalism: A History of the Present*. Chicago: University of Chicago Press.

Terris, Milton. 1999. “The Neoliberal Triad of Anti-Health Reforms: Government Budget Cutting, Deregulation, and Privatization.” *Journal of Public Health Policy* 20 (2): 149.

Thaut, Michael. 2013. *Rhythm, Music, and the Brain: Scientific Foundations and Clinical Applications*. New York: Routledge.

Thaut, Michael, and Donald A. Hodges, eds. 2019. *The Oxford Handbook of Music and the Brain*. First edition. Oxford: Oxford University Press.

Thaut, Michael, and Volker Hoemberg. 2014. *Handbook of Neurologic Music Therapy*. Oxford: Oxford University Press.

Timmermans, Stefan, and Marc Berg. 2003. *The Gold Standard: The Challenge of Evidence-Based Medicine and Standardization in Health Care*. Philadelphia: Temple University Press.

Tronto, Joan C. 1993. *Moral Boundaries: A Political Argument for an Ethic of Care*. New York: Routledge.

Trouillot, Michel-Rolph. 2003. *Global Transformations: Anthropology and the Modern World*. New York: Palgrave Macmillan.

Tse, Mimi M. Y., M. F. Chan, and Iris F. F. Benzie. 2005. “The Effect of Music Therapy on Postoperative Pain, Heart Rate, Systolic Blood Pressure and Analgesic Use Following Nasal Surgery.” *Journal of Pain & Palliative Care Pharmacotherapy* 19 (3): 21–29.

Tyler-Ameen, Daoud. 2019. “A Toast To ‘My Way,’ America’s Anthem Of Self-Determination.” NPR. 2019. https://www.npr.org/2019/11/19/774805536/frank-sinatra-my-way-self-determination-american-anthem.

Ueda, Tomomi, Yoshimi Suzukamo, Mai Sato, and Shin-Ichi Izumi. 2013. “Effects of Music Therapy on Behavioral and Psychological Symptoms of Dementia: A Systematic Review and Meta-Analysis.” *Ageing Research Reviews* 12 (2): 628–41.

Ulrich, G., T. Houtmans, and C. Gold. 2007. “The Additional Therapeutic Effect of Group Music Therapy for Schizophrenic Patients: A Randomized Study.” *Acta Psychiatrica Scandinavica* 116 (5): 362–70.

Underman, Kelly, and Laura E. Hirshfield. 2016. “Detached Concern?: Emotional Socialization in Twenty-First Century Medical Education.” *Social Science & Medicine* 160 (July): 94–101.

Vaudreuil, Rebecca. 2021. *Music Therapy with Military and Veteran Populations*. London: Jessica Kingsley Publishers.

Verney, Rachel, and Gary Ansdell. 2010. *Conversations on Nordoff-Robbins Music Therapy*. Gilsum, NH: Barcelona Publishers.

Wall, Willem van de. 1944. “The Use of Music in Hospitals for Mental and Nervous Diseases.” New York, NY: The National Music Council.

———. 1948. *Music in Hospitals*. New York: Russell Sage Foundation.

Warth, Marco, Jens Keßler, Thomas K. Hillecke, and Hubert J. Bardenheuer. 2015. “Music Therapy in Palliative Care.” *Deutsches Aerzteblatt Online*, November. https://www.aerzteblatt.de/10.3238/arztebl.2015.0788.

Warth, Marco, Jens Kessler, Julian Koenig, Alexander F Wormit, Thomas K Hillecke, and Hubert J Bardenheuer. 2014. “Music Therapy to Promote Psychological and Physiological Relaxation in Palliative Care Patients: Protocol of a Randomized Controlled Trial.” *BMC Palliative Care* 13 (1): 60.

Weber, Max. (1905) 2002. *The Protestant Ethic and the Spirit of Capitalism: And Other Writings*. Translated by Talcott Parsons. London; New York: Routledge.

Weiner, Annette B. 1985. “Inalienable Wealth.” *American Ethnologist* 12 (2): 210–27.

Weller, Claire M., and Felicity A. Baker. 2011. “The Role of Music Therapy in Physical Rehabilitation: A Systematic Literature Review.” *Nordic Journal of Music Therapy* 20 (1): 43–61.

Wendland, Claire L. 2010. *A Heart for the Work: Journeys through an African Medical School*. Chicago: The University of Chicago Press.

WFMT. 2020. “WFMT Membership.” *World Federation of Music Therapy (WFMT)* (blog). 2020. https://wfmt.info/wfmt-membership-2017-2020/.

———. 2021. “Annual Report 2020-2021.” World Federation of Music Therapy. http://wfmt.info/wp-content/uploads/2021/08/WFMT-Annual-Report-2020-2021_FINAL2.pdf.

Wheeler, Barbara L. 2015. “Music Therapy as a Profession.” In *Music Therapy Handbook*, 5–16. New York: Guilford Publications.

Whittall, Jane. 1991. “Songs in Palliative Care: A Spouse’s Last Gift.” In *Case Studies in Music Therapy*, edited by Kenneth E. Bruscia, 603–810. Phoenixville, Pennsylvania: Barcelona Publishers.

Wigram, Tony, Inge Nygaard Pedersen, and Lars Ole Bonde. 2002. *A Comprehensive Guide to Music Therapy: Theory, Clinical Practice, Research and Training*. London: Jessica Kingsley Publishers.

Wilf, Eitan Y. 2014. *School for Cool: The Academic Jazz Program and the Paradox of Institutionalized Creativity*. Chicago: University of Chicago Press.

Williams, Raymond. 1977. “Structures of Feeling.” In *Marxism and Literature*, 128–35. Oxford: Oxford University Press.

Wool, Zoë H. 2015. *After War: The Weight of Life at Walter Reed*. Durham: Duke University Press.

Wynter, Sylvia. 2006. “On How We Mistook the Map for the Territory, and Reimprisoned Ourselves in Our Unbearable Wrongness of Being, of Desêtre: Black Studies toward the Human Project.” In *A Companion to African-American Studies*, edited by Lewis R. Gordon and Jane Anna Gordon, 107–18. Malden: Blackwell Publishing.

Yaman Aktaş, Yeşim, and Neziha Karabulut. 2019. “Relief of Procedural Pain in Critically Ill Patients by Music Therapy: A Randomized Controlled Trial.” *Complementary Medicine Research* 26 (3): 156–65.

Yeo, Jeong Kyun, Dae Yeon Cho, Mi Mi Oh, Seok San Park, and Min Gu Park. 2013. “Listening to Music During Cystoscopy Decreases Anxiety, Pain, and Dissatisfaction in Patients: A Pilot Randomized Controlled Trial.” *Journal of Endourology* 27 (4): 459–62.

Yinger, O. S., and L. F. Gooding. 2015. “A Systematic Review of Music-Based Interventions for Procedural Support.” *Journal of Music Therapy* 52 (1): 1–77.

Yinger, Olivia Swedberg. 2016. “Music Therapy as Procedural Support for Young Children Undergoing Immunizations: A Randomized Controlled Study.” *Journal of Music Therapy* 53 (4): 336–63.

York University. 2021. “Nursing: Future Students.” York University. 2021. https://futurestudents.yorku.ca/program/nursing.

Young, Laurel. 2009. “Multicultural Issues Encountered in the Supervision of Music Therapy Internships in the United States and Canada.” *The Arts in Psychotherapy* 36 (4): 191–201.

———. 2016. “Multicultural Musical Competence in Music Therapy.” *Music Therapy Perspectives* 34 (2): 127–28.

Zhang, Jing Wen, Mary A Doherty, and John Francis Mahoney. 2018. “Environmental Music in a Hospital Setting: Considerations of Music Therapists and Performing Musicians.” *Music and Medicine* 10 (2): 71.

Zhang, Jun-Mei, Pu Wang, Jia-xin Yao, Lei Zhao, Mellar P. Davis, Declan Walsh, and Guang H. Yue. 2012. “Music Interventions for Psychological and Physical Outcomes in Cancer: A Systematic Review and Meta-Analysis.” *Supportive Care in Cancer* 20 (12): 3043–53.

Zhang, Yingshi, Jiayi Cai, Li An, Fuhai Hui, Tianshu Ren, Hongda Ma, and Qingchun Zhao. 2017. “Does Music Therapy Enhance Behavioral and Cognitive Function in Elderly Dementia Patients? A Systematic Review and Meta-Analysis.” *Ageing Research Reviews* 35 (May): 1–11.

Zhou, Kaina, Xiaomei Li, Jin Li, Miao Liu, Shaonong Dang, Duolao Wang, and Xia Xin. 2015. "A Clinical Randomized Controlled Trial of Music Therapy and Progressive Muscle Relaxation Training in Female Breast Cancer Patients after Radical Mastectomy: Results on Depression, Anxiety and Length of Hospital Stay." *European Journal of Oncology Nursing* 19 (1): 54–59.

Zola, Irving Kenneth. 1972. "Medicine as an Institution of Social Control." *The Sociological Review* 20 (4): 487–504.