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Association canadienne des musicothérapeutes

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From the Editor in Chief and English Content Editor

Welcome to the 2023 issue of the *Canadian Journal of Music Therapy!* On behalf of our editorial team, I am so thrilled to present this wonderful collection of ideas, research, reflections, and reviews. This issue highlights the extraordinary growth our profession has witnessed and offers readers an opportunity to both look back on where we have been, and look forward to where we hope to go. As music therapists in this current health-care climate, we stand on the shoulders of remarkable pioneers: countless clinicians, researchers, activists, advocates, students, teachers, administrators, and community members who have built an incredible foundation upon which we stand. The 2023 World Congress of Music Therapy, held in Vancouver, Canada this past July, was a testament to this legacy and all the extraordinary work that has been done in our field, while also giving us pause to consider the potential and promise that the future holds for music and health.

Our current issue takes up the breadth of this work. We begin our issue with Nicola Oddy's examination of vocal improvisation as a practice of listening awareness through her project *The Singing Field*, an invitation to consider the power and role of the voice in shifting perceptions of self and environment. Stéphane Scotto Di Rinaldi's study of a group protocol of receptive music therapy (termed DéPi-AM) applied to hospitalized adolescents suffering from anorexia nervosa presents promising results for further application of receptive techniques within this population. Daniel Kruger's historical study of the inaugural year of the Canadian Association of Music Therapists gives us an impressive window into our rich Canadian landscape, and all the groundwork that was required to establish our association, looking back through the eyes of several pioneering music therapists. In parallel, Adrienne Pringle and Cathy Thompson invite us to look back on forty unique conversations that explore the depth and breadth of music therapy in Canada through their interviews on the Canadian Music Therapy Podcast—conversations that offer perspective as we look towards the future of our profession. This issue also brings us three book reviews, encouraging us to consider pathways

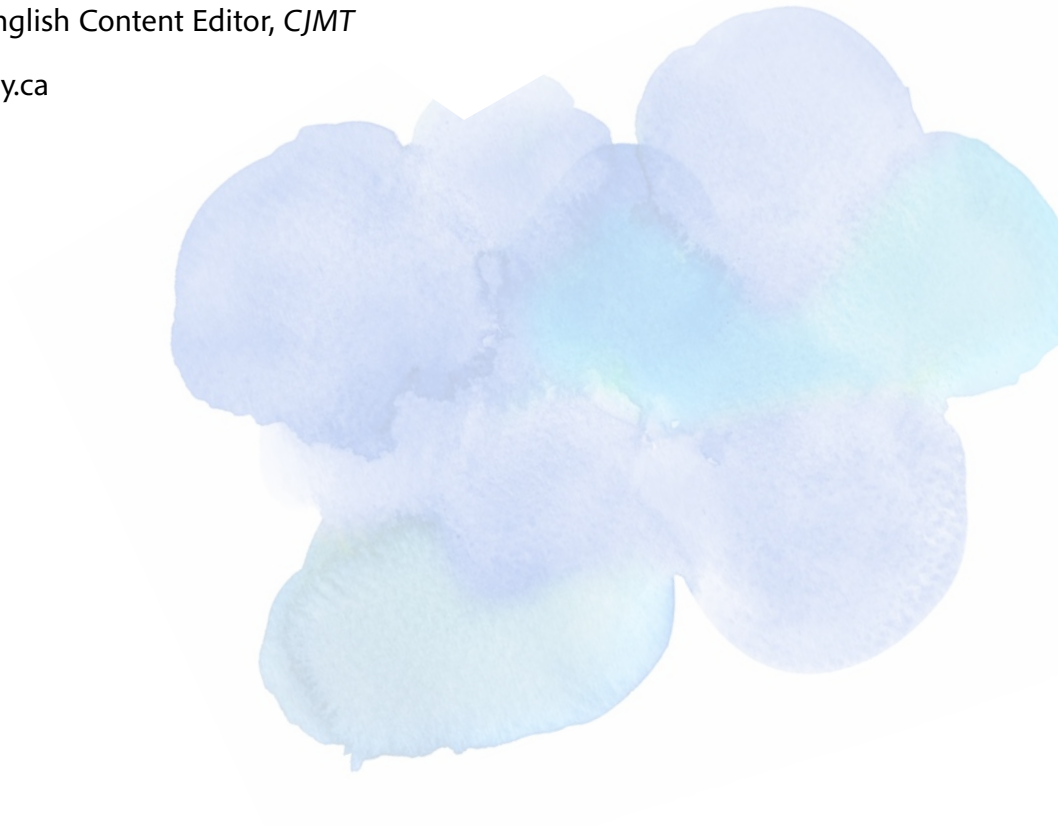
forward within education, clinical care, and research. Melissa Jessop reviews *Developing Issues in World Music Therapy Education and Training*, edited by Karen D. Goodman; Sue Baines reviews *Sociocultural Identities in Music Therapy*, edited by Susan Hadley; and Jonathan Tang reviews *Trauma-Informed Music Therapy: Theory and Practice*, edited by Laura E. Beer and Jacqueline C. Birnbaum. My sincerest thanks to all our contributors for their excellent work and commitment to our journal.

Working with our authors on this issue has presented me with the opportunity to both reflect back with pride and look forward with renewed optimism about the innovative and collaborative music therapy work being done in Canada and beyond. Though we can only present a small sample of groundbreaking Canadian music therapy projects and research in this issue, there is so much being done every day in clinical care, education, and research that continues to drive music therapy forward with tremendous momentum. As this is my final issue as Editor-in-Chief of the *CJMT*, I feel deeply grateful as I reflect on the history of the journal and the countless volunteer hours that have gone into making it a powerful representation of our field. I want to extend my heartfelt thanks to our incredible editorial team, an extraordinary group of people who have made the past three years such a meaningful time of learning and growth for me, both personally and professionally. To Annabelle Brault, our phenomenal French Content Editor, your support and friendship have been invaluable and so special to me, and your absolute brilliance and detail-oriented thoughtfulness have always been very inspiring. To Sara Pun, our journal's very first Associate Editor, your exemplary willingness to jump into this new role and your beautiful vision for expansion and growth of the journal have been so energizing and exciting. To our amazing copy editors, Jess Herdman, Sophie Pallotta, and Cheryl O'Shea, we could not do this without you, and I am personally so thankful for your wisdom, insight, patience, and remarkably thorough, thoughtful, and excellent work. Our editorial review board is made up of dozens of deeply caring, remarkably intelligent, and supremely committed individuals, who have given freely of their time and expertise, and for this I am eternally grateful. To the CAMT

Board, thank you for your support and belief in the importance of Canadian music therapy scholarship. To Pam Lansbergen, thank you for working so hard to ensure that the journal has the support it needs to continually produce high-quality content, especially through your advocacy for our new open access platform, which mobilizes the journal's spirit of enhancing our profession and making music therapy accessible.

I, too, stand on the shoulders of many editors who have come before me, who have loved and believed in the journal. I am extremely thankful to all those who have built what we have, and excited about the future. I trust that the journal will continue to take Canadian music therapy scholarship to new heights. I am so inspired and encouraged by our authors, a diverse blend of emerging scholars, current academics, and seasoned veterans in the field, and am deeply honoured to have been able to serve at the *CJMT's* Editor-in-Chief. I look forward to all that is to come in our beautiful profession, which has and will continue to change the world for the better.

Dr. SarahRose Black, PhD, RP, MTA
Editor-in-Chief and English Content Editor, *CJMT*
journal@musictherapy.ca



Mot de la rédactrice en chef et directrice du contenu en anglais

Bienvenue à l'édition 2023 de la *Revue canadienne de musicothérapie!* Au nom de notre équipe de rédaction, j'ai grand plaisir à vous présenter cette merveilleuse collection d'idées, de réflexions, de travaux de recherche et de critiques d'ouvrages. Ce numéro témoigne de l'extraordinaire croissance de notre profession et offre aux lecteurs l'occasion de jeter un regard sur le chemin parcouru et sur nos espoirs pour l'avenir. En tant que musicothérapeutes dans le climat actuel du secteur de la santé, nous sommes redevables à d'innombrables pionniers et pionnières remarquables. Toutes ces personnes — les cliniciens, chercheurs, militants, défenseurs, étudiants, enseignants, administrateurs et membres de la communauté —ont jeté les bases du travail que nous accomplissons fièrement aujourd'hui. En juillet dernier à Vancouver, le Congrès mondial de musicothérapie de 2023 a mis en lumière cet héritage et l'extraordinaire travail accompli dans notre domaine. Nous avons aussi pris la mesure du potentiel de la musique dans les soins de santé et envisagé les perspectives d'avenir.

Ce numéro reflète l'ampleur de tout ce travail. Nous débutons avec un article de Nicola Oddy, qui examine la pratique de l'improvisation vocale pour développer l'écoute consciente dans le cadre de son projet *The Singing Field*, et nous invite à réfléchir au pouvoir et au rôle de la voix dans le réajustement de la perception de soi et du milieu. L'étude de Stéphane Scotto Di Rinaldi évalue les effets d'une série de séances de musicothérapie réceptive (DéPi-AM) réunissant un groupe d'adolescentes atteintes d'anorexie mentale. Les résultats laissent entrevoir de nouvelles avenues dans l'usage des techniques réceptives auprès de cette population. L'étude historique de Daniel Kruger sur l'année inaugurale de l'Association canadienne des musicothérapeutes offre un impressionnant aperçu de la richesse du paysage de la profession au Canada et du travail effectué en amont pour établir notre association, que décrivent quelques-unes des pionnières du domaine. Dans la même veine, Adrienne Pringle et Cathy Thompson nous convient à un retour sur quarante conversations qui explorent les tenants et les aboutissants de la musicothérapie au Canada. Ces entrevues menées dans

le cadre de leur balado *Canadian Music Therapy Podcast* mettent en perspective l'avenir de la profession. Ce numéro présente aussi trois critiques d'ouvrages qui nous encouragent à envisager de nouvelles avenues dans les domaines de l'éducation, des soins cliniques et de la recherche. Melissa Jessop nous livre un compte rendu de *Developing Issues in World Music Therapy Education and Training*, édité par Karen D. Goodman; Sue Baines présente ses réflexions sur l'ouvrage *Sociocultural Identities in Music Therapy*, édité par Susan Hadley; et Jonathan Tang analyse *Trauma-Informed Music Therapy : Theory and Practice*, édité par Laura E. Beer et Jacqueline C. Birnbaum. Je remercie très sincèrement tous les collaborateurs de la RCM pour leur excellent travail et leur engagement.

Travailler avec nos auteurs et autrices m'a permis, d'une part, de prendre la mesure du chemin parcouru et, d'autre part, de me tourner vers l'avenir avec un optimisme renouvelé devant les efforts de collaboration et d'innovation déployés en musicothérapie, au Canada et ailleurs. Nous ne pouvons présenter qu'un aperçu des projets et de la recherche en cours en musicothérapie au Canada dans ce numéro de la Revue, mais il y a tant de nouvelles avancées dans les domaines des soins cliniques, de l'éducation et de la recherche que la musicothérapie progresse à pas de géant. Ce numéro étant mon dernier à titre de rédactrice en chef, j'éprouve une immense gratitude envers les innombrables bénévoles qui, depuis la création de la RCM, ont si bien présenté les enjeux qui touchent notre profession. Je tiens à remercier du fond du cœur notre incroyable équipe éditoriale, des gens extraordinaires grâce à qui j'ai vécu les trois dernières années sous le signe de l'apprentissage et de la croissance personnelle et professionnelle. Annabelle Brault, notre phénoménale directrice du contenu en français; ton précieux soutien et ton amitié me sont particulièrement chers, et ta finesse d'esprit et ton souci du détail ne cessent de m'inspirer. Sara Pun, notre toute première rédactrice adjointe; ton empressement exemplaire à endosser ce nouveau rôle et ta superbe vision du développement et de la croissance de la revue ont été des plus énergisants et motivants. Nos réviseures Jess Herdman, Sophie Pallotta et Cheryl O'Shea; nous n'y arriverions pas sans vous, et je vous suis personnellement reconnaissante pour votre sagesse, vos idées et votre patience, de

même que pour l'excellence de votre travail méticuleux et réfléchi. Notre comité de rédaction, ces douzaines de personnes profondément bienveillantes, intelligentes et consciencieuses qui nous offrent leur temps et leur expertise. Je vous serai éternellement reconnaissante. Je remercie les membres du Conseil de l'ACM pour leur soutien et pour leur foi en l'importance de la recherche en musicothérapie au Canada. Je remercie également Pam Lansbergen, qui travaille dur pour s'assurer que la revue reçoive le soutien nécessaire pour publier du contenu de qualité, particulièrement en prenant fait et cause pour notre nouvelle plateforme en libre accès, dans l'esprit de la revue, qui est vouée à l'avancement de la profession et à la démocratisation de l'accès à la musicothérapie.

Je dois beaucoup moi-même aux nombreux directeurs et directrices qui m'ont précédée, qui ont aimé cette revue et eu foi en elle. Je suis extrêmement reconnaissante envers ceux qui ont bâti ce que nous avons aujourd'hui, et très enthousiaste quant à l'avenir. Je suis convaincue que la revue va continuer de faire progresser la recherche en musicothérapie au Canada. Je suis particulièrement inspirée et encouragée par nos auteurs et autrices, un groupe diversifié de jeunes chercheurs, universitaires et vétérans du travail de terrain. Ce fut un grand honneur pour moi que d'agir comme rédactrice en chef de la RCM. J'envisage avec optimisme l'avenir de notre belle profession, qui vise encore et toujours à créer un monde meilleur.

Dre SarahRose Black, Ph.D., RP, MTA
Rédactrice en chef et directrice du contenu en anglais, *RCM*
journal@musictherapy.ca

Mot de la Directrice du contenu en français

L'année 2023 aura été une année marquante pour la musicothérapie au Canada. Notamment, l'Association canadienne des musicothérapeutes a accueilli, pour la première fois en juillet, le Congrès mondial de musicothérapie à Vancouver. Ce congrès en présentiel aura été un moment important pour la communauté internationale, en plus de faire valoir l'expertise des musicothérapeutes canadiens qui y ont participé en grand nombre. C'est aussi un moment dans notre histoire où nous devons examiner avec soin les barrières systémiques qui limitent l'accès à la profession et aux services de musicothérapie. La pandémie, en plus des crises humanitaires liées aux changements climatiques et aux enjeux sociopolitiques, aura réduit la résilience des personnes et des communautés marginalisées, en plus d'exacerber les facteurs de risques entraînant la détresse psychologique et la violence. La polarisation est un enjeu particulièrement inquiétant. Il importe donc pour les professionnels de la santé de redoubler d'efforts afin d'assurer l'accès aux services de soutien et d'amplifier les voix des peuples autochtones, des personnes en situation de handicap, des personnes racisées et des membres des communautés 2SLGBTQI+ qui subissent de façon disproportionnelle les conséquences marginalisantes de la pandémie et des autres crises. Au sein de notre profession, nous devons également nous poser plusieurs questions : Qui a accès à la formation en musicothérapie et aux possibilités de dissémination des savoirs? Quels savoirs sont valorisés dans les établissements d'enseignement et dans les revues scientifiques? Quelles sont les barrières systémiques auxquelles nous contribuons? Nous avons espoir que les articles du présent numéro de la Revue canadienne de musicothérapie pourront contribuer à un discours critique touchant le passé, le présent, et l'avenir de la musicothérapie au Canada.

C'est donc avec plaisir que je vous présente les contributions francophones de l'édition 2023, volume 28 de la Revue canadienne de musicothérapie. Stéphane Scotto Di Rinaldi nous présente une recherche inédite portant sur la musicothérapie réceptive auprès d'adolescents en milieu hospitalier. Dans le cadre de cette recherche exploratoire, M. Di Rinaldi a recueilli

des données préliminaires auprès de huit adolescentes âgées de 13 à 17 ans, souffrant d'anorexie mentale et hospitalisées à temps plein dans un service de pédopsychiatrie en France. Ces participantes ont pris part à des séances de musicothérapie réceptive de groupe afin de réduire l'effet des moments anxiogènes vécus dans le cadre de leur hospitalisation, notamment les pesées hebdomadaires. Il nous présente ses observations cliniques, les résultats préliminaires, ainsi qu'un protocole groupal de détente psychomusicale instrumentale pour les personnes souffrant d'anorexie mentale. Pour cette édition de la Revue, nous vous offrons également la traduction de trois critiques d'ouvrages. Je vous encourage fortement à les lire pour vous familiariser davantage avec ces ouvrages opportuns qui traitent d'enjeux importants en lien avec le contexte mondial actuel, comme le pluralisme, la réflexivité culturelle et les pratiques tenant compte des traumatismes.

J'aimerais conclure en remerciant chaleureusement la Dre SarahRose Black, qui nous quitte après avoir accompli son mandat de trois ans à la direction de la RCM. SarahRose a su nous guider avec brio durant une période charnière dans l'histoire de la revue : son passage au libre accès. Je salue son dévouement à faire valoir les diverses perspectives formant la mosaïque de la profession de musicothérapeute, en particulier celles des étudiants en musicothérapie et des musicothérapeutes novices. Notre collaboration m'a permis de non seulement découvrir une rédactrice empressée et généreuse de son soutien, mais aussi de tisser les liens d'une nouvelle et précieuse amitié. Je suis triste de voir notre collaboration au sein de la RCM tirer à sa fin, mais je lui souhaite une prochaine étape remplie de promesses et de succès à tous les égards.

Annabelle Brault, Ph. D (c), M. A., MTA, MT-BC
Directrice, contenu en français, *RCM*
revue@musictherapy.ca

From the French Content Editor

2023 has been a landmark year for music therapy in Canada, especially with the Canadian Association of Music Therapists hosting the World Congress of Music Therapy for the first time, in Vancouver last July. This in-person conference—a major event for the international community—showcased transnational expertise in music therapy, including that of Canadian music therapists, who turned out in large numbers. We are also at a moment in our history when we need to carefully examine the systemic barriers that restrict access to music therapy services and to the profession itself. Aside from the humanitarian crises linked to climate change and the intensification of sociopolitical issues, the pandemic weakened the resilience of marginalized peoples and exacerbated risk factors that lead to psychological distress and violence. Polarization is a particularly troubling issue. As healthcare professionals, we should therefore redouble our efforts to amplify the voices of certain groups—Indigenous Peoples, racialized people, disabled populations, and members of the 2SLGBTQIA+ communities who are disproportionately impacted by the marginalizing outcomes of the pandemic and other crises—while ensuring they have access to support services. We also need to ask ourselves a number of questions as practitioners: Who has access to music therapy training and to knowledge dissemination opportunities? What types of knowledge are favoured in educational institutions and academic journals? What systemic barriers are we perpetuating? We hope the articles in this issue of the *Canadian Journal of Music Therapy* will help foster a critical discourse about the past, the present, and the future of music therapy in Canada.

I am therefore pleased to present the French-language contributions in the 2023 edition, Volume 28 of the *Canadian Journal of Music Therapy*. Stéphane Scotto Di Rinaldi discusses his original research into receptive music therapy among youth in a hospital setting. For this exploratory research, Di Rinaldi gathered preliminary data from eight females aged 13 to 17 years presenting with anorexia nervosa, who were inpatients in a child

psychiatry hospital in France. These participants engaged in group receptive music therapy sessions intended to mitigate the effect of anxiety-producing periods experienced while in hospital, especially during the weekly weigh-in. Di Rinaldi presents his clinical observations, preliminary findings, and a group protocol for instrumental psychomusical relaxation for people with anorexia nervosa. This edition of the *CJMT* also includes three book reviews translated into French. I strongly encourage you to read them so you can be more familiar with these timely works that cover major issues related to today's global context, such as pluralism, cultural reflexivity, and trauma-informed practice.

I would like to close by extending my heartfelt thanks to Dr. SarahRose Black, who is leaving us at the end of her three-year term as Editor-in-Chief of the *CJMT*. SarahRose provided expert guidance during a key transition in the history of this publication: the shift to open access. I commend her dedication to highlighting the diverse perspectives that form the mosaic of our profession, especially those of music therapy students and newcomers in this field. Through our collaboration, I have discovered a diligent and supportive editor, and have developed a valued new friendship. I am saddened to see our collaboration on the *CJMT* draw to a close, but I wish her every success and a full range of promising opportunities in the next stage of her career.

Annabelle Brault, PhD(c), MA, MTA, MT-BC
Editor, French Content, *CJMT*
revue@musictherapy.ca

Singing Our Way to Awareness:

Trusting the River Through the Practice of Environmental Vocal Exploration (EVE)

[Chanter pour atteindre la pleine conscience : Faire confiance à la rivière dans la pratique de l'exploration vocale expérimentale (EVE)]

Nicola Oddy, PhD, RP, MTA

Abstract

This article explores vocal improvisation as a practice of listening awareness. I examine the use of the voice when singing in place as a way of changing perceptions of the self and the environment, through an improvisational performance practice I call environmental vocal exploration (EVE). This article describes the project *The Singing Field: A Performance of Environmental Vocal Exploration*, a summer-long commitment from five singers who joined me in six EVE performances in various locations, during which we used vocal improvisation as our primary way of interacting with different environments and with each other. The performers shared their perspectives through interviews, debriefs, and journal writing. Using autoethnographic, ethnographic, and research-creation methodologies to analyze our experiences, I developed the concepts of *environmental countertransference, environmental vocalist,* and *xeno-song.* The results of my research highlight that singing with listening awareness in place can create a relationship between self and place, leading to a new awareness and attunement to both.

Keywords: vocal improvisation, listening awareness, environment, soundsinging, environmental vocal exploration

Sommaire

Cette article se penche sur la pratique de l'improvisation vocale pour développer l'écoute consciente. J'examine l'usage de la voix et du chant pour changer la perception de soi et de son environnement par le biais de séances d'improvisation vocale que j'appelle exploration vocale expérimentale (EVE). L'article décrit le projet *The Singing Field: A Performance of Environmental Vocal Exploration.* Cinq chanteurs se sont joints à moi durant tout un été pour donner six prestations d'EVE à divers endroits. Nous avons utilisé l'improvisation vocale comme principal outil d'interaction avec différents environnements, et les uns avec les autres. Les artistes ont exprimé leurs points de vue en entrevue, lors de séances de débreffage et par l'écriture d'un journal. En recourant à des méthodes autoethnographiques, ethnographiques et de recherche-création pour analyser notre expérience, j'ai développé les concepts de *contre-transfert environnemental, de vocaliste environnemental et de xéno-chanson.* Les résultats de ma recherche indiquent que la pratique du chant dans un contexte d'écoute consciente peut permettre d'établir une relation entre le soi et l'environnement, ce qui mène à une expansion de la conscience et à une meilleure harmonisation entre le soi et l'environnement.

Mots-clés : improvisation vocale, écoute consciente, environnement, soundsinging, exploration vocale environnementale

Singing Our Way to Awareness: Trusting the River Through Environmental Vocal Exploration (EVE)

The saying "don't push the river" invites us to resist resistance, to go with the flow. Psychologist Mihaly Csikszentmihalyi, a great proponent of flow, suggests that one way of preventing ourselves from becoming stuck is by challenging ourselves with tasks that we take on for their own sake, allowing ourselves to be engaged without any expectations about the outcome (2014). I have always found the concept of going with the flow, rather than trying to resist the direction of the river, useful. Many people can relate to the experience of trying to push the river and having things not go as planned. Or things go as planned, but we encounter enormous obstacles along the way. Because I did my research during the COVID-19 pandemic, I learned that there was no point in trying to push the river. Instead, I needed to trust my intuition and allow myself to be carried along. The power was just too vast—the power of the river, the power of our lives, the power of our chosen paths.

I hope that what I share with you will invite a change in your perspective of the world around you, and a transformation of your perception of your self in that world. I also hope that you will consider how intentional, improvisatory singing in place can allow for communication and reciprocity between our selves and our environment.

Background

I have been a music therapist, vocalist, choir director, and performer for nearly 40 years, and an educator for the past 12 years. This substantial career has inspired my diverse perspectives on singing, and has had a significant influence on my PhD research. As a music therapist, the voice has always been my primary medium of intervention and interaction. Singing is the main tool I use when helping people work towards the goals that are important to them.

For my master of arts (MA) thesis, I explored how singing can be difficult for many people (Oddy, 2001). The group members I studied as part of my master's research had been told as children that they should not be heard singing, and that they should mouth

the words to songs in choir or not join in at all. Sometimes the criticism came from teachers, parents, siblings, or music teachers, and sometimes the criticism came from within. Our voices are personal and can reveal so much of who we are. We live in a culture, however, wherein singing is often considered to be something that should be left to the "professionals," something we should refrain from doing if we are not behind a microphone or have not attained the approval of others. To me, the voice is an extension of the self: The quality of our voices is as different from one another as are the features on our faces. I believe that every voice is beautiful in its uniqueness. As music therapists, we are gifted with the privilege of hearing a range of voices through our work.

In my MA research, I sought to find ways that people could learn to appreciate their voices anew. One of the approaches I used was to have people explore different ways of singing. Since the breath is the precursor to singing, we began with the breath. We then added some small sounds sung to our selves, after which we added community singing—singing together. At this point, I began to explore some hypotheses. First, to see if singing in a reverberant place would help to change their vocal self-perspective, I took participants to the stairwell of the local library. Indeed, it had a profound effect on them; according to one of the participants, the stairwell of the library became a sacred place (Oddy, 2001). Second, to query whether singing outside would change their vocal self-perspective, I brought participants to the lake. The open air offered a different kind of liberating experience, perhaps because of participants' associations between outdoor song and singing around the campfire, where vocal self-perception has no bearing on one's involvement.

This research launched me into many years of helping people see how singing in place could elicit change. The workshop I did with those six people became the basis for structuring dozens of subsequent workshops (Oddy, 2011). I was no longer focused solely on those who were told they could not sing, however; I was helping people with self-growth. The flow of the river then brought me to my PhD studies. After decades of exploring how making sound in different locations could enable a person to learn something about themselves, I now wanted

to explore how that act could enable an individual to learn about the reciprocal relationship between the self and the places in which they were singing.

As part of my PhD, I conducted a study entitled "Seeking Awareness of Our Selves and the Environment Through Vocal Improvisation in *The Singing Field*" (Oddy, 2022). *The Singing Field* is the name of the performance that I created in summer 2020 during the fieldwork for my study. It is based on an experience that I call *environmental vocal exploration* (EVE). Broadly defined, EVE is a way of using improvisational singing as a listening practice. When engaging in EVE, participants use vocal improvisation to sing in specific environments. I find that using vocal improvisation can release us from the confines of pre-composed melodies and lyrics, and allow for open exploration. I came to this research having already established the concept and practice of EVE in my personal practice: I had named it and had a great deal of experience with it already. In the spirit of learning how to deepen our listening both to the world around us and to our selves, I wanted to learn more about how singing could be a listening practice. In April of 2017, as I was developing EVE as a concept, I went for a walk along the Cornish coast in Dorset, England, and did a sing at St. Catherine's Chapel in Abbotsbury (Figure 1). To have a sing means that I took in the place and the feelings I was having there, and then engaged in a vocal improvisation. As the nature of the improvisation emerged, I experienced a reciprocity between my self and the place. It is that reciprocity that is key to the EVE experience.

Figure 1

Photograph of the Outside St. Catherine's Chapel

A recording of my sing at St. Catherine's Chapel is available here: Singing in St. Catherine's Chapel (https://nicolaoddy.com/from-sound-to-song/singwalk). Doves are nested in the chapel (Figure 2). When the recording begins, you will hear the doves and then my singing. At the end of the recording, you will hear the wind whistling through the windows.

Figure 2

Photograph of the Doves in St. Catherine's Chapel

Theoretical Foundations of EVE

Each word in the appellation EVE describes a part of the practice's theoretical foundations. The word *environmental* is related to the term acoustemology. A combination of the words acoustics and epistemology, this term was conceived by ethnomusicologist Steven Feld as part of his concept of knowing through sounding (2015). He developed this term as a result of his fieldwork with the Kaluli of Papua New Guinea, who relate to their environment through singing. The idea of this relationship was important to me as I explored how we could learn from our own environments by singing in them.

For the word *vocal,* I focused on vocality scholar and ethnomusicologist Nina Sun Eidsheim's discussion of intermateriality (Eidsheim, 2015). Considering the materiality of an environment was key for me as I thought about how human-made structures or natural materials affected the dynamic between the environment and the singer. The experience of singing in a highly resonant concrete tunnel, for example, might differ significantly from the struggle of singing against the overpowering sounds of a dam site.. Eidsheim (2015) sees

singing and listening as a vibrational, multisensory practice that changes with the materiality of the environment. She writes that although sound, body, and voice are separate entities, they are interconnected when sounding in place (2019, 38). She points out that vibrations have no boundaries and that "their relations are defined by process, articulation and change across material" (17). She adds that musicking—the act of listening to or making music (Small, 1998)—is a vibrational practice, ever changing with each moment that sound is in transmission. This focus on vibration comes from her desire to think about music as a practice, rather than an object. Eidsheim's theory resonates with my work in *The Singing Field,* where we considered the effect that the materiality of place and body had on our perceptions of self and place. I also take the effects of place into account in my music therapy practice, as a serious element in the therapeutic space.

When doing the fieldwork for my study, I considered the idea of singing as a listening practice as performance. The word *exploration*, in that context, was connected to the theatre of confluence, a term created by Canadian composer R. Murray Schafer to describe how the arts come together while maintaining their distinct identities. I follow his lead of creating performances that were taken out of the concert hall, that were immersive, that were potentially transformative, and that often explored relationship with environments (2002). Schafer was not satisfied with the kind of concert where you just sit down, listen, and watch. For him, it was also important for the audience to be engaged and to be a part of what was going on.

Singing as a Listening Practice

Listening and engaging in EVE emerged from an experience called *soundwalking*, which is the act of listening with intention while moving through a place, to engage in what Andra McCartney calls "intimate listening" (2016, 40). McCartney thinks of listening as a form of improvisation, a way of keeping us "open to the possibilities of the moment" (2016, 38). She does not include singing in her listening practice, but the sensibility of her impassioned listening resonates with my own passion for singing in environments.

The practice of soundwalking has a long history. It began with Max Neuhaus around 1966, when he led his audience around New York City neighbourhoods to listen to the sounds of the city in his "Concert of Traveled and Traveling Music" (Murph, n.d.). He wanted listeners to embrace urban sounds in keeping with John Cage's (1961) idea of music as sounds that one hears. It was not until 1977, however, that R. Murray Schafer coined the term soundwalk, in the early days of the World Soundscape Project, when he asked people to engage in aural explorations of place to consider the implications of the sounds therein.

Many practitioners have carried Schafer's ideas forward, such as singer and improviser Vivian Corrigan, who says that soundwalking is about "waking up a listening perception" (2018). For Corrigan, soundwalking is a way of strengthening the ear and a way of understanding more about the environment through the sounds made in it. Similarly, the composer and performer Pauline Oliveros uses the voice in her practice of Deep Listening (2005). She developed a practice of listening to the world around us and within us, saying that to listen is to "give attention to what is perceived both acoustically and psychologically" (2005, xxiii). Much like McCartney, Oliveros writes about the importance of "listening inclusively to all that can be perceived in the moment" (2016, 82) with no prior commitment to any sound. Deep Listening is about the participant learning to open themselves to the complexity of sound and to expand their awareness of this complexity. Oliveros calls her sonic meditations "attention strategies," which she describes as "nothing more than ways of listening and responding in consideration of oneself, others and the environment" (2005, 29).

Like Oliveros and McCartney, philosopher Jean-Luc Nancy advocates for listening as a form of awareness, saying that to listen is to stretch the ear, through "an intensification, a concern, a curiosity or an anxiety" (2007, 5). He argues that when we listen, we enter into tension with ourselves as we search "to be on the lookout for a relation to self" (12). Nancy's conception of listening is thus connected to how a music therapist may look beyond surface-level meanings while listening to and engaging in improvisation. Listening in general is an extremely important element when singing our way to awareness. Soundwalking, Deep Listening, and listening as a way of stretching the ear are all concepts that informed me as I developed my project.

Seeking Awareness of Our Selves and the Environment Through Vocal Improvisation in *The Singing Field*

During my PhD, in order to study the relationality between our selves and our environments, I put out the call for singers who would like to join me in improvisational singing at six locations around Ottawa. Five singers came forward. Each singer was given the option of using a pseudonym, but they each chose to have their names used publicly. Ellen was a retired teacher of children who are blind, Helen was a musician and retired schoolteacher, Cait was a musician and receptionist, Frances was a writer and singer, and Kelly-Anne was a music therapist.[1] I recruited them through social media, my choir, my association with Schafer's work *And Wolf Shall Inherit the Moon* (2002), and by talking to people about the study I was about to embark upon.

The research questions for this study were:

1. Can performative vocal improvisation in different environments lead to a transformed relationship with those environments, and if so, with what effects?
2. What is the affective force of EVE (e.g., personal, emotional, spiritual) and what impact does it have on performers?

Methodology

My project was autoethnographic: I was the sixth singer. I sang with the other five participants so that I could engage in the experience and have a personal understanding of it. I wanted to be in the experience and not just observe others. I wrote the first draft of my autoethnography before *The Singing Field* began, as it gave me a chance to position myself within the project, while also enabling me to relate to the experience as it unfolded. I felt this was important in order to examine my own biases and leanings (Denzin, 2003).

I also used research-creation methodology (Stévance & Lacasse, 2013), meaning in this case that the creation, *The Singing Field,* came first, and the research followed. There were

[1] At first, Kelly-Anne opted for a pseudonym, but when the film was complete and she approved of it, she changed her mind for future publications. This is why in the film she is referred to as Karen.

three main outputs of this research-creation project: one was the performance of The Singing Field; a second was the written dissertation; and a third was the film. Hasi Eldib of Carleton University filmed the entirety of the fieldwork, including the opening and closing interviews, and the post-performance debriefs. He and I worked together to create a film to help place this work in context. The film can be viewed at either of these websites: https://vimeo.com/hasi/thesingingfield or, https://vimeo.com/hasi/thesingingfielddescribed. The trailer is available here: https://vimeo.com/hasi/thesingingfieldtrailer.

Lastly, my project was ethnographic. The five singers who joined me in *The Singing Field* were collaborators both as fellow performers and because their input helped me to answer my research questions. Ethnographic data was gathered during a preparatory workshop that I led, in one-on-one interviews both before and after the set of performances, and during group debriefs that took place after each sing event. In addition, I asked participants to journal throughout the performances in order to capture thoughts and feelings that occurred between sing events.

Locations for the Fieldwork

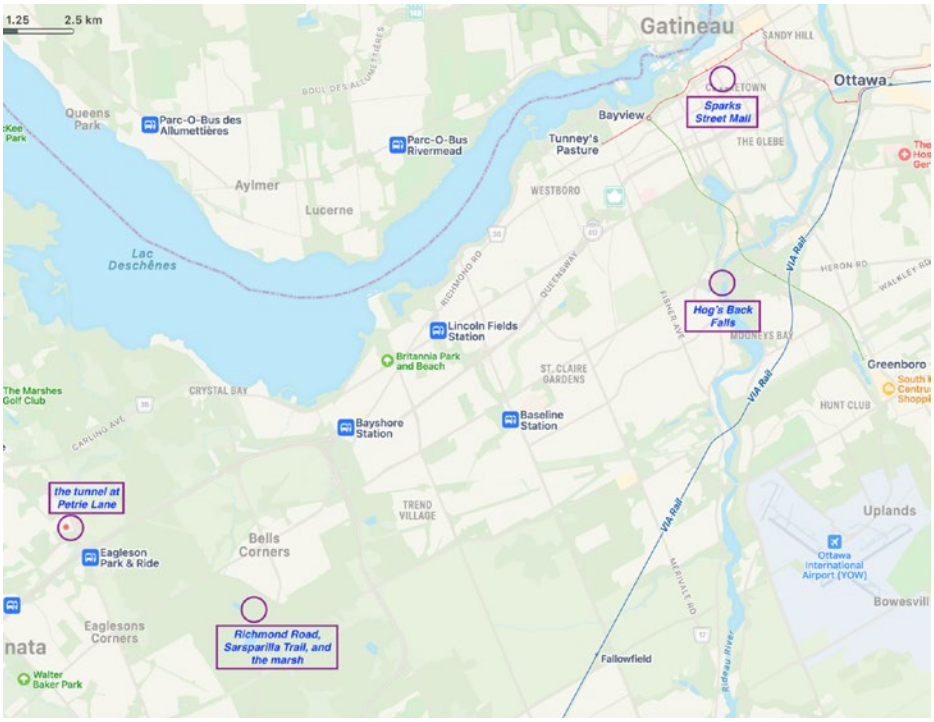


Figure 3

Map of Singing Locations for *The Singing Field*

The locations in which we sang included a reverberant tunnel at Petrie Lane in Ottawa (Figure 4), Hog's Back Falls, a dam site near Carleton University (Figure 5), the city centre (Figure 6), a busy road (Figure 7), a nature trail (Figure 8), and a viewing platform overlooking a marsh (Figure 9). For a map of the locations, see Figure 3. These sites were chosen in order to provide a variety of EVE experiences. As a consequence of COVID-19, I did not always have the option of using locations I had originally hoped for and my choices required flexibility.

Figure 4

Photograph of the Six Performers Singing on the Inside of the Tunnel

Figure 5

Photograph of Ellen Singing at the Dam

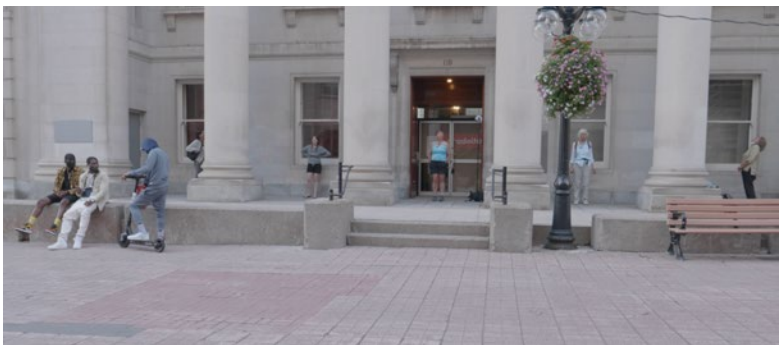


Figure 6

Photograph of a Pillared Building in the City Centre with Five Singers Engaged in EVE

Figure 7

Photograph of Frances Singing at a Busy Roadside (Richmond Road)

Figure 8

Photograph of the Singers on the Nature Trail (Sarsparilla Trail)

Figure 9

Photograph of Singers on the Viewing Platform Overlooking the Marsh

Each location took on a character of its own that influenced our singing, how we felt about the places in which we sang, and how we reflected on our selves. I was hoping to explore indoor places too, but due to COVID-19 indoor options were off limits (as were public gardens and outdoor amphitheatres).

Format of the Sing Events

Sing events all followed the same performance arc of ritual opening, singing, and ending with a debrief with each other. The ritual was important for establishing a grounding and a link from one performance to the next. The use of ritual is an important factor in my work as a music therapist, so going into the project I was aware of its benefits as a way of establishing the beginning and ending of an experience, and of guiding the process of creating order in our small community. Carolyn Kenny has been a deep influence on me in terms of my use of ritual in sessions. In her book *The Mythic Artery,* Kenny discusses ritual as an event that incorporates patterns, processes, images, and symbols (1982). Ritual creates a container for the experience, helping participants understand what is going to happen from session to session, or providing a sense of security and an intention for the proceedings. During my own experiences with *And Wolf Shall Inherit the Moon*—a performance piece by R. Murray Schafer (2002)—I was buoyed by the unchanging ritual element of our days, which began with an aubade and a community circle, followed by the act of creation, sharing with others, and ending with a nocturne.

In *The Singing Field,* our ritual included the simple formation of a community circle at the beginning and end of each sing event. The opening ritual was different each time, depending on what the group required in that moment—a need for grounding or a need for energy, for example. After the ritual opening, we sang with one another in an unscripted and improvisational manner. We sang as a group, in solos, and alone-but-together in what I would describe as parallel play. In these instances, participants sang at the same time throughout the space, though not necessarily engaging with each other. Then there was a final closing circle and debrief after each sing, which provided necessary processing time and closure in our performance arc. To encourage the debrief and to help create a framework, I often asked each person to think of two words to describe how they felt after the sing event; this helped them to express what they had experienced. The final debrief was a crucial time for sharing, and an opportunity for me to gain significant insights from the performers.

I invite you to try the EVE process, which I will describe briefly here. The practice starts with a moment of mindfully engaging with the world around us. We do that by standing silently in the place we are about to sing in. While standing, we listen, look, smell, notice the play of the light, and take in any movement around us. We then go inward and begin to create intuitive sound based on our experience of the place, starting with breathing, to the creation of a small sound, to a sound that others can hear, and then to a full vocal expression of our being in the environment. We end by closing our eyes for a few seconds, taking stock of how our bodies feel, and then by opening our eyes again. We think about what has transpired emotionally, spiritually, and personally. We then take a moment to think about what has changed in our perceptions of place since our initial sensory observations. It helps us to then speak, write, or draw about the experience.

If We Are Singing in Environments, How Can We Be Listening too?

When we have a verbal conversation with someone, we go back and forth. We cannot listen unless we are silent and focused on what the other person is saying. How can we truly listen in conversation unless we use the turn-taking skills we learned as children? But when we have a musical conversation with someone, we make music *together.* When we play music together, we listen to each other in order to inform the music that we are going to make. We listen *while* we musick. Our listening then informs what we will do next. Will we match the other person's music, reflect on it, do something completely different, or develop the original idea? There is reciprocity in music making. When we enhance the music of the person we musick with, our own music becomes enhanced. We help each other to create by playing together: We musick together as a listening practice.

When engaging in EVE, we use singing as our listening practice. By singing to, with, and through the environment, we are listening to and musicking not only with the environment, but also through the energy of the environment—the tension or the beauty of the environment—which allows for insights on the other side of the experience.

Composers and performers of environmental music reflect a great deal on this kind of music-making experience. R. Murray Schafer discusses the unique tones of each natural soundscape, including sounds that other creatures make, such as bird song, insect sounds, and the sounds of water, creatures, and animals. He writes that, in order for humans to join in with the world around us, we need to extend our vocality to include growling, howling, whimpering, grunting, roaring, and screaming (2002). David Rothenberg (2002), composer, clarinetist, and author, also engages with the soundscape as an improviser. He suggests that we can inhabit a bird's song by improvising along with it. He refers to the voice and the power of environmental interaction in, for example, the effect of an echo: "Take your ax and go stand in the bottom of a canyon. Blow in the instrument, pluck it, strike it, let out a piercing wail. Listen to what the world gives back. Play with the response, question it, explore the sonic shape of the land" (2002, 70). Bernie Krause thinks along these same lines too, writing that we need to embrace an awareness of the world around us by being an active listener through what he calls "careful listening" (2012, 223). He feels that by being a careful listener our connection to the biosphere will intensify.

This research confirmed for me that listening can go beyond what we can hear with our ears. As we gain the awareness to be alert to something, we find that we can not only listen to the environment, but also listen to how the environment affects us in turn. We can notice how we affect each other, how we listen inwardly, and how we listen to what is *implied* by what we hear with our ears.

Analysis and Outcomes

I interpreted the ethnographic data generated by this study by using an analytical coding of fieldnotes (Emerson et al., 2011) and by contemplating on my findings through a systems approach called field theory (Kenny, 1985). Through this process, alongside my own reading, my personal experiences, and my conversations with the other singers, I discovered that, through singing in place, people experienced increased listening awareness, which in turn created a relationship with place and the vocal self. That relationship was filtered through their emotional experience.

Vocal Self

Some of the subthemes that emerged under the *vocal self* included acoustics, spirituality, vulnerability, and playfulness. The acoustic was vital to the nature of the experience. There was only one highly reverberant sing event in my study: the tunnel. This space gave people a chance to play with the structure of the place, showing that singing in a reverberant place can enhance a person's confidence through the overt experience of sonic reciprocity. The harmonics in such a place and the experience of hearing the various eigentones[2] therein gave the space a special aesthetic.

In the tunnel, several performers noted that singing in an environment that reflected our voices back on to us was a spiritual experience. Performers commented on the spiritual dimensions of their experiences in all of the locations, however. For example, in reference to singing at the Sparks Street Mall in Ottawa's city centre, Ellen wrote:

> By investing myself for an hour or two to this process, this place, and these people, I am changed. It feels like I have just meditated and have emptied myself of much of the inner chatter that otherwise often occupies my head, the remembering and planning

[2] Described on https://www.sfu.ca/~gotfrit/ZAP_Sept.3_99/r/resonance.html as "an acoustical resonance or standing wave in an enclosed space caused by parallel surfaces." The eigentone can be found by standing in a resonant place, and by sliding the voice from one's lowest range to the highest. At some point, the voice sounds amplified. This occurs because the voice has touched on a pitch that is sympathetic (i.e., is a note within the harmonic series) to the room in which the singer is located.

> of an adult life. This sound-making empties me of all of the past and future and I am engrossed in the now (journal entry, summer 2020).

Helen said, "Those moments were intensely present. Singing is generally intensely present. . . it's very much being in the moment" (exit interview with author, August 26, 2020). These are just two examples of the sense of numinosity that we all experienced throughout *The Singing Field.*

The Singing Field tested our feelings of vulnerability. Was the experience negative in this sense? Positive? Perhaps it is not surprising that all six women, including me, felt vulnerable at times. By placing ourselves in public places and making unusual sounds in the presence of others, we put ourselves at risk of being policed (Tonelli, 2020a). We spoke about these conditions and how they made us feel vulnerable, including how being in a community of women afforded us a feeling of protection in most cases, how a sense of exposure affected our vocalizations, and how we protected ourselves. Despite the unusual nature of what we were doing, singing in public in an unconventional manner with a mutually supportive group of women was, for some of us, less threatening than being a woman in many of the male-dominated spaces in which we work and live. The fact that women improvising together is not an everyday occurrence (Smith 2004) led us to discuss how, because we were women, we were used to feelings of vulnerability. The result was that vulnerability actually gave us an extra boost of courage to be creative in these unusual circumstances.

A sense of play, curiosity, and creativity permeated our activities at all of the sites. Through vocal and rhythmic play, we felt a sense of curiosity and creativity in terms of the sounds we made and the ways that we interacted with one another and with the sites. Play offered possibilities for new insight. Ellen experienced playfulness at the Sparks Street Mall when she made rhythmic sounds with her hands and feet as she sang: "It feels very childlike (in a good way) to approach all these surfaces with curiosity to see what will come of it" (group debrief at Sparks Street Mall, August 5, 2020). Kelly-Anne experienced a different kind of playfulness at Hog's Back Falls dam site, where she noticed

> a space between two rocks that you couldn't see down in between. And I wanted to be a part of it. I wanted to sing to that. It was like a hidden special place that I connected to even though it was one place where I wasn't getting all of the visual stimulation. It was a secret hidden spot, and I sang into that quite a bit (group debrief at Hog's Back Falls, July 22, 2020).

Place

Under *place,* themes related to settler culture, built environments, and natural environments emerged. The places in which we sang were at the heart of the study. In a sense, places were characters in the play and improvising partners in our performances. Our experiences in *The Singing Field* highlighted the effects of humans on places. These effects were evident even when we sang in more natural locations, such as the trail and marsh, where we could still hear the road and the occasional airplane flying overhead and could see the hydro lines near the marsh and the refuse left behind by former visitors to the site. All of this affected our experiences and our perceptions of our selves and of these locations.

The built environment had a significant impact on each of our sings, ranging from the stark, reverberant walls of the tunnel to the rushing water and concrete dam at the falls, from the architectural variety of the pedestrian mall to the gentle forested pathway and viewing platform overlooking marshland framed by hydro lines. Built elements were everywhere and inspired conversation about the impact that humans have on the natural world. These discussions ranged from expressions of acceptance to feelings of overwhelm. Some participants even felt empowered and inspired. Frances's initial thoughts at the tunnel at Petrie Lane were about the cement from which the tunnel was made, and how it was "a nightmare material." But then, Frances said, "when I got to the end, I felt an overwhelming gratitude to be able to sing there. So much is given by a bike tunnel. That seems a windfall—one of those things that happens that is so generous—to be given that space" (group debrief at the tunnel, July 6, 2020).

When singing in place we were struck by an awareness of the ways that settler culture, history, and industrialization converge. We found that there was an array of experiences to be

had in the built environment, ranging from gratitude to surprise; we even felt a thrill when singing in some places. We felt a strange juxtaposition, sensing the human impact from both positive and negative viewpoints. There is beauty in the built environment, in history, in industrialization. But it is also—literally—concrete evidence of settler culture, surrounding us at all times. When in a city, I will often marvel at the architecture, the amenities, the other people, or the storefronts. It was when singing in place that I became acutely aware of what had come before, and the means by which the city had become what it is. Our experience at Sparks Street Mall prompted such discussions, as that space is a microcosm of the history of settler colonialism in Ottawa, an environment completely taken over by colonial architecture. Frances said,

> There were lots of different feelings in some of those doorways or in the pillared building, plus the place in general. I wasn't thinking about the environment in there. I was thinking about human history—settler history. A human history environment (group debrief at Sparks Street Mall, August 5, 2020).

Overall, I learned that EVE can change the intensity of a person's listening—both inwardly and outwardly. I also learned that developing listening awareness of the world around us through EVE can help us develop compassion for that world. When we sing to, with, and through environments and heighten our listening, we can engage with the details around us. In short, through EVE, I have learned to embrace the reciprocity between place and the self.

Figure 10 provides a diagrammatic illustration of my overall of analysis of the study.

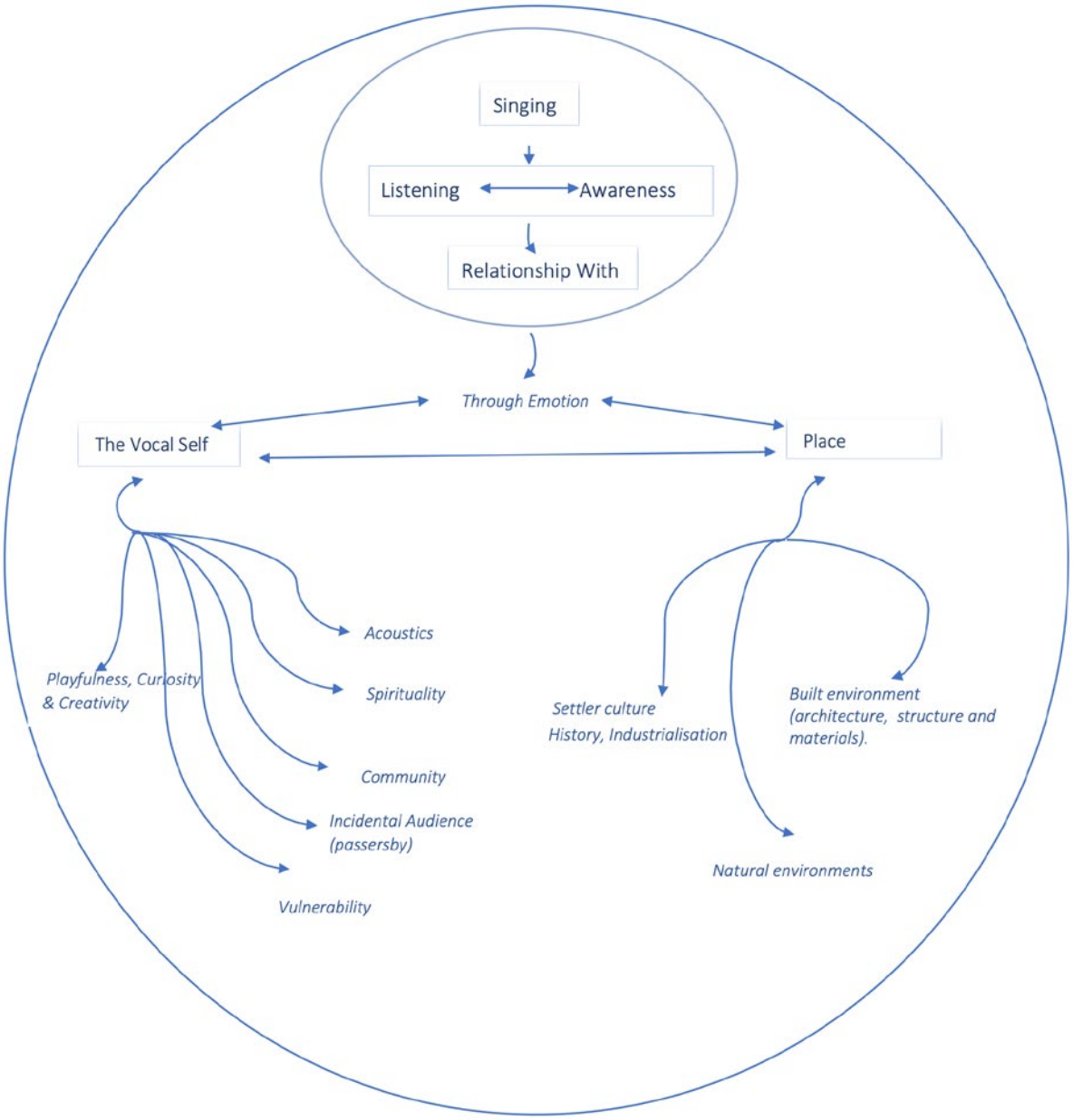


Figure 10

Analysis Diagram of The Singing Field

Three Emergent Terms

The data analysis and autoethnographic process rendered three key terms related to singers' experiences: vocal environmentalist, environmental countertransference, and xeno-song.

Vocal environmentalist: This was the first term I developed, in order to describe my own experience of feeling a change in my relationship to the environment after dozens of EVE experiences.

Environmental countertransference: This term describes the feeling of knowing something about a place because we sang in it. One very concrete example of this experience took place when I sang in the caves near a village called Morwenstow when on my walk around the South West Coast Path in Cornwall, England. Although I did not have any knowledge of the history of the area, the caves elicited strong feelings of grief. It was only that evening, when settling in at my lodgings for the night, that I learned that that cove had been the site of the most shipwrecks on the Cornish coast.

Xeno-song: This term offered me a way of describing the emotion-driven singing that seemed to happen when a singer was given permission to use their voice in any way they saw fit. I adapted the word from philosopher Roland Barthes (1985) who, when discussing the "grain" of the voice, coined the terms "pheno-song" and "geno-song," referring to that which is difficult to describe in the essence of the singing voice. He describes it as "hearing the body" in the voice (181). He adapted his terms from linguist, philosopher, and psychoanalyst Julia Kristeva (1986) who originally created the terms "phenotext" and "genotext" to refer to that similar elusiveness in text. In turn, I have adopted their terms, adding the concept of "xeno-song," meaning "other-song," referring to the sounds that we *leave out* of our singing vocabulary. The sounds that we leave out are not just melodic sounds, but any sound—including screaming, wailing, clicking, popping, etc. Vocal improvisers have used the term *soundsinging* (Tonelli, 2020a) to describe this full-spectrum use of the voice, and my use of xeno-song draws on such practices.

Free Vocal Improvisation: Extralinguistics

To grasp the depth of vocal improvisation traditions from which xeno-song derives, I will examine them briefly here. Free vocal improvisation, broadly defined, is the use of the voice in any way that it can be used. It does not necessarily mean there is a melody, although there may be. It may not be based on tones or pitch at all. The term *extralinguistics* is often used when describing the full range of expression one uses when communicating, "refer[ing] to anything in the world outside language that is relevant to the utterance" (Oxford Dictionary of English Grammar, n.d.). In a wider sense, this term includes such elements as gesture, body language, and sign language.

When singing, embracing extralinguistics means that we can use traditional elements of music such as melody, harmony, rhythm, and timbre. In addition, though, it can include percussive elements such as clicking or popping, dental sounds such as hissing, or the use of consonants such as "t-t-t-t-t" or "k-k-k-k." It could be based on emotional elements such as wailing, roaring, laughing, or growling. It can include shouting, sneezing, coughing, crying, panting, clicking, or buzzing. If it can be articulated, it can be included in vocal improvisatory expression.

There are a range of performers, composers, and scholars who work with extralinguistics. R. Murray Schafer calls it "raw vocable sound" (1970, 1). He seeks to break vocal tradition in what he calls a "desperation" for people to use the whole voice in order to overcome inhibition and "to find the personality of each individual voiceprint" (1). Vocal improviser and researcher Christopher Tonelli (2020a) encourages the use of a full range of vocal possibilities when singing. He welcomes these sounds into his practice to break away from the use of "pure" pitches (3). Tonelli says that they are, in fact, valid, important, and powerful extensions of the singing voice (4). I could not agree more.

Paul Dutton began his career as a sound poet who added his poetry to improvisational music ensembles. He was the performer who coined the now widely-used term soundsinging to describe the use of extralinguistics in his vocal improvisation (Tonelli, 2017). Dutton

uses soundsinging in choirs, in small groups, and in his solo work. Phil Minton, another soundsinger, leads a vocal improvisation choir called The Feral Choir (Tonelli, 2020b). He includes bodily sounds in his singing such as retching, vomiting sounds, and burping. Christine Duncan, a singer based in Toronto, also uses an extensive range of sounds in her solo singing and with the choir she leads, The Element Choir (Sofar Sounds, 2018). Maggie Nicols, originally a jazz singer, began using a wide range of improvisational vocal sounds early in her career. She can be heard singing with Minton, Dutton, and others in small group settings. In addition, we can hear this kind of singing in the creative sounds of Gabriel Dharmoo (http://gabrieldharmoo.org), Sarah Albu (https://www.sarahalbu.com), and Kathy Kennedy (https://kathykennedy.ca), all of whom reside in Montreal. In their performances, there are no limits to the sounds they use.

Xeno-song goes beyond soundsinging or the use of extralinguistics, however. It also refers to the emotion behind the use of those sounds. We see this frequently as music therapists in the unusual voices of those we work with—the one who yells, the one who buzzes their lips, the one who uses only vocal fry. For this reason, I think that xeno-song is an important concept for music therapists, as we need to be comfortable with any way that people make sound.

In the Words of the Participants

Through singing in place, the six performers (including myself) experienced personal change and awareness of place. We could not always articulate the essence of our experiences in words, though we tried to. Ellen said,

> The singing changed me. Because it became one more thing. The leaves and the wind and the raindrops and the sun and the wood chips under my feet are all external to me. But once I tried to interact with those factors, I became another factor. . . . Singing made the experience more cohesive. It made me more of a partner instead of an observer" (exit interview with author, August 25, 2020).

Frances explained, "It always brings me into how complex the natural world is and how I'm only a tiny part of that. . . . In fact, there's so much more that we are unaware of most of the time, that is deeply, deeply flowing within us" (exit interview with author, August 26, 2020).

For Kelly-Anne, it was a particularly emotional experience: "*The Singing Field* was this beautiful way of bringing my internal experience outside. It empowered me to use my voice in all sorts of ways to wake up, express joy, experience emotion, and to have them flow" (exit interview with author, August 24, 2020). For Cait: "It seemed like we all entered with an idea of what we expected to hear and then we left with a changed perspective on the other side" (exit interview with author, August 24, 2020). And for Helen:

> The environment felt like it was listening, which may be my imagination, but the living plants and animals undoubtedly perceived the singing at some level. I was quieter and more respectful of being in their place, a visitor, perhaps welcomed, but not necessarily. I was listening to the life and responding, echoing, joining in. Listening and singing in *The Singing Field* is like a new form of art. I feel like a beginner sounding out the environment, finding what sounds work when and where, by listening and feeling (exit interview with author, August 26, 2020).

All of us noticed that sense of intensification that Jean–Luc Nancy refers to.

What Is Next?

A Pilot Project

Currently, I am creating a model of group practice called Environmentally Engaged Music Therapy. As I write this, I am beginning new research, entitled "Singing Toward Personal and Community Change: Environmental Vocal Exploration (EVE) Enters the Music Therapy Session." This emerging research focuses on the development of a workshop using the approach outlined in *The Singing Field* above, but extending the ritualistic opening and closing. I plan to take people to different kinds of places for a series of sing events, focusing

on how singing in place allows for both personal and group transformation within a small research community. What might happen if we sang at a vehicle graveyard? A human graveyard? In canoes on the water?

My research question will be: Is environmental vocal exploration a valid tool for personal and community change in the music therapy setting? I will continue to use ethnographic and research-creation methodologies, but this new study will not be autoethnographic. This pilot project may become a case study that I will use in my development of the EVE concept as a music therapy model.

Other Uses of EVE

Beyond the use of EVE as performance practice (as was the case for my dissertation) and as a music therapy practice (as is the case for this new research), I am currently involved in a study that uses EVE as a mindfulness practice. The study is entitled "The Effectiveness of Mindfulness Training on the Experience of Music Performance Anxiety in Young Adult Musicians," and the principal investigator is Dr. Gilles Comeau of the University of Ottawa Music and Health Research Institute (Stanson et.al., 2022). Just as soundwalking can be a practice of awareness or an educational tool, EVE can be used as a mindfulness modality: for community groups or for choral groups (such as the Ottawa Youth Choir, who I was privileged to lead through EVE experiences in spring of 2022), it can be a way to connect people to each other; it can be an educational tool in school settings to raise awareness of the self in relation to surrounding environments; and it can raise awareness in support of environmental activism.

Final Words

That is where the river has taken me over these past two years. I have felt the flow—there is no question about that. Through this research, I have indeed come to a new place and I hope that what I have shared here contributes to your safe passage towards a new place of engaging with the voice as a listening practice, towards considering that listening in music-making means

that we do it together, that we do it at the same time. I hope your new place includes voicing in environments as you seek new awareness of your self and the places you are in.

References

Barthes, R. (1985). *The Grain of the Voice: Interviews 1962–1980.* Hill and Wang.

Cage, John. (1961). *Silence.* Wesleyan Press.

Corrigan, A. (2018). Hildegard Westercamp. *Sound Symposium.* http://www.soundsymposium.com/ssxix-hildegard-westerkamp/

Csikszentmihalyi, M. (2014). *Flow and the foundations of positive psychology: The collected works of Mihaly Csikszentmihalyi*. Springer.

Denzin, N. (2003). *Performance ethnography: Critical pedagogy and the politics of culture.* Sage Publications.

Eidsheim, N. S. (2015). *Sensing sound: Singing and listening as vibrational practice.* Duke University Press.

Eidsheim, N. S. (2019). Multisensory investigation of sound, body, and voice. In M. Bull (Ed.), *The Routledge companion to sound studies* (pp. 35–42). Routledge.

Emerson, R. M., Fretz, R. I., & Shaw, L. L. (2011). *Processing fieldnotes: Coding and memoing. In Writing Ethnographic Fieldnotes* (2nd ed., pp. 171–195). University of Chicago Press.

Feld, S. (2015). Acoustemology. In D. Novak & M. Sakakeeny (Eds.), *Keywords in sound* (pp. 12–21). Duke University Press.

Kenny, C. (1982). *The Mythic artery: The magic of music therapy* (2nd ed.). Ridgeview Publishing Company.

Kenny, C. (1985). Music: A whole systems approach. *Music Therapy, 5*(1), 3–11.

Krause, B. (2012). *The great animal orchestra: Finding the origins of music in the world's wild places.* Little, Brown and Company.

Kristeva, J. (1986). *The Kristeva reader* (T. Moi, Ed.). Columbia University Press.

McCartney, A. (2016). How am I to listen to you? In G. Siddall & E. Waterman (Eds.), *Negotiated moments: Improvisation, sound and subjectivity* (pp. 37–54). Duke University Press.

Murph, M. (n.d.). Max Neuhaus's sound works and the politics of noise. *Ecomusicology Review.* https://ecomusicology.info/max-neuhauss-sound-works-and-the-politics-of-noise/

Nancy, J.–L. (2007). *Listening.* Fordham University Press.

Oddy, N. (2001). *A field of vocal discovery: A descriptive study of vocal perception* [Unpublished master's thesis]. McGregor School of Antioch University.

Oddy, N. (2011). A field of vocal discovery: The workshop. In F. Baker & S. Uhlig (Eds.), *Voicework in music therapy: Research and practice* (pp. 83–99). Jessica Kingsley Publishers.

Oddy, N. (2022). *Seeking awareness of our selves and the environment through vocal improvisation in* The Singing Field [Doctoral dissertation, Carleton University]. Carleton University Research Virtual Environment. https://curve.carleton.ca/a420c777-6f70-4e74-ae4b-d4a9cb03e4da

Oliveros, P. (2005). *Deep listening: A composer's practice.* Deep Listening Publications.

Oliveros, P. (2016). Improvising composition: How to listen to the time between. In *Negotiated moments: Improvisation, sound and subjectivity* (pp. 75–90). Duke University Press.

Oxford University Press. (n.d.). *Oxford dictionary of English grammar.* Retrieved September 24, 2021, from https://www.oxfordreference.com.

Rothenberg, D. (2002). *Sudden music: Improvisation, sound, nature.* University of Georgia Press.

Schafer, R. M. (1970). *When words sing.* Berandol Music.

Schafer, R. M. (1977). *The tuning of the world.* The Canadian Publishers.

Schafer, R. M. (2002). *The complete Patria.* Arcana Press.

Small, C. (1998). *Musicking: The meanings of performing and listening.* Wesleyan University Press.

Smith, J. D. (2004). Playing like a girl: The queer laughter of the Feminist Improvising Group. In D. Fischlin & A. Heble (Eds.), *The other side of nowhere: Jazz, improvisation and communities in dialogue* (pp. 224–243). Wesleyan University Press.

Sofar Sounds. (2018, March 29). *The Elemental Choir – Improv 1 | Sofar Toronto* [Video]. Youtube. https://www.youtube.com/watch?v=rt_8HXyLEac

Stanson, N, Comeau, G., Smith, A., Swirp, M. (2022, December). The Effectiveness of mindfulness training on the experience of music performance anxiety in young adult musicians. A preliminary investigation. *Revue Musicale Oicrm, 9*(2), 102–115. https://revuemusicaleoicrm.org/rmo-vol9-n2/the-effectiveness-of-mindfulness-training/

Stévance, S., & Lacasse, S. (2013). *Research-creation in music and the arts: Towards a collaborative interdiscipline.* Routledge.

Tonelli, C. (2017). Unimagining song: Making kin in the vocal scene. *Yearbook for Traditional Music, 49*, 150–217. https://doi.org/10.5921/yeartradmusi.49.2017.0149

Tonelli, C. (2020a). *Voices found: Free jazz and singing.* Routledge.

Tonelli, C. (2020b, August 8). *Phil Minton's 1st Online Feral Choir (with Groningen, St John's & Guelph Vocal Exploration Choirs)* [Video]. *Youtube.* https://www.youtube.com/watch?v=E1aIQGp0B0o

Author Information

Nicola has been a certified music therapist for nearly 40 years with people of all ages and abilities. She engages with "singing as a listening practice" in workshops and in her current work as a supervisor for professional music therapists. She has taught part-time at Concordia University since 2010 and currently teaches at Carleton University. Her research with Environmental Vocal Exploration can be seen at https://vimeo.com/hasi/thesingingfield.

Musicothérapie réceptive auprès d'adolescents en milieu hospitalier

Présentation d'un protocole de détente psychomusicale instrumentale pour les personnes souffrant d'anorexie mentale : le « DéPi-AM »

[Receptive Music Therapy and Anorexia Nervosa in Hospitalized Adolescents. Presentation of a Psychomusical Relaxation Protocol: The "DéPi-AM"]

Stéphane Scotto Di Rinaldi, Ph.D(c), BMT

Résumé

La prise en charge de l'anorexie mentale reste encore difficile notamment en phase aiguë nécessitant une hospitalisation (Peretti et Bargiacchi, 2017). En France, les prises en charge traditionnelles sont axées davantage sur la parole et son émergence pour le patient et sa famille. On peut aussi avoir recours aux thérapies non médicamenteuses et non verbales, mais cela n'est pas fait de manière systématique. Après une recension de la littérature sur la musicothérapie auprès de personnes souffrant de troubles des conduites alimentaires, en particulier l'anorexie mentale, nous présenterons les modalités de fonctionnement d'un protocole groupal de musicothérapie réceptive : la détente psychomusicale instrumentale pour personnes souffrant d'anorexie mentale (que nous avons nommé « DéPi-AM ») appliquée à des adolescents hospitalisés. Durant plus de deux ans, nous avons utilisé le DéPi-AM dans des moments vécus ou perçus comme hautement anxiogène pour les jeunes patients hospitalisés. Nous illustrerons l'utilisation de ce protocole par quelques données et observations cliniques qualitatives basées sur notre pratique que nous discuterons. Nos premiers résultats exploratoires et observations cliniques dénotent une recrudescence des émotions négatives en l'absence de séance

de musicothérapie et une augmentation des pensées positives et d'une perception des effets de relaxation en cours de séance. Nous proposerons également une réflexion plus étendue sur l'utilisation de la musique à des fins de relaxation, dans le cadre de la pratique de la musicothérapie, et nous tenterons d'esquisser un profil de patients pour qui cette démarche thérapeutique pourrait s'avérer pertinente dans un parcours de soins pluridisciplinaires.

Mots-clés : *Anorexie mentale, troubles des conduites alimentaires, musicothérapie réceptive, détente psychomusicale, relaxation, adolescent, unité d'hospitalisation*

Abstract

The treatment of anorexia nervosa remains challenging, particularly during the acute phase that requires hospitalization. In France, traditional care centres on talk therapy with the patient and their family; although non-pharmacologic and non-verbal therapies may be used, they have not been applied systematically. After a review of the literature on the use of music therapy for eating disorders, focusing primarily on anorexia nervosa, we will present the modalities of a group protocol of receptive music therapy (which we have termed DéPi-AM) applied to hospitalized adolescents suffering from anorexia nervosa. For more than two years, we used DéPi-AM in institutional situations that patients were experiencing as highly anxiety-inducing. We will discuss the use of this protocol through qualitative clinical data and observations from our practice. Our preliminary results point to an increase in negative emotions in the absence of a music therapy session and an increase in positive thoughts and a sense of relaxation during the session. We will also recommend a more extensive reflection on the use of music for relaxation within music therapy practice and attempt to define a patient profile for whom this therapy could prove useful when integrated into a course of multidisciplinary care.

Keywords: *anorexia nervosa, eating disorders, receptive music therapy, psychomusical relaxation, relaxation, adolescents, hospitalization unit*

Introduction

Anorexie mentale

L'anorexie mentale (AM) est un trouble des conduites alimentaires (TCA) qui s'installe généralement à l'adolescence ou au début de l'âge adulte (Attia et Walsh, 2007). L'AM est caractérisée par une restriction prolongée des apports énergétiques, une peur intense de prendre du poids, et une dysmorphophobie — c.-à-d. une altération de la perception du poids et/ou de la forme de son corps (American Psychiatric Association, 2013). L'AM peut être de type hyperphagique/purgatif ou de type restrictif — c.-à-d. réduction importante de l'alimentation, régime, jeûne ou hyperactivité physique (APA, 2013).. La personne souffrant d'AM peut percevoir et éprouver son corps ou une partie de celui-ci comme lui étant étranger, ce qui peut entrainer un clivage corps-esprit, voire être perçu par certains patients comme une ascèse consistant à sublimer l'esprit au détriment de leur corps (Carraz, 2009).

En France, les recommandations de bonnes pratiques de la Haute Autorité de Santé (HAS, 2010) encouragent une démarche pluridisciplinaire (somatique, nutritionnelle et psychologique) modulable en fonction de la réalité somatique et psychique du patient hospitalisé. Globalement, ces recommandations sont similaires aux recommandations internationales par rapport à cette population *(National Institute for Health and Care Excellence* : NICE, 2017), même si ces dernières ne mentionnent ni la musique, ni l'art-thérapie, ni la musicothérapie dans l'accompagnement des TCA (NICE, 2017). Pour les patients hospitalisés à temps plein, la priorité est donnée à l'aspect somatique des soins, conjugué à des éléments psychologiques et sociaux (thérapie de soutien, psychothérapie) ainsi que pharmacologiques. Par ailleurs, des approches psychocorporelles, comme la méditation de pleine conscience, le yoga (Peretti et Bargiacchi, 2017), ou encore les thérapies par les arts (Dubois, 2010) favoriseraient la prise de conscience du corps par la détente corporelle. Alors que les données probantes sont encore insuffisantes en ce qui concerne ces pratiques, on peut proposer la musicothérapie groupale en complément des thérapies individuelles, comme la psychothérapie (HAS, 2010).

Dans cet article, après une recension de la littérature, nous présenterons les modalités « types » du fonctionnement d'un protocole inédit et adapté à cette population que nous désignons par l'acronyme « DéPi-AM » (Détente Psychomusicale instrumentale pour les personnes souffrant d'anorexie mentale), utilisé auprès de patients ayant vécu des moments comme hautement anxiogènes dans le cadre de leur hospitalisation. Par la suite, nous illustrerons l'utilisation de ce protocole au moyen de quelques données et observations cliniques qualitatives, et discuterons de ceux-ci par rapport à notre pratique.

Intérêt de la musicothérapie dans l'accompagnement des TCA

À notre connaissance, il existe dans la littérature quelques données concernant l'utilisation de la musicothérapie auprès d'adultes souffrant de TCA, mais très peu par rapport aux adolescents. La musicothérapie serait utilisée en appui des autres méthodes d'accompagnements pour améliorer des éléments clés de la symptomatologie anorexique (émotionnelle, communicationnelle, psychopathologique, psychosociale, sphère psychocorporelle). Chez ces adolescents, la musicothérapie active a été plus étudiée (Robarts et Sloboda, 1994; Robarts, 2000; McFerran, 2006), en comparaison à la musicothérapie réceptive. Hilliard (2001) présente un protocole de musicothérapie basé sur une approche cognitiviste ayant un volet de détente psychomusicale, mais pas ses résultats. Quelques études font état de cette modalité de prise en charge chez l'adulte (Justice, 1994; Pasiali *et al.*, 2020; Shah *et al.*, 2021).

Dans une revue systématique des effets de la musique regroupant 119 études, Testa *et al.* (2020) en ont retenu 16, dont deux seulement répondaient aux critères de contrôle et de randomisation de la médecine fondée sur des données probantes (*evidence-based medicine*), pour un total de 3 792 patients. Les études en question s'intéressaient davantage à l'AM ou à la boulimie nerveuse (BN). Cet examen suggère qu'un travail sur les sensations corporelles, difficilement prises en charge en psychothérapie standard, pourrait être intéressant en musicothérapie. *In fine*, la musique aurait une influence positive sur le

comportement alimentaire et sur les apports alimentaires, sur l'anxiété, les biais attentionnels, les enjeux thérapeutiques et les expériences corporelles (Testa *et al.*, 2020). Toutefois, l'exposition à la musique semble bénéfique lorsqu'elle est encadrée par des thérapeutes, mais se révèle potentiellement néfaste lorsqu'elle est « consommée » sans surveillance sous la forme de médias sociaux ou de clips vidéo (Testa *et al.*, 2020). Ceci rappelle les différentes utilisations « saines » ou « malsaines » de l'écoute musicale et la mise en échec probable de l'autorégulation émotionnelle. En effet, auprès d'adolescents hospitalisés en phase aiguë, la musique peut aussi intensifier les humeurs négatives et dépressives, favoriser les pensées négatives (par rumination), ou encore rappeler et faire revivre des souvenirs traumatiques (Hense, Silverman et Skewes McFerran, 2018).

En outre, dans le cadre de la musicothérapie active (*c.-à-d.* où patient et thérapeute jouent) et à la lumière du concept de « *moments significatifs* »[1], Trondalen (2003) propose une analyse musicale d'une patiente de 26 ans souffrant depuis 6 ans d'AM. Par l'autoécoute de sa production musicale, le patient peut prendre conscience du clivage « corps-esprit » et de la dimension spatio-temporelle (le passé; le moment présent; le futur) suffisante et nécessaire pour lâcher prise.

Dans un autre usage de la musicothérapie, la détente psychomusicale – forme de musicothérapie réceptive – cherche à induire une sensation de relâchement et de bien-être sans participation active du patient (*c.-à-d.* que le patient ne joue pas d'instrument). L'écoute peut être instrumentale (jeu « *en live* » par le musicothérapeute), ou rendue possible par l'intermédiaire d'une bande sonore précise créée « sur mesure » selon les préférences et la sensibilité musicale de la personne. Cette bande respecte des caractéristiques musicales particulières en fonction de l'effet que le musicothérapeute cherche à induire (montages en « U » pour la relaxation, en « J » pour la stimulation sensorielle ou en « L » pour

[1] Le concept de « *moments significatifs* » développé par Gro Trondalen (2003) désigne de brefs instants d'une séance en musicothérapie active où le patient et le thérapeute éprouvent les bienfaits d'une communication intersubjective. Cette dernière pourrait soutenir la mémoire procédurale et la mémoire émotionnelle (Trondalen, 2003).

l'endormissement). Ces différents montages sonores requièrent différentes modalités musicales. Pour le montage en « J », visant la stimulation, on mettra l'accent sur une augmentation progressive du rythme et du nombre d'instruments ou de l'intensité sonore (de faible à modéré/rapide). Pour le montage en « L », qui vise l'endormissement, ce sera l'inverse. Pour le montage en « U », dont l'objectif est la relaxation (et le sujet du présent article), on misera davantage sur une diminution progressive du rythme (de 100 battements par minute ou BPM à 30, voire 20) et du nombre d'instruments et de l'intensité sonore, suivie, une dizaine de minutes plus tard, d'une augmentation progressive de l'intensité sonore et du rythme (de 20/30 à 80 BPM). Que le musicothérapeute fasse écouter des pièces musicales connues, préenregistrées ou jouées en séance, il veille à respecter les paramètres précis des contrastes rythmiques et mélodiques de la musique.

Des techniques de relaxation par induction musicale existaient déjà depuis Dardart et Jost (Guilhot *et al.*, 1979) dont le protocole mêlait techniques de relaxation, écoute musicale et massages. Initialement conçu par Guiraud-Caladou (1979), le montage en « U » (trois étapes : stimulation, relaxation et éveil) est une technique de détente psychomusicale reprise et standardisée par Guétin *et al.* (2010). Plus récemment, une technique instrumentale et verbale a été présentée auprès de personnes présentant des difficultés psychosociales (Wheeler, 2019). De nos jours, des études impliquant des outils innovants de détente psychomusicale comme le Montage Audio Personnalisé en musicothérapie réceptive (MAP), ont montré des résultats prometteurs et encourageants par rapport à la réduction de l'anxiété pour des enfants et des adolescents hospitalisés (Archambault *et al.*, 2019), et pour des jeunes sans-abris (Vaillancourt *et al.*, 2022). Utilisé auprès d'enfants et d'adolescents hospitalisés, le MAP favorise également une amélioration générale de l'humeur par la diminution des affects négatifs (Archambault *et al.*, 2019).

Dans l'accompagnement du TCA, la littérature appuie une diversification des techniques. Justice (1994) décrit (sans toutefois citer les effets obtenus) une technique de relaxation incluant la musique qui s'inspire de pratiques de relaxation verbales et corporelles

traditionnelles (p. ex. : Jacobson, Yoga, respiration, imagerie mentale) et se rapproche de la détente psychomusicale. Shah *et al.* (2021) présentent les bienfaits de la méditation de pleine conscience conjuguée à la musique. Par ailleurs, bien qu'elle ne soit pas une technique de détente psychomusicale, la Méthode Bonny (*Bonny Method of Guided Imagery and Music* ou GIM) met en lien la musique et l'imagerie guidée. Dans le cadre de cette méthode, qui nécessite une formation particulière, on laisse la musique agir sur les souvenirs, les images et les émotions inconscientes (Vaillancourt, 2012). Dans le cas du TCA, certaines études rapportent que le GIM présente des éléments de prise en charge de certains traumatismes et des émotions liées à l'image corporelle (Justice, 1994 ; Pasiali *et al*., 2020). D'autres dispositifs utilisant des supports acoustiques et vibrotactiles présentent quelques résultats auprès d'adolescents hospitalisés pour AM. L'association des modalités multisensorielles semble amplifier l'intellectualisation des émotions perçues, qui sont nommées d'une part et métaphorisées d'autre part (Patiño-Lakatos *et al*., 2020). Hors TCA, il existe une autre étude qualitative qui présente l'efficacité d'une thérapie vibroacoustique pour améliorer l'autorégulation émotionnelle, la connaissance de soi et la conscience corporelle chez les adolescentes hospitalisées pour forte anxiété, faible estime de soi ou faible perception corporelle (Rüütel *et al*., 2004). Dans le cadre du TCA, l'écoute de musique aiderait à mieux identifier et exprimer des émotions vécues (Applewhite *et al*., 2020; Krishna Priya *et al*., 2021). L'écoute d'une pièce musicale peut entrainer toute une gamme d'émotions et de souvenirs (positifs ou négatifs), et peut s'avérer un moyen pour faire face à des émotions difficiles et des cognitions anorexiques[2] ou s'en distraire (Applewhite *et al*., 2020; Krishna Priya *et al*., 2021). Toutefois, les personnes souffrant de TCA peuvent écouter de la musique en double tâche (plusieurs heures par jour), mais rarement sans faire autre chose (Krishna Priya *et al*., 2021). Or, la musique semble réduire le sentiment d'anxiété en devenant une nouvelle

[2] Ensemble de pensées pathologiques, envahissantes et excessives (provoquées par des stimuli externes ou internes) tournées vers l'alimentation, les moments d'hospitalisation en lien avec le TCA (*par exemple*, « la pesée », un rendez-vous avec un médecin ou la diététicienne, les repas passés ou à venir), l'estime de soi, l'image du corps (avec ou sans dysmorphophobie), le poids, les calories… et tout biais cognitif de confirmation en lien avec le TCA.

stratégie pour composer avec une situation, s'autoréguler et faire face aux émotions difficiles (Smeijsters, 2012). De plus, il semble que les personnes souffrant de TCA ont un plus haut niveau d'attention soutenue, un état de vigilance et une activité cérébrale accrus, en situation de repos comme de stimulation musicale (Sparlato *et al.*, 2020).

De son côté, une équipe australienne a obtenu des résultats significatifs en utilisant la musicothérapie active et réceptive pour réduire l'anxiété post-prandiale d'adultes souffrant d'AM, hospitalisés (Bibb *et al.*, 2015) et en prise en charge ambulatoire (Bibb *et al.*, 2019). La musicothérapie peut être utilisée comme un « coupe-circuit » contre les cognitions anorexiques et anxieuses faisant suite à un repas (Bibb *et al.*, 2016). Ces trois études démontrent le bien-fondé d'un soutien verbal et musical à l'issue des repas et les bienfaits d'une médiation pour aider les patients à se distraire des cognitions anorexiques.

L'ensemble de ces éléments peut donc justifier l'utilisation d'une démarche thérapeutique basée sur la relaxation psychocorporelle pour accompagner la réduction de l'anxiété dans des moments vécus comme anxiogènes par les patients hospitalisés.

Méthodologie

Présentation générale du protocole de musicothérapie : le DéPi-AM

Le DéPi-AM est un protocole de musicothérapie[3] spécifique inédit, adapté aux particularités des patients souffrant de TCA et à une pratique groupale proposée une quarantaine de minutes avant « la pesée » hebdomadaire des patients hospitalisés (*cf.* tableau 1). À notre connaissance, il n'existe pas de tel groupe dans cette population ni à ce moment précis de l'hospitalisation. Depuis 2020, à des fins d'exploration et comme elle semblait

[3] Ce protocole est largement adapté d'une technique de détente psychomusicale instrumentale individuelle non standardisée et non publiée à ce jour et à notre connaissance. Cette technique a été mise au point par l'ancien responsable pédagogique du Diplôme Universitaire de Musicothérapie de Montpellier (France). Nous nous sommes également inspirés du montage en « U » de Guétin *et al.* (2010), adapté à notre jeu de l'instrument et non à l'écoute par casque audio. Ces deux techniques complémentaires sont, à l'origine, utilisées de manière individuelle auprès d'autres populations adultes (algologie, maladie d'Alzheimer, troubles dépressifs majeurs). Dans le cadre précis de cette pratique, nous avons tenté de regrouper et d'adapter ces techniques aux caractéristiques de l'AM, à nos observations cliniques et aux différentes littératures existantes. Pour ce faire, nous avons exclus les exercices trop axés sur le corps ou les silences trop prononcés, par exemple.

indiquée dans ce contexte clinique, nous avons intégré cette démarche aux soins courants d'une unité d'hospitalisation en temps plein dans un service de pédopsychiatrie. Deux à huit patients étaient réunis dans une grande salle aux qualités acoustiques adaptées dans laquelle les bruits blancs parasites de la climatisation/chauffage étaient limités, et une faible luminosité ainsi qu'une température agréable (environ 20°) étaient favorisées. D'une part, nous savons que, similairement au sommeil, l'état de relaxation entraine une diminution de la température corporelle (environ 0,3°C) (Larroque, 2013) et, d'autre part, que l'AM peut provoquer une hypothermie (<35,5°C) (APA, 2013; HAS, 2010). Ainsi, lors de séances hivernales, on demandait aux patients d'apporter une couverture. Par ailleurs, la position allongée pouvant être très difficile (malgré une hypertonie constatée chez certains patients), on leur demande de s'installer le plus confortablement possible (en position allongée ou semi-allongée sur des tapis de gym), les yeux fermés. Afin de réduire les tensions musculaires et le gainage en position semi-allongée, des ballons physio (c.-à-d. ballons de rééducation antidérapants de différentes tailles détournés ici de leur usage initial) pouvaient être mis à disposition. En raison de la problématique principale des patients au sujet de leur corps, nous n'avons pas inclus les suggestions verbales traditionnellement utilisées dans le « balayage corporel » et la détente progressive musculaire (*p. ex.*, Jacobson ou Schultz). Aussi, les phases de silence ont été réduites notamment par un jeu de la mailloche sur l'acier de l'instrument, entre le son des notes. Ces mesures permettent de diminuer l'accès aux cognitions anorexiques et aux pensées négatives en lien avec « la pesée » qui suit la détente. La séance se termine par un jeu lent de l'instrument par le musicothérapeute, en respectant davantage le principe du montage en « U » (Guétin *et al.*, 2010). Comme la verbalisation en groupe est plus difficile, nous avons recueilli par écrit les propos des participants en fin de séance, et le psychologue pouvait prévoir du temps, lors de ses entretiens cliniques, pour faire le point sur les séances et le vécu des patients.

Tableau 1

Différents temps du dispositif DéPi-AM.

Temps 1 : Installation	Les patients ont pour consigne de s'installer confortablement, de fermer les yeux, d'inspirer profondément, puis d'expirer complètement, à leur rythme. On leur suggère ensuite de porter attention au jeu instrumental et à l'ensemble des sons musicaux entendus dans la pièce. En présence de possibles sons parasites (bruits dans le couloir, ouverture de portes, personnes qui parlent en dehors de la salle, bruits dans la salle…), on leur demande de concentrer leur attention uniquement sur les sons de l'instrument.
Temps 2 : Jeu instrumental	**Phase A** (3 à 4 minutes) : En début de séance, on adapte le jeu instrumental à l'état de vigilance des patients. S'il parvient à relever les constantes physiologiques (tension artérielle systolique, diastolique, fréquence cardiaque) des participants avant la séance, le musicothérapeute les gardera en mémoire. Il observe, entre autres, la fréquence respiratoire. Ceci lui permet de calquer la pulsation à la noire sur le mouvement d'inspiration et d'expiration du patient qui respire le plus vite dans le groupe. Le rythme frappé est en croche et double croche, et reste soutenu entre les notes jouées. Les temps faibles sont marqués sur l'acier de l'instrument, et les temps forts sont marqués sur l'acier ou sur les notes. La note fondamentale (Si min ici) ponctue chaque mesure et permet de créer un espace sonore contenant. Cette note est jouée tout au long de la séance et permet, par sa régularité, d'induire un état de relaxation et de détente, en maintenant une certaine attention sans dormir. **Phase B** (6 à 10 minutes): Progressivement, la pulsation va diminuer pour atteindre un tempo entre 20 et 30 BPM. Cette progression dans le jeu musical laisse entendre la profondeur des harmoniques. À cette phase, on recherche davantage les intervalles naturels. Des intervalles harmoniques voire des accords sont toujours possibles au début de cette phase, mais font progressivement place à une forme d'arpège ou d'intervalles mélodiques. **Phase C** (≈ 3 minutes) : Le jeu est ponctué par la résonance des sons et des silences qui vont induire la rythmicité de la musique. Durant cette phase, en fonction de l'état de vigilance du groupe, le jeu instrumental peut s'intensifier très légèrement.

Temps 3 : Exercices de reprise	Ce temps est marqué par le jeu instrumental qui s'intensifie progressivement, et le volume de la voix du thérapeute douce, neutre et régulière augmente progressivement au fur et à mesure qu'avancent les exercices. Ces derniers permettent de revenir à un état de vigilance ordinaire. Les patients sont encore allongés, les yeux fermés. Les consignes données, entrecoupées de pauses (d'environ 5 à 10 secondes), sont les suivantes : - À présent, tournez la tête vers la droite - Puis, vers la gauche - Pointez votre menton vers le haut - Pointez votre menton vers le bas - Vous pouvez reposer votre tête - Tendez votre bras droit - Fléchissez-le - Faites de petits mouvements avec votre main droite - Relâchez votre bras - Tendez votre bras gauche - Fléchissez-le - Faites de petits mouvements avec votre main gauche - Vous pouvez relâcher votre bras - À présent, prenez une grande inspiration puis expirez, à votre rythme - Fléchissez votre jambe droite - Relâchez votre jambe - Fléchissez votre jambe gauche - Relâchez votre jambe - Faites de petits mouvements avec votre pied droit - Faites de petits mouvements avec votre pied gauche - Vous pouvez relâcher - Pour celles qui le souhaitent, vous pouvez vous étirer profondément - Prenez une grande inspiration puis expirez, à votre rythme - Enfin, prenez une grande inspiration puis expirez, mais cette fois au rythme de la musique (*le musicothérapeute joue un mouvement conjoint ascendant lors de l'inspiration et descendant lors de l'expiration – cette étape peut être répétée selon l'anxiété du groupe*) - Et quand vous le souhaitez, vous pouvez ouvrir les yeux et vous redresser

Déroulement type des séances

Les séances sont réalisées par un psychologue lui-même musicothérapeute clinicien et musicien (auteur de l'article) avec un instrument mélodico-rythmique (métallophone type *handpan* ou *tongue drum*) de forte amplitude afin d'induire une contenance sonore suffisante pour se détendre. L'instrument utilisé par le musicothérapeute sur l'ensemble des trois temps (*cf.* tableau 1) peut se jouer sur sa fondamentale et sur ses intervalles naturels (*c.-à-d.* sa tierce, sa quinte, sa septième et l'octave) afin de faire sonner les harmoniques[4] et des résonances plus profondes. Ces types de métallophones qui peuvent être utilisé en musicothérapie n'ont cependant pas tous la même qualité acoustique et harmonique. Dans ce dispositif, l'instrument utilisé est un *Rav Vast*[5] accordé en Si mineur. La recherche des harmoniques se fait donc autour des notes Si (fondamentale), Ré (tierce), Fa# (quinte), La (septième) et Si (octave).
Si cet instrument se joue généralement avec les mains, dans le cadre de la musicothérapie, des mailloches sont utilisées pour réduire l'effet percussif du claqué des mains et obtenir des sonorités plus douces. On privilégiera des mailloches pour timbales (notamment en raison de leur feutre), ni trop souple ni trop rigide pour obtenir de la rondeur et une attaque maitrisée.

À l'issue du temps 2 (jeu instrumental), sans dépasser 20 minutes, nous proposons un temps de reprise et de réveil corporel, pour favoriser la reprise de conscience de l'ensemble du corps, segment par segment. Pour ces exercices de reprise, nous suivons les lois développementales céphalo-caudales et proximo-distales qui régissent le développement psychomoteur, et l'appliquons d'abord à un hémicorps, puis à l'autre. Le musicothérapeute reprend la parole toutes les 5 secondes à 10 secondes, avec une prosodie douce dont la hauteur et le débit varient et progressent pour atteindre une voix plus forte et un rythme

[4] L'harmonique d'une note est une fréquence dont le multiple entier correspond à une fréquence fondamentale. Sur ces instruments, chaque lame en dispose de plusieurs.

[5] Instrument métallique (entre 1,5 à 2 mm d'épaisseur) idiophone mélodique appartenant à la famille des *tongue drums*, composé de 9 lames mises en vibration traditionnellement par la percussion des mains. Il est généralement en acier, rarement en inox, et son accordage est réalisé sur sa fondamentale et 4 à 7 de ses harmoniques, ce qui permet une grande précision et une justesse dans le temps, malgré le travail de l'acier au fil des années.

normal à l'issue du temps 3 (exercices de reprise). Cela favorise une émergence progressive depuis l'état de relaxation. Pour soutenir les patients dans la mobilisation de leur corps, le jeu instrumental se poursuit de manière plus énergique lors des exercices de reprise.

Participants

Dans l'objectif de poursuivre le raffinement de ce protocole, nous illustrerons ici quelques données qualitatives exploratoires recueillies. Parmi l'ensemble des patients bénéficiaires de cette prise en charge, nous présenterons les premières données de huit adolescentes souffrant d'AM âgées de 13 à 17 ans (âge moyen 14;8 ans; ±2;4), hospitalisées à temps plein dans un service de pédopsychiatrie durant 4 mois en moyenne. Leurs indices de masse corporelle (IMC) variaient de 12,83 à 15,06 kg/m^2 (IMC moyen de 14,02±0,77) lors de leur première séance, de 14,16 à 16,3 après 8 semaines (fin des séances de musicothérapie – T1) (IMC moyen de 15,13±0,68), et de 15,8 à 17,17 après 16 semaines (fin du T2 – IMC moyen de 16,21±0,48). Six d'entre elles présentaient une AM restrictive et une dysmorphophobie plus ou moins envahissante. Deux autres présentaient une AM purgative (comportement purgatif – avec ou sans diurétique, laxatif; vomissements). La plupart présentent ou ont présenté des comportements compensatoires avant et durant leur(s) hospitalisation(s) (hyperactivité physique, comportement purgatif, vomissements, potomanie), une anxiété de performance ou des troubles psychiatriques comorbides (idées noires, fléchissement thymique, anxiété de séparation, phobie sociale et/ou isolement social, scarifications, effondrement de l'estime de soi, troubles obsessionnels compulsifs). Cinq avaient déjà pratiqué de la relaxation. Trois sont musiciennes, pratiquent ou ont pratiqué la musique (chant, guitare, piano, batterie).

Les participantes s'intégraient progressivement à un groupe ouvert. Les critères d'inclusion étaient les suivants : sur 16 pesées hebdomadaires effectuées, 8 ont été précédées d'une séance de musicothérapie (T1) et 8 ont été précédées d'aucun soin (T2). Les critères d'exclusion étaient les suivants : ne pas avoir rempli ou avoir rempli partiellement une fiche (*cf.* annexes; remise à l'issue des séances – T1 – et dans les périodes sans séances – T2), avoir

donné des réponses écrites correspondant aux biais de désirabilité sociale ou aux biais de réponses binaires (en tout ou rien sur l'ensemble des séances).

Ce travail s'intègre dans le cadre du soin courant. Il n'y a pas eu de recrutement, car il s'agissait de l'offre de soins habituelle proposée au patient, n'entrainant aucune modification dans le parcours de soin. L'échantillonnage de ces 8 patients a été réalisé entre juin 2020 et avril 2021 et est conforme à la déclaration d'Helsinki[6]. Les patients et leurs familles ont été informés des modalités d'utilisation des données et du droit de rétractation. Personne ne s'est opposé à cette récolte de données pour ce travail.

Les données qualitatives hebdomadaires ont été recueillies par le même intervenant (auteur de l'article) sur 16 semaines (8 semaines avec musicothérapie – T1 – suivie de 8 semaines sans musicothérapie – T2) par écrit sous forme de suggestions (sur la nature des émotions) et de zone de réponse libre, puisque la verbalisation orale est difficile en groupe (*cf.* annexes 1 et 2). Les questions portaient sur la nature des pensées survenues pendant le jeu instrumental du musicothérapeute (à T1) ou lors des « pesées » sans musicothérapie (à T2) (au moyen d'une échelle de Likert pour les émotions; et des cartouches libres pour la nature des pensées immédiates ou survenues en cours de séances). Les questions relatives aux émotions ont été regroupées en deux items (émotions positives/négatives) à des fins de synthèse. Après chaque séance, le patient exprimait par écrit son vécu du dispositif DéPi-AM. Une grille de cotation a été créée *ad hoc* pour le recueil et l'analyse des réponses écrites (dans les zones de textes libres). En nous basant sur la récurrence des réponses, nous avons catégorisé les réponses en 7 items généraux et 6 items relatifs à la musicothérapie (*cf.* tableau 2). Nous avons retenu ces catégories qui nous paraissaient les plus explicites et représentatives et nous avons regroupé par thèmes l'ensemble de réponses qui étaient similaires. En raison de notre faible échantillon (*n=8*), nous nous servirons de statistiques descriptives pour l'analyse.

[6] https://www.wma.net/fr/policies-post/declaration-dhelsinki-de-lamm-principes-ethiques-applicables-a-la-recherche-medicale-impliquant-des-etres-humains/

Résultats

Dans l'ensemble, ces résultats témoignent des bienfaits de ce type de protocole pour ces patients (*cf.* tableau 2). On observe une recrudescence des émotions négatives (*p. ex.*, en lien avec des évènements institutionnels ou personnels passés ou à venir dans la semaine) en l'absence de séance de musicothérapie (pour 69 % des patientes). La musicothérapie pourrait jouer un rôle dans l'émergence d'émotions positives (69 %) ainsi que dans la diminution des projections anxieuses à long terme (13 % en condition musicothérapie – T1 – *vs* 33 % en condition sans musicothérapie – T2). Lors des séances, les patientes décrivent une émergence de pensées positives directement en lien avec la séance (48 %), et certaines décrivent des effets relaxants (36 %).

Tableau 2

Résultats des questionnaires qualitatifs après séances et sans séances de musicothérapie.

Items en lien avec le vécu de l'AM et l'hospitalisation	*Nombre d'occurrences*			
	Après musicothérapie (T1)		*Sans musicothérapie (T2)*	
	Occurrences (score max. 64)	*%*	*Occurrences (score max. 64)*	*%*
Émotions positives	44	69 %	29	45 %
Émotions négatives	34	53 %	44	69 %
Projections anxieuses à long terme (*p. ex.*, « *peur de ne jamais y arriver* »)	8	13 %	21	33 %
Projections anxieuses à court terme (*p. ex., périodes d'hospitalisation, pesée, rdv médicaux…*)	20	31 %	20	31 %
Cognitions anorexiques	11	17 %	5	8 %
Émergence de pensées positives distinctes de l'hospitalisation	26	41 %	14	22 %
Émergence de pensées négatives distinctes de l'hospitalisation	18	28 %	17	27 %
Items relatifs aux séances de musicothérapie (T1)				
Pensées non définies liées à la relaxation (nature, voyage, univers…)	8	13 %	-	-
Pensées positives liées à la séance	31	48 %	-	-
Pensées négatives liées à la séance	6	9 %	-	-
Remarques positives sur le jeu instrumental	6	9 %	-	-
Remarques négatives sur le jeu instrumental	2	3 %	-	-
Effets de relaxation, de détente ressentis	23	36 %	-	-

Discussion

Ces premiers résultats pourraient indiquer que le contexte de musicothérapie peut temporairement favoriser l'émergence d'émotions positives, de pensées ou de souvenirs positifs (récents comme plus anciens), et contourner certaines projections anxieuses à long terme. Cela correspond aux données trouvées dans la littérature chez l'adulte (Bibb, 2015; 2016; 2019; Shah *et al.*, 2021). Toutefois, nous proposons la musicothérapie dans les phases les plus aiguës de la maladie, or il existe un ralentissement fonctionnel dans l'AM notamment lié à la dénutrition (APA, 2013) pouvant expliquer les difficultés de décentration des patients sur les cognitions anorexiques (notamment en différant certaines stratégies compensatoires). Sur le plan clinique, nous observons qu'à mesure que l'indice de masse corporelle des patients augmente, les cognitions anorexiques peuvent diminuer et l'adhésion au soin peut devenir plus facile, même si ce n'est pas toujours systématique. Ainsi, la musicothérapie pourrait gagner en pertinence dans des phases moins aiguës.

Par ailleurs, en raison de l'hétérogénéité interindividuelle et intra-individuelle (*p. ex.*, dans l'expression de la maladie et des trajectoires développementales, dans l'histoire de vie du patient), il est difficile de généraliser nos propos. Néanmoins, dans le sillon de certains cliniciens (Carraz, 2009), il ne s'agira pas ici de proposer la supériorité d'une technique par rapport à une autre ou d'opposer les pratiques entre elles, mais plutôt d'en tirer un apprentissage clinique. Ainsi, sur la base combinée de ces premiers résultats renforcés par une pratique hebdomadaire de plus de deux ans (auprès de plusieurs dizaines de patients) et de nos observations cliniques, nous pouvons définir un profil de patient pour lequel cette forme de musicothérapie réceptive peut être ou non prescrite/indiquée dans le cadre d'une hospitalisation (*cf.* tableau 3). Nous ne disposons pas de données suffisantes pour comprendre le lien entre la sensibilité à la musique, le jeu d'un instrument et une pratique antérieure d'une forme ou d'une autre de relaxation par les patients pour faciliter ou non ce type de soin. Ce tableau n'est donc pas exhaustif; il faut plutôt l'étudier au cas par cas, et le raffiner au fil des travaux de recherche ultérieurs.

Tableau 3

Profils d'adolescents souffrant d'AM pour qui la musicothérapie peut être prescrite/indiquée.

Musicothérapie réceptive indiquée	- Patient adhérant au soin somatique et psychique; - Patient ayant engagé un réel travail de psychothérapie (absence de déni de la maladie, critique des cognitions anorexiques, externalisation); - Patient ayant un fonctionnement métacognitif efficient et/ou des capacités introspectives soutenantes; - Patient ayant un IMC plus élevé (lien avec la renutrition et un recours plus fonctionnel aux capacités cognitives nécessaires pour ce type de prise en charge); - Patient ayant réduit ou supprimé les stratégies compensatoires (*p. ex.*, hyperactivité physique, potomanie, vomissements, usage de laxatifs); - Patient ayant déjà eu une expérience positive de la relaxation verbale (p. ex., Jacobson, Schultz, cohérence cardiaque), sophrologie, méditation (ou automéditation au moyen d'une vidéo *Youtube*), méditation de pleine conscience.
Musicothérapie réceptive non indiquée, prescrite ou pouvant être envisagée ultérieurement	- Patient résistant aux soins proposés ou s'y opposant, avec peu d'alliance thérapeutique dans l'ensemble des espaces de soins médicaux, diététiques et thérapeutiques qui lui sont proposés; - À l'inverse, patient trop « bon élève » adhérant à tout, mais sans y mettre de sens; - Patient ayant des mécanismes de défense très présents (déniant, défensif, ou recours excessif à l'intellectualisation); - Patient ayant un IMC trop bas associé à une hyperactivité physique trop élevée entrainant des hypertonies, ou des stratégies compensatoires dans sa posture « assise » (contractions, gainage) et des difficultés pour s'allonger complètement ou partiellement; - Patient ayant des comorbidités psychiatriques trop envahissantes (*p. ex.*, idées suicidaires avec ou sans passage à l'acte, états dépressifs, troubles obsessionnels compulsifs); - Patient dont la dysmorphophobie est très envahissante; - Patient utilisant des stratégies de régulation émotionnelle basées sur les problèmes ou dont les capacités d'autorégulation émotionnelles sont trop affaiblies; - Patient prépubère ou à l'entrée de l'adolescence (<12 ans) pouvant avoir des difficultés de décentration importante; - Patient présentant un certain manque de maturité émotionnelle, des difficultés introspectives et métacognitives trop importantes.

Réflexions sur la relaxation et les caractéristiques musicales

Nous pensons que la musique permettrait de créer son propre monde interne, de manière libre, sans guidance verbale de la part du thérapeute. Ici, nous nous sommes fondés sur le postulat voulant que la musique seule soit inductive. Or, nous connaissons encore mal ce qui est thérapeutique dans ce type de musique relaxante[7], qui reste, selon nous, fortement subjectif, et il demeure difficile à ce jour de comprendre si la musique utilisée seule reste thérapeutique. En musicothérapie, comme le média utilisé est à la fois tangible (*instrumentarium*) et impalpable (aspect sonore), il nous apparait difficile de généraliser et de déterminer clairement la dimension thérapeutique de ce type de séance. C'est pourquoi nous pensons que l'élément thérapeutique résulte d'une succession de facteurs (comme la présence du musicothérapeute, sa technicité musicale et sa subjectivité, le choix de l'instrument, de la technique de jeu, des caractéristiques musicales produites en séance et propres aux objets sonores utilisés, de même que l'existence et la dynamique de la relation thérapeutique).

Si le choix des mots dans les techniques de relaxation verbale, ou encore de la suggestion hypnotique, est primordial (Servant, 2009), nous pensons que l'étude des caractéristiques cliniques de la musique doit être soumise à la même analyse, tant sur le plan des émotions que celle-ci peut faire ressentir que dans les souvenirs que l'on peut y associer. Citons ici l'exemple d'une patiente à nouveau hospitalisée qui indique lors d'une reprise des séances (après plusieurs mois d'arrêt) que l'écoute de bandes « en U » et le retour à des séances de musicothérapie semblent revêtir pour elle, une dimension mnésique. Elle indique se souvenir de séances précédentes, du moment d'anxiété y étant associé et du moment précis de la relaxation. Cela invite à diversifier les instruments de même nature (*p. ex.*, en termes de gammes), et à réfléchir aux caractéristiques sonores de l'instrument (oscillation de son, présence de *tremolo*, temps de résonance des harmoniques, modalité majeure ou mineure).

[7] Nous qualifierons ici de « musique relaxante », toute musique écoutée permettant de se détendre tant physiquement que psychiquement. Si nous sommes conscients que la qualité subjective de la relaxation reste propre à la personne (selon son histoire personnelle, identitaire, culturelle, émotionnelle, mnésique [liées aux souvenirs]), nous pouvons observer la pertinence de certains invariants présents dans ce type de musique (*p. ex.*, sonorités particulières, son cristallin, jeu doux et contenant, présence de bruits de la nature).

Si la sonothérapie (thérapie par le son ou sonologie) peine à prouver son efficacité, celle-ci présente toutefois un axe de réflexion important pour la musicothérapie. On peut définir cette démarche comme étant une sorte de méditation par le son et les vibrations provoquées par le praticien jouant l'instrument. Cette technique vibratoire fait usage d'un *instrumentarium* particulier résonnant entre 32 et 4225 Hz (diapason thérapeutique, bols tibétains, vaisseaux de cristal, cloches, gongs, table harmonique), ou des techniques de chant particulier (chants harmoniques, mantras, chants taoïstes) (Haugmard, 2010). Dans ce travail, nous avons utilisé un instrument mélodico-rythmique accordé en 440 Hz (ce qui correspond à l'accordage fréquemment utilisé en musique contemporaine). L'exploration de différents diapasons pourrait être tout aussi intéressante à observer, mais sur des cohortes de participants plus nombreux. Aussi, le musicothérapeute doit réaliser une analyse consciente et sensible de l'instrument par rapport à ses objectifs thérapeutiques, et proscrire le choix par défaut (*instrumentarium* limité, raisons financières). Dans le DéPi-AM, le Rav, qui n'est pas un simple ersatz du célèbre Hang suisse (dont sont aujourd'hui dérivés les métallophones à forme arrondie d'une dizaine de notes), est choisi pour ses qualités propres (harmoniques riches, métal plus épais, écho, résonance et vibrations importantes, amplitude sonore remplissant une salle entière – sans amplification – adaptée à un groupe).

La technique de jeu du musicothérapeute peut être discutée également. En effet, bien que le jeu à la main procure une plus grande richesse harmonique et des contrastes sonores plus intéressants, il demeure trop percussif (*p. ex.*, jeu avec les phalanges, paumes orientées vers l'instrument ou avec le poing fermé, jeu claqué ou étouffé, accords possibles en frappant simultanément trois ou quatre notes plutôt que deux notes avec les mailloches, harmoniques qui sonnent mieux au doigt en obstruant une partie de la lame). Les mailloches doivent être choisies de manière à créer une contenance sonore qui diminue l'attaque et augmente la résonance accrue de l'instrument malgré une frappe plus légère. On peut, par ailleurs, enrichir le jeu par le recours à différentes techniques de maintien des baguettes (prise croisée, méthodes Burton ou Stevens) propres aux joueurs de percussions à clavier

(marimbas, xylophones, vibraphones, glockenspiels). Ainsi, le musicothérapeute pourrait jouer simultanément avec 4 mailloches et développer différents motifs rythmiques et mélodiques pour obtenir un jeu plus riche, apparenté au jeu à la main et aux doigts.

Le jeu d'instrument conserve une part d'improvisation musicale, selon l'inspiration et l'état interne du musicothérapeute qui veille à ne pas créer de redondance. Les commentaires des patients quant à la qualité des séances n'indiquent aucune lassitude, ni d'effets néfastes propres à l'usage du DéPi-AM. Une patiente écrira à l'issue de sa 8e séance : « *c'était vraiment trop agréable ! C'est fou comme chaque séance est différente !* ». Afin de potentialiser les effets de cette démarche thérapeutique, une bonne connaissance des différents dispositifs instrumentaux et de leurs effets respectifs serait de mise.

Une application numérique seule ou une simple écoute de musique de relaxation en accès libre ou payant (*p. ex., Music Care* utilisée dans le milieu hospitalier) ne saurait remplacer le travail du thérapeute, puisque celui-ci dispose de la capacité d'ajuster son travail musical aux besoins particuliers de l'individu. En effet, il semble difficile d'assurer une utilisation autonome adéquate de ces dispositifs tant que les mécanismes de défense (déni de la maladie, opposition passive, attitude défensive, recours excessif à l'intellectualisation) sont à l'œuvre, et que le patient reste dans une non-demande de prise en charge ou refuse de s'inscrire dans une dynamique générale de soin (qu'il s'agisse de musicothérapie ou de thérapie somatique, psychiatrique, psychologique, diététique ou infirmière). Aussi, indépendamment de la qualité de la relation thérapeutique, en s'abandonnant à une écoute active de musique à visée relaxante, le patient en phase aiguë risque de compromettre cette maladie qui lui interdit le lâcher-prise, augmente le contrôle de ses pensées et ses émotions, le pousse à intellectualiser tout ressenti ou vécu corporel, et lui cause de la culpabilité pour tout plaisir vécu. Paradoxalement, la musicothérapie semblerait être indiquée pour des patients qui souffrent d'AM ayant un fonctionnement opératoire (pensée utilitariste, concrète, dénuée de conscientisation par rapport à leurs problématiques) et qui éprouvent des difficultés à identifier et à exprimer leurs émotions (Dubois, 2010).

Bien qu'encore méconnu de cette population, le jeu acoustique pourrait présenter un intérêt non négligeable contrairement à la musique diffusée dans un casque audio, en raison de ses qualités vibratoires. C'est d'ailleurs ce que propose l'étude de Patiño-Lakatos et ses collègues (2020) auprès d'adolescents souffrant d'AM. En effet, si l'on arrive à repérer les « moments significatifs » grâce à la musicothérapie active auprès de cette population (Trondalen, 2003), il serait intéressant d'envisager que le jeu spontané du musicothérapeute puisse créer ce type de moment entre le monde sonore qu'il propose et le monde intérieur des patients. Le chant thérapeutique (sous forme de vocalises tenues ou ponctuelles, chantées ou fredonnées) pourrait soutenir l'instrument et combler les moments de silence trop profond, et serait du ressort du musicothérapeute. En effet, alors que le silence fait partie de la musique (au même titre qu'il fait partie du langage parlé), il peut ici s'avérer anxiogène et donner lieu à l'émergence de cognitions anorexiques.

Par ailleurs, alors que le recours à un groupe ouvert semble mieux indiqué ici, il présente tout de même, pour le thérapeute, des difficultés à maintenir sa visibilité pour constituer un groupe homogène, comme à garantir la contenance et la dynamique d'un groupe qui dépend des problématiques psychologiques des patients « sortants » et « entrants ». En effet, le thérapeute connaît généralement l'histoire du patient et s'assure, après chaque séance, de comprendre ce qui a pu le motiver à venir, ses éventuelles résistances, ce qui a pu gêner la séance, son adhésion au soin général. Il doit aussi tenir compte de la dynamique générale du groupe (la vie du groupe dans l'unité d'hospitalisation aussi bien que dans le cadre des séances de musicothérapie). En contexte hospitalier, l'espace groupal en musicothérapie est généralement ouvert, car le clinicien ne peut déterminer d'avance la durée de la prise en charge globale, puisque celle-ci dépend du patient (Guittard, 2021).

Nos observations cliniques nous poussent à favoriser l'utilisation de cette technique en séance individuelle et à la demande des patients, parce qu'elle permet d'ajuster le jeu de l'instrument au rythme des constantes physiologiques (fréquences cardiaques et respiratoires), pour accompagner d'autres moments vécus par le patient hospitalisé comme étant

anxiogènes. Par ailleurs, comme l'aspect de groupe a été peu étudié jusqu'à maintenant (dans ce cadre précis), le thérapeute doit demeurer vigilant pour éviter des effets psychosociaux de conformisme social et les phénomènes de contagion émotionnelle, de compétition et de comparaison (HAS, 2010). Aussi, ce groupe ne vise pas l'acquisition de compétences, contrairement à d'autres techniques de relaxation plus traditionnelles (Servant, 2009). Ces dernières favorisent l'autonomisation du patient et la généralisation des effets à d'autres contextes. Nous pensons que cette autonomisation est possible en fonction de la demande des patients, mais serait plutôt rare pour des adolescents hospitalisés souffrant d'AM. Il s'agissait donc ici de proposer un espace où chaque personne expérimente la possibilité de la relaxation dans un instant présent difficile à vivre.

Enfin, dans ce cas précis, la pratique rythmique s'inscrit dans un tempo institutionnel plus délicat. Différentes temporalités s'entrechoquent dans le cadre d'une hospitalisation (temporalités internes au patient, évolutions de l'AM, de la vie extérieure à celle de l'hôpital, de la qualité et l'authenticité de l'alliance thérapeutique). Les temporalités psychiques de chaque personne ne sont pas toujours vécues au même rythme que celles de l'hospitalisation et des soins somatiques et diététiques. Dans l'AM, la prise de poids est généralement plus rapide que la prise de conscience psychique et corporelle qui devrait l'accompagner. Le DéPi-AM cherche donc à ralentir le temps qui, aux patients, semble éternel et répétitif et, pour le personnel médical, dicte la pertinence de l'urgence d'une hospitalisation brève pour éviter d'une part la rechute et d'autre part que l'AM ne devienne chronique. Un travail d'équilibriste s'impose ici, puisque le DéPi-AM s'inscrit dans un moment au double tempo.

Perspectives

En ce qui concerne la musicothérapie, les séances ont fait émerger des demandes de création de bandes sonores avec des montages en « U » ou en « L » pouvant se poursuivre selon les besoins de chacun et/ou les comorbidités anxio-dépressives associées au TCA. Ces bandes sonores pourraient être réalisées selon la méthode du montage composite réceptif

(MCR), qui a montré une amélioration significative de l'humeur lors du traitement de patients dépressifs hospitalisés (Delpech et Sudres, 2021). Cette technique de musicothérapie réceptive comporte trois phases (A : musiques stimulantes et négatives; B : musiques relaxantes à connotation négative puis positive; C : musiques d'éveil et positives). Selon le même principe, afin de réguler l'anxiété et les émotions associées, le MAP (Archambault *et al.*, 2019 ; Vaillancourt *et al.*, 2022), pourrait également s'avérer très utile.

Aussi, une seconde séance à un autre moment de la semaine moins lourd de connotations émotionnelles, pourrait permettre aux patients de comparer les bienfaits ressentis d'une séance à l'autre et de se les remémorer avant la pesée. La relaxation permet la décentration des pensées automatiques négatives et des ruminations anxieuses (Servant, 2009). Si la détente psychomusicale seule ne fonctionne pas pour certains patients, une nouvelle combinaison peut être proposée. Par exemple, une relaxation guidée associée à la musicothérapie, pourrait accompagner une hyperconscientisation de soi positive et contourner les cognitions anorexiques émergentes.

Sur le plan méthodologique, de futures recherches devront adopter 1) une méthodologie transversale qui tient compte de la forte hétérogénéité de la manifestation symptomatologique de l'AM; 2) une méthodologie davantage mixte (quantitative et qualitative); 3) un effet d'ordre (musicothérapie/contrôle) contrôlé, même dans une logique de soins continus. Enfin, on pourra améliorer le dispositif de manière à renforcer les effets obtenus (utilisation de masques oculaires, recours éventuels à des couvertures lestées pour améliorer la conscience corporelle – à proposer au cas par cas, selon les préférences et particularités de chaque personne).

Conclusion

La réduction de l'anxiété liée à la prise ou à la perte de poids est un enjeu important dans la prise en charge d'adolescents souffrant de TCA. En outre, une hospitalisation n'est pas un évènement anodin dans la vie et la construction identitaire d'un adolescent. Dans ce contexte, le recours à la musicothérapie, pour laquelle on n'a observé ou rapporté aucun effet néfaste, permettrait d'optimiser l'offre limitée de soins pour ces patients hospitalisés, en dépit de la difficulté qu'ils éprouvent à s'inscrire dans « l'ici et le maintenant ». On doit tenir compte des biais méthodologiques inhérents aux recherches en musicothérapie (échantillonnage limité, hétérogénéité des protocoles de recherche et d'intervention, techniques de musicothérapie non suffisamment explicitées) dans de futurs travaux de recherche clinique sur ce sujet, notamment en se servant de méthodologies transversales et mixtes. Aussi, des études fondamentales pourraient être entreprises pour étudier les effets neurophysiologiques de la relaxation musicale sur les états de conscience modifiés, ainsi que les effets à moyen terme possibles (*p. ex.,* au cours de la journée, sur la qualité du sommeil).

Par ailleurs, si en France, la musique est entrée dans certains hôpitaux, la personne du musicothérapeute semble encore rester à leurs portes. Pourtant, la détente psychomusicale est de plus en plus standardisée dans l'accompagnement individuel d'autres personnes ayant des pathologies diverses. Ces protocoles utilisent la musique écoutée avec un casque audio, sur une application calibrée par un soignant (non musicothérapeute, généralement infirmier), dans des conditions similaires à l'utilisation du DéPi-AM. Or, nous pensons que les vibrations provoquées par l'instrument et ressenties par les patients, ainsi que le jeu et la présence du musicothérapeute et la relation humaine et thérapeutique qu'il entretient avec les patients, restent des éléments qu'il est nécessaire d'envisager dans cet accompagnement. La musicothérapie devrait être une indication thérapeutique à part entière, et devrait n'être ni occupationnelle, ni un choix par défaut, même si sa prescription ou son indication peut encore porter cette forme, en France notamment (Sudres, 2012). C'est pourquoi l'utilisation du DéPi-AM peut être sérieusement envisagée auprès de ces patients, non par dépit comme

son nom pourrait le supposer, mais en raison de son utilité clinique aujourd'hui constatée. Ce dispositif permettrait d'accompagner ces patients pour les aider à se distancer de leurs pensées anorexiques, prévenir la recrudescence de pensées anxieuses et permettre un lâcher-prise cognitif et corporel. Dans la pratique d'art-thérapie auprès de cette population, l'idée d'un lâcher-prise « *dans le sens d'être face à soi, pour soi et avec soi ; tout cela sans culpabilité et intellectualisation* » (Sudres, Bordet, & Brandibas, 2020) est déjà présente.

Tout en sachant que la musicothérapie doit encore faire valoir sa validité scientifique auprès de cette population, on peut néanmoins lui trouver une place dans l'accompagnement individuel et groupal de l'AM dans les différentes périodes anxiogènes vécues par ces adolescents dans le cadre de leur hospitalisation. La musique qu'utilise le thérapeute comporte ses codes, son langage, sa théorie, sa technique. Tout en étant paradoxale dans sa lecture, de par son essence tantôt ineffable et éphémère, tantôt très claire et prévisible, elle semble néanmoins se substituer au langage parlé utilisé dans la tradition thérapeutique classique. En effet, la musicothérapie se révèle être un outil pertinent qui s'inscrit dans un *continuum* langagier, entre le verbal et le non-verbal. Le DéPi-AM, quant à lui, peut se situer dans le champ des psychothérapies brèves[8], en cela qu'il est une thérapie de l'instant, de l'immédiat, touchant les vicissitudes de l'hospitalisation de l'adolescent, et complétant l'hétérorégulation émotionnelle comprise dans un accompagnement plus traditionnel.

Conflit d'intérêts

L'auteur déclare ne pas avoir de liens d'intérêts.

[8] Approche psychothérapeutique consistant à obtenir des résultats sur une courte période de prise en charge d'un client ou d'un patient. En France, Jacqueline Verdeau-Pailles (2003), désigne la musicothérapie comme une forme de psychothérapie non verbale.

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Références

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders DSM-5* (5e éd.). American Psychiatric Publishing.

Applewhite, B., Krishna Priya, A., Cardi, V., Himmerich, H. (2020). A software-assisted qualitative study on the use of music in people with Anorexia Nervosa. Dans H. Himmerich (dir.), *Weight Management* (p. 195–206). IntechOpen.

Archambault, K., Vaugon, K., Deumié, V., Brault, M., Macabena Perez, R., Peyrin, J., Vaillancourt, G., Garel, P. (2019). MAP: A personalized receptive music therapy intervention to improve the affective well-being of youths hospitalized in a mental health unit. *Journal of Music Therapy*, *56*(4), 381–402. https://doi.org/10.1093/jmt/thz013

Attia, E. et Walsh, B.T. (2007). Anorexia Nervosa. *American Journal of Psychiatry*, *164*(12), 1805–1810. https://doi.org/10.1176/appi.ajp.2007.07071151

Bibb, J., Castle, D., Newton, R. (2015). The role of music therapy in reducing post meal related anxiety for patients with anorexia nervosa. *Journal of Eating Disorders*, *3*(1), 1–6. https://doi.org/10.1186/s40337-015-0088-5

Bibb, J., Castle, D., Newton, R. (2016). « Circuit breaking » the anxiety: Experiences of group music therapy during supported post-meal time for adults with anorexia nervosa. *Australian Journal of Music Therapy*, *27*, 1–11. https://doi.org/10.1186/s40337-015-0088-5

Bibb, J., Castle, D., Skewes McFerran, K. (2019). Reducing anxiety through music therapy at an outpatient eating disorder recovery service. *Journal of Creativity in Mental Health*, 14(3), 306–314. https://doi.org/10.1080/15401383.2019.1595804

Carraz, J. (2009). *Anorexie et boulimie : approche dialectique*. Elsevier Masson.

Delpech, L., et Sudres, J.-L. (2021). Le MCR : de la musicothérapie pour soutenir l'hospitalisation de la dépression. *L'Encéphale*, *47*(6), 533–539. https://doi.org/10.1016/j.encep.2020.10.006

Dubois, A.-M. (2010). Art-thérapie et addictions, l'exemple des troubles du comportement alimentaire. *Annales Médico-psychologiques, revue psychiatrique*, *168*(7), 538–541. https://doi.org/10.1016/j.amp.2019.11.011

Guétin, S., Giniès, P., Picot, M.C., Brun, L., Chanques, G., Jaber, S., Hérisson, C., Touchon, J. (2010). Évaluation et standardisation d'une nouvelle technique de musicothérapie dans la prise en charge de la douleur : le montage en « U ». *Douleurs*, *11*, 213–218. https://doi.org/10.1016/j.douler.2010.06.001

Guilhot, J., Guilhot, M.A., Jost, J., Lecourt, E. (1979). *La Musicothérapie et les méthodes nouvelles d'association des techniques*. Editions ESF.

Guiraud-Caladou, J.M. (1979). *Un chant d'action*. J.-M. Fuzeau

Guittard, E. (2021). Expériences de musicothérapeutes travaillant à court terme avec des groupes d'adolescents en santé mentale. *Canadian Journal of Music Therapy*, *27*(1), 34–48.

Haugmard, I. (2010). ABC de la thérapie par les sons. Grancher.

Haute Autorité de Santé (HAS), Association Française pour le développement des approches spécialisées des troubles du comportement alimentaire (AFDAS-TCA), Institut National de la Santé et de la Recherche Médicale (Inserm ; 2010). *Recommandation de bonnes pratiques. Anorexie mentale : prise en charge. Argumentaire*. Saint-Denis La Plaine : ANESM, HAS. https://www.has-sante.fr/upload/docs/application/pdf/201009/argu_anorexie_mentale.pdf

Hense, C., Silverman, M. J., Skewes McFerran, K. (2018). Using the healthy-unhealthy uses of music scale as a single-session music therapy intervention on an acute youth mental health inpatient unit. *Music Therapy Perspectives*, *36*(2), 267–276. https://doi.org/10.1093/mtp/miy013

Hilliard, R. E. (2001). The use of cognitive-behavioral music therapy in the treatment of women with eating disorders. *Music Therapy Perspectives*, *19*(2), 109-113. https://doi.org/10.1093/mtp/19.2.109

Justice, R. W. (1994). Music therapy interventions for people with eating disorders in an inpatient setting. *Music Therapy Perspectives*, *12*(2), 104-110. https://doi.org/10.1093/mtp/12.2.104

Krishna Priya, A., Applewhite, B., Au, K., Oyeleye, O., Walton, E., Norton, C., Patsalos, O., Cardi, V., et Himmerich, H. (2021). Attitudes surrounding music of patients with Anorexia Nervosa: A survey-based mixed-methods analysis. *Frontiers in Psychiatry*, *12*, 1–7. https://doi: 10.3389/fpsyt.2021.639202

Larroque, M. (2013). Les procédés de relaxation hier et aujourd'hui. *L'Information Psychiatrique*, *89*(9), 751–758. https://doi:10.1684/ipe.2013.1120

McFerran, K., Baker, F., Patton, G. C., Sawyer, S. M. (2006). A retrospective lyrical analysis of songs written by adolescents with Anorexia Nervosa. *European Eating Disorders Review: The Professional Journal of the Eating Disorders Association*, *14*(6), 397–403. https://doi.org/10.1002/erv.746

National Institute for Health and Care Excellence (NICE) (2017). *Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders*. En ligne : https://www.nice.org.uk/guidance/ng69

Pasiali, V., Quick, D., Hassall, J., Park, H. A. (2020). Music therapy programming for persons with eating disorders: A review with clinical examples. *Voices: A World Forum for Music Therapy*, *20*(3), 1–15. https://doi.org/10.15845/voices.v20i3.2785

Patiño-Lakatos, G.,Lindenmeyer, C., Magalhaes, I. B., Corcos, M., Letranchant, A., Genevois, H., et Navarret, B. (2020). Dispositif de médiation thérapeutique par le son, la musique et la vibration : Sentir, ressentir, entendre l'inaudible du corps dans les anorexies mentales. *L'Évolution Psychiatrique*, *85*(4), 541–558. https://doi.org/10.1016/j.evopsy.2020.07.001

Peretti, N. et Bargiacchi, A. (2017). *Troubles des conduites alimentaires de l'enfant et de l'adolescent*. Elsevier Masson.

Robarts, J. Z. (2000). Music therapy and adolescents with anorexia nervosa. *Nordic Journal of Music Therapy*, *9*(1), 3–12. https://doi.org/10.1080/08098130009477981

Robarts, J. Z., & Sloboda, A. (1994). Perspectives on music therapy with people suffering from anorexia nervosa. *Journal of British Music Therapy*, *8*(1), 7–14. https://doi.org/10.1177/135945759400800104

Rüütel, E., Ratnik, M., Tamm, E., Zilensk, H. (2004). The experience of vibroacoustic therapy in the therapeutic intervention of adolescent girls. *Nordic Journal of Music Therapy*, *13*(1), 33–46. https://doi.org/10.1080/08098130409478096

Servant, D. (2009). *La relaxation : nouvelles approches, nouvelles pratiques*. Elsevier Masson.

Smeijsters, H. (2012). Analogy and metaphor in music therapy. Theory and practice. *Nordic Journal of Music Therapy*, *21*(3), 227–249. https://doi.org/10.1080/08098131.2011.649299

Shah, P., Mitchell, E., Remers, S., Van Blyderveen, S. et Ahonen, H. (2021). The impact of group music therapy for individuals with eating disorders. *Approaches: An Interdisciplinary Journal of Music Therapy*, *1–22.*

Spalatro, A. V., Marzolla, M., Vighetti, S., Daga, G. A., Fassino, S., Vitiello, B., et Amianto, F. (2021). The song of Anorexia Nervosa: A specific evoked potential response to musical stimuli in affected participants. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity*, *26*(3), 807–816. https://doi.org/10.1007/s40519-020-00898-4

Sudres, J.-L. (2012). Anorexie et Art-thérapie : Eléments pour une pratique. *Psychothérapies*, *32*(2), 73–83. https://doi.org/10.3917/psys.122.0073

Sudres, J.-L., Bordet, A., et Brandibas, G. (2020). Art-thérapie et troubles des conduites alimentaires. Évaluation en follow-up. *Annales Médico-psychologiques*, *178*(1), 52–59. https://doi.org/10.1016/j.amp.2019.11.006

Testa, F., Arunachalam, S., Heiderscheit, A., et Himmerich, H. (2020). A systematic review of scientific studies on the effects of music in people with or at risk for eating disorders. *Psychiatria Danubina*, *32*(3-4), 334–345. https://doi.org/10.24869/psyd.2020.334

Trondalen, G. (2003) "Self-listening" in music therapy with a young woman suffering from anorexia nervosa. *Nordic Journal of Music Therapy*, *12*, 3–17. https://doi.org/10.1080/08098130309478069

Vaillancourt, G. (2012). Une musicothérapeute en musicothérapie, ou quand la cliente est une musicothérapeute ! *Canadian Journal of Music Therapy/Revue canadienne de musicothérapie*, *18*(1), 8–25.

Vaillancourt, G., Peyrin, J., Brault, A., Thibeault C.-A., et Gosselin, N. (2022) Personalized audio montage: Impact of a receptive music therapy method-variation on youth experiencing homelessness. *Nordic Journal of Music Therapy*, *32*(4), 307–320. https://doi.org 10.1080/08098131.2022.2129428

Verdeau-Pailles, J. (2003). La médiation de la musique en psychothérapie. *Annales Médico Psychologiques*, *161*, 97–100. https://doi.org/10.1016/S0003-4487(02)00011-2

Wheeler, B. (2019). La musique dans l'appui et le soutien psychosocial (MPC). Dans M. Thaut, et V. Hoemberg (dir.), *Manuel clinique de rééducation par la musique. Comment la musique contribue à soigner le cerveau* (p. 421–460). Editions DeBoeck Supérieur.

Annexe 1

Questions écrites distribuées directement après la séance de musicothérapie

Lors de cette relaxation, as-tu eu des pensées :

- Positives
- Plutôt positives
- Plutôt négatives
- Négatives

Précise la nature de tes pensées :

Qu'as-tu pensé de cette séance ?

Annexe 2

Questions écrites (distribuées à l'issue de la prise en charge, au même moment, mais sans musicothérapie)

En ce moment as-tu eu des pensées :

- Positives :
- Plutôt positives :
- Plutôt négatives :
- Négatives :

Précise la nature de tes pensées :

A propos de l'auteur

Stéphane Scotto Di Rinaldi est doctorant français en psychopathologie au laboratoire CERPPS (EA 7411) à l'Université Toulouse Jean Jaurès (UT2J), psychologue clinicien du développement, musicothérapeute clinicien (Diplôme universitaire de Montpellier) et chargé d'enseignement à l'UT2J. Ses travaux de recherche appliquée en musicothérapie portent sur l'anorexie mentale et, parallèlement, sur l'autisme et sur la déficience visuelle. Lui-même musicien, il exerce actuellement la psychologie et la musicothérapie au service de pédopsychiatrie de l'Hôpital Salvator à Marseille, utilisant une démarche théorico-clinique intégrative auprès d'adolescents en unité d'hospitalisation en temps plein.

scotto.stephane@hotmail.fr

A Historical Study of the First Year of the Canadian Association of Music Therapists

[Une étude historique de la première année de l'Association canadienne des musicothérapeutes]

Daniel Kruger, MTA, MA

Abstract

This study presents a historical narrative of the inaugural year of the Canadian Association of Music Therapists (CAMT). The purpose of the study is to place music therapists' lived experiences of the first year of the CAMT in conversation with primary source historical documents published between the first two CAMT conferences (August 3, 1974 and May 2, 1975). Using phenomenological and historical methodologies, this article focuses on open-ended, semi-structured interviews with three Canadian music therapists who were active during 1974–75. The experiences they shared in their interviews are examined in relation to primary source historical documents obtained from the CAMT historical archives. Three primary themes emerge from the analysis of the interviews and primary source documents: "development of identity," "defining music therapy/music therapist," and "emergence of an alternative profession." This study offers new information about significant conflicts, issues, and developments in the early CAMT, providing important insights into the history of music therapy in Canada.

Keywords: Canadian Association of Music Therapists, CAMT, music therapy, Canada, history, identity, alternative professions

Sommaire

Cette étude présente un récit historique de l'année inaugurale de l'Association canadienne des musicothérapeutes (ACM). Elle vise à faire le lien entre l'expérience vécue par les musicothérapeutes durant la première année d'existence de l'ACM et les documents historiques de sources primaires publiés entre les deux premiers congrès de l'ACM (3 août 1974 et 2 mai 1975). Pour y parvenir, l'auteur applique des méthodes phénoménologiques et historiques et se fonde sur des entrevues ouvertes et semi-structurées avec des musicothérapeutes canadiennes exerçant la profession en 1974-1975. Les expériences décrites durant les entrevues sont analysées en conjonction avec des documents historiques de sources primaires tirés des archives de l'ACM. Trois thèmes principaux se dégagent de l'analyse des entrevues et des documents, soit le développement de l'identité, la définition de la musicothérapie et du musicothérapeute, ainsi que l'état de profession alternative émergente. L'étude apporte de nouveaux renseignements sur les conflits, enjeux et développements d'envergure ayant marqué les premières années de l'ACM et met en relief des éléments importants de l'histoire de la musicothérapie au Canada.

Mots-clés : Association canadienne des musicothérapeutes, ACM, musicothérapie, Canada, histoire, identité, professions alternatives

Introduction

Music therapy is evolving quickly in Canada.[1] Since the Canadian Association of Music Therapists (CAMT)[2] formed in 1974, its membership has increased from 63 to 1197 as of 2023 (Sharpe, 1977; P. Lansbergen, personal communication, April 25, 2023). Canadian music therapists have used diverse clinical approaches including humanistic, behavioural, psychodynamic, and psychoeducational since the CAMT's inception (Moffitt, 1993). More recently, feminist music therapy, the Bonny Method of Guided Imagery in Music, neurologic music therapy, community music therapy, and music therapy in the neonatal intensive care unit have contributed to an expanding clinical landscape (Aigen, 2018; Curtis, 2006; de L'Étoile & LaGasse, 2013; The Academy of Neurologic Therapy, 2016). Further, the prevalence of online music therapy practice has increased since the beginning of the COVID-19 pandemic, and efforts to regulate music therapists under provincial regulatory counselling/psychotherapy colleges are gathering momentum (Agres, Foubert, & Sridhar, 2021; Summers, 2019). As these developments propel the evolution of the profession, further knowledge of and reflection on the history of Canadian music therapy is needed to provide a referent foundation for Canadian music therapists to contextualize future decisions and changes.

This article is based on research completed for my master's thesis at Concordia University, the primary aim of which was to deepen Canadian music therapists' self-knowledge through historical inquiry of the inaugural year of the CAMT. I interviewed three Canadian music therapists who were active between August 3, 1974 and May 2, 1975, the time period between the opening day of the inaugural CAMT conference and the second annual conference (Sharpe, 1975). In this article, I seek to answer two interrelated questions: 1) What are the experiences of Canadian music therapists who were active during the CAMT's

[1] This research was supported by the Social Sciences and Humanities Research Council of Canada. This study was approved by the Research Ethics Board at Concordia University.

[2] The CAMT was originally named the Canadian Music Therapy Association (CMTA). For the sake of simplicity, it is referred to by its current name, the "Canadian Association of Music Therapists" throughout this article.

inaugural year?; 2) How does primary source historical information from the first year of the CAMT relate to the experiences of music therapists? After offering some context on the existing literature and historical approaches to music therapy, I will examine these research questions through an integrated phenomenological–historical study of both the interviews and primary source materials (Jackson, 2016; Wheeler & Bruscia, 2016).

Historical Research on Professional Music Therapy

For centuries, communities around the world have used music for its health benefits (Davis & Hadley, 2015). Long before European contact, and continuing into the present day, Indigenous Peoples of North America have maintained diverse, holistic healing practices in which music is used therapeutically (Archibald, Dewar, Reid, & Stevens, 2012; Davis & Hadley, 2015). Ancient literate traditions in China, India, and the Middle East have also documented practices of the therapeutic use of music (Horden, 2000). In this article, "music therapy," will denote a professionalization of the therapeutic use of music. Although the profession of music therapy was built on decades of work by pioneering music therapists in England, the United States, Canada, and elsewhere, it owes a larger debt to global communities that have, over millennia, illuminated the potential of many physical, spiritual, and emotional gifts of music making.

There has been a recent groundswell of historical monographs published on music therapy (Bibb, 2013; Davis, 2012; Garrido & Davidson, 2013; Im & Lee, 2017; Intveen & Edwards, 2012; Reschke-Hernandez, 2011). A focal point in the recent research has been the history of the professional development and reputation of music therapy (Kim, 2009; Moore, 2015; Register, 2013). Literature of larger scope, like Hryniw Beyer's (2016) book on the history of the music therapy profession, is more difficult to find.

Scholars outside the music therapy discipline have criticized the historical literature on music therapy for having an agenda to legitimize music therapy practice (Ruud, 2000). Gouk's (2000) theory that the traditional purpose of historical research is to "hold up individuals,

groups, or nations as examples to propagate moral and religious values" (p. 5) offers context for this criticism. Solomon and Heller (1982) have suggested that a more desirable purpose of historical research on music therapy is to better understand, rather than justify, the present by studying the past.

Early Music Therapy in Canada

The first music therapy programs in Canada began in the 1950s, led by music therapy pioneers Fran Herman, Norma Sharpe, and Thérèse Pageau, respectively (Green, Charboneau, & Gordon, 2014). Music therapy became a recognized profession in Canada at the inaugural CAMT conference in St. Thomas, Ontario in 1974 (Sharpe, 1977). This early history has primarily been narrated through autobiographies by prominent music therapists, or through historical pieces presented by music therapists who participated in the history they studied. The only exception I found to this is a biographical chapter about the life of music therapy pioneer Norma Sharpe (Im & Lee, 2017). Through primary source material—including personal correspondence, case studies, clinical notes, and archival material related to Sharpe's work with the CAMT—Im's study (2015) explored Sharpe's personality, examined her clinical interests, and offered illustrations of relevant issues of her time.

The three-volume series *The Lives of Music Therapists: Profiles in Creativity* offers several autobiographical chapters written by pioneering Canadian music therapists (Mahoney, 2017; Mahoney, 2018; Moreno, 2017). Of relevance are chapters by Fran Herman and Nancy McMaster, who were active music therapists during the CAMT's inaugural year in 1974–75 (Herman, 2017; McMaster, 2017). These chapters contain historical information that may help us to identify common characteristics among early Canadian music therapists. For example, Herman, Sharpe, and McMaster were all classically trained pianists who decided not to pursue careers in performance, and who initially worked with children (Herman, 2017; Im & Lee, 2017; McMaster, 2017).

These trailblazers faced challenges as they sought to develop music therapy in Canada from the 1950's to the 1970's, partially because the small number of practicing music therapists was spread across Canada's vast geography (Buchanan, 2009). Although the size of Canada continues to be a significant obstacle to the development of music therapy today, the geographical isolation of music therapists in the 1970s contributed to the development of many unique approaches to the practice (Buchanan, 2009). This diversity, however, created challenges in negotiating the values and priorities of the CAMT in its early years (Howard, 2009).

Existing Literature on the History of the CAMT

All three published articles on the history of the CAMT were written by current or past presidents of the association (Alexander, 1993; Ivy, 1983; Sharpe, 1977). Historical literature about an association that is produced by that association should be read with Gouk's (2000) theory in mind. Despite their potential biases, the authors' insider position allowed them to offer detailed timelines of important events and descriptions of pertinent issues that illuminated the inner workings of the early CAMT. These articles serve as starting points for further research on the CAMT by researchers with less vested interest in the association.

Inaugural CAMT Conference

The inaugural CAMT conference was held August 3–4, 1974 at the St. Thomas Psychiatric Hospital in Ontario, and was organized primarily to unify Canadians involved in music therapy (Sharpe, 1977). Sixty-three people attended from across Canada (Sharpe, 1977). Delegates drafted a constitution for the association with four principal goals: to improve music therapists' status in the workplace, to develop and assess university music therapy courses in Canada, to support the creation of provincial music therapy associations, and to be a central resource for music therapy information (Sharpe, 1977). The conference's banquet consisted of a fried chicken dinner on the front lawn of the St. Thomas Psychiatric Hospital while Norma Sharpe provided musical accompaniment on a pedal-organ (Shugar, 2009).

Canadian Music Therapy Identity

Diversity is commonly identified as a crucial characteristic of Canadian music therapy (Curtis, 2015; Gross & Young, 2014; Howard, 2009; Moffitt, 1993). Dibble's (2010) unpublished master's thesis, the only literature available that examines Canadian music therapy identity as its primary focus, cites "commonality" and "diversity" as the two most salient characteristics of this identity. The literature's use of the term "diversity" usually refers to the varied clinical training, experiences, and musical backgrounds of pioneering music therapists (Alexander, 1993; Sharpe, 1977). Today's social discourse emphasizes the importance of race, gender, sexual identity, and (dis)ability when considering a community's diversity. I was unable to find data on racial, gender, sexual identity, or (dis)ability demographics amongst Canadian music therapists. In 2017, 81.6% of music therapists worldwide identified as female, while 0.2% identified in a category named "other" (Kern & Tague, 2017). 82.4% of the respondents for Kern & Tague's survey were North American or European. In the United States, 86.4% of music therapists identified as female, 0% as trans women, and less than 1% as trans men. 88.3% of American music therapists identified as Caucasian, while the next largest racial group was Black/African American at 2.39% (American Music Therapy Association, 2021). Although this data is not Canada-specific, the significant North American representation in the data suggests it is safe to assume that Canadian demographics would be comparable, if not virtually the same. According to the available data, the Canadian music therapy community appears to lack diversity in each of these categories—making it clear that "diversity" in the music therapy literature is not referring to race, gender, sexual identity, or (dis)ability.

Solomon and Davis (2016) have argued that the study of music therapy history can "increase [music therapists'] collective sense of identity and purpose and to ensure our future and the continued progress and evolution of our discipline" (p. 2442). Following this argument, further study of Canadian music therapy history would buttress the literature examining identity among Canadian music therapists.

Methodology

Situatedness

As a new music therapist familiarizing myself with the culture and history of the profession, I have less of a personal investment in the history of music therapy than its future. This is an important difference between my relationship and the participants' relationship to the topic: while this narrative is an integral part of each participant's existing identity, I examined this narrative as a basis from which to develop my future identity. In part, my motivation to examine this history was to identify a place for myself in the narrative. The participants' places are long solidified. I prioritized being as transparent as possible about my biases and assumptions throughout this study.

Interviews

I conducted semi-structured, open-ended qualitative interviews with three music therapists who were active in 1974-75. Each participant agreed to have her name published in this study. I included the participants' names so the reader can populate the historical narrative with identifiable people, and to emphasize that the perspectives in this study are not generalizable, but the unique experiences of the participants: Susan Munro, Colleen Purdon, and Bernadette Kutarna.

Initially, participants were recruited by compiling a list of names and contact information of attendees of the conference obtained from the CAMT archives in London, Ontario. One eligible participant was recruited. After expanding the criteria to include English-speaking music therapists active in Canada during the CAMT's inaugural year, and adjusting the research question, I recruited two more participants through snowball sampling. Because the "Music Therapist Accredited" accreditation did not exist until 1979, I used three criteria to define an active music therapist. Between the dates of August 3, 1974 and May 2, 1975, participants had to meet at least one of the following criteria:

1. Was a graduate of a music therapy training program.
2. Was enrolled in a music therapy training program.
3. Was doing work that they and others in the Canadian music therapy community considered music therapy.

Each participant received an electronic invitation to participate including a description of the study and an informed consent agreement.

Interviews were conducted virtually and lasted approximately one hour. I transcribed each interview in a minimally reconstructive style by cleaning up messy or confusing utterances and eliminating non-verbal words for legibility and comprehension (Brinkmann, 2013). Participants were given the option to review or change their transcripts.

Historical Documents

I collected primary source documents from the CAMT archives in London, Ontario on two occasions. During the first trip my primary research question focused on the CAMT conference in 1974. I made a second trip after expanding the scope of the study to the CAMT's inaugural year. During both trips, I copied and obtained primary source documents including newspaper articles, journals, photographs, personal correspondences, conference proceedings, official CAMT materials, and other material.

Data Analysis

I began the analysis by listening to the interview recordings while highlighting significant statements using the following criteria:

1. The statement relates to the primary research question.
2. The statement provides unique information in the context of the interview.
3. The statement summarizes recurring information.
4. The participant identifies the statement as significant.
5. The statement changed the way I think about the primary research question.

The first criterion needed to be met for a statement to be highlighted. Additionally, at least one of the subsequent criteria needed to be met. After reviewing each interview, I assigned preliminary codes to the statements to sort them into thematic groups. Through data-driven coding, I then formed three final thematic categories from the significant statements (Brinkmann, 2013).

During the next stage I looked for information in the primary source historical documents that related to the themes I identified from the interviews. I culled the documents during this stage by eliminating any that were not related to the three themes. I grouped the remaining documents with the significant interview statements under each thematic category.

Finally, I considered the grouped data to elucidate the essence of the phenomenon according to my analysis, the participants' responses, and the primary source historical documents.

Transcription Legend:

Italics: Signify verbal emphasis, usually an increase in volume or pitch.

. . . Ellipses: Signify omitted material between the beginning and end of ellipses.

[Square Brackets]: Indicate that I replaced a non-descriptive word (e.g., it, that, or this) or a silence with descriptive words to provide context.

~ Tildes: Indicate a pause in speech of roughly 1-2 seconds. A double tilde "~ ~" indicates a pause of three seconds or more.

>> Double Arrows: Indicate the following material was taken from a part of the interview at least one paragraph after the previous phrase.

Results and Analysis

The three core themes that I identified in participants' interviews were the development of identity, definitions of music therapy/music therapist, and the emergence of an alternative profession.

Development of Identity

> Susan: I think "music therapy in Canada" happened much later than 74'. . . it became more Canadian when [Capilano] had their program, and then a bit more Canadian as we moved the conference from place to place. . . And if you look at Canada and music therapy now, it has its own face in each province. (S. Munro, personal interview, April 23, 2018)

Susan suggested that an identity for Canadian music therapy was not established before conferences were held in multiple provinces, signifying the importance of distinct provincial philosophies in forming a national identity. The following section will highlight two significant discussions that were crucial in the early development of a national identity for Canadian music therapy.

Behaviourism and humanism, psychology-centered and music-centered

> Daniel: So [behaviourism] was prevalent at the conference?
>
> Colleen: Oh yeah, that was *the* mainstream, behavioural therapy, in the 70s. . . In the Canadian scene it was not so much [about] that, but certainly it was present. It was more people like Fran Herman who were expressive, fun, creative, and child-focused. . . that was one of the things from the conference that struck me, was that there were all these different ways that music was being used. (C. Purdon, personal interview, October 10, 2017)

Colleen was brand new to music therapy when she attended the inaugural conference, so her observation that the Canadian music therapy scene was distinct from mainstream

psychology suggests that a preliminary national identity was already visible, even to a newcomer. She saw that Fran Herman's emphasis on expression and creativity was more common in Canada; however, Herman's approach was not universally accepted.

> Colleen: [The variety of approaches] was confusing for someone like me who didn't know anything. It was a bit like a smorgasbord! (Laughs). . .
>
> >> Daniel: Was that smorgasbord harmonious? Was it all working together?
>
> Colleen: No. No, it wasn't harmonious and it certainly wasn't working together. There was a lot of competition and ~ jockeying, in a way. . . there were very clear positions on types of music, like recorded music, or live music, or what instruments [should be used]. . . There were some people who would *never* use recorded music. >> I could never figure out why people get dogmatic about this stuff. Even at that time it was like ~ Come *on.* (C. Purdon, personal interview, October 10, 2017)

The presence of dogmatic belief in subjective debate does not make the early history of Canadian music therapy unique. However, the participants' emphasis on "diversity" as a crucial component of Canadian music therapy identity suggests the result of the early tension in the profession was significant. There was no winner—no approach was discredited or eliminated—nor was there a coup within the community. Instead, from the participants' perspectives, contrasting approaches engendered a level of acceptance, respect, and mutual admiration.

> Daniel: What do you think contributed to that diverse culture being fostered?
>
> Bernadette: I think it has to do with the debate turning into dialogue and the dialogue continuing. . . Canadian music therapists brought people who had differing perspectives on music therapy to conferences, and we all *listened* to them. . . I think [the diverse culture] comes from that. (B. Kutarna, personal interview, April 16, 2018)

Music therapy was a nascent profession in 1974–75; therefore, the evolution from dogmatic debate to dialogue may have allowed myriad new ideas about music therapy enough breathing room that they were eventually understood and respected. Bernadette's

comment suggests that combative debate, rather than dialogue, was the more common method of idea-sharing during the CAMT's first year. Conflicting philosophies and therapists were often treated as threats to each other, rather than as mutually augmentative.

> Susan: When [music therapists] mentioned a name you always had the feeling they were talking about enemies. And with Fran [Herman] we started to say, "Where can we work together?". . . And then [we] started to work together. (S. Munro, personal interview, April 23, 2018)

As a diverse landscape of approaches to music therapy began to develop, common priorities also emerged amongst Canadian music therapists.

> Susan: In that first year I think a lot of discussions went on with the approaches . . . do you go from a psychologically-based approach or do you go from a musically-based approach? . . . What do we want in Canada as a philosophy? . . . we decided early on that music's at the center. The person's in the center. >> Psychology is important too, but the key issue is: "Where's the music in the person?". . . That's what differentiates us from other therapies is *music*. (S. Munro, personal interview, April 23, 2018)

The juxtaposition of Alexander (1974) and Korsen's (1974) articles in Vol. 2 no. 2 of the *Canadian Music Therapy Journal* illuminated the music versus psychology-centered discussion Susan described. Alexander argued that music *in* therapy is a more effective approach than music *as* therapy.

> I cannot view music as the therapy, per se, for the music is essentially the basic "tool" of the therapist within a therapy, especially within behaviouristic modalities. It appears to me that the important question to ask is not "How does music therapy bring about desirable changes in behaviour?" but "How do the roles of music within, for example, a behavior modification treatment modality affect behavior and why?" (Alexander, 1974, p. 7)

Fran Herman's article–who was Frances Korsen at the time–followed Alexander's article in contrast. The therapeutic goals for Korsen's (1974) work with children living with muscular dystrophy were:

> 1. To encourage the child to express himself through music and to provide him with mental stimulation.
> 2. To reduce the child's isolation and to give him a sense of group participation and a feeling of achievement.
> 3. To help the child develop his latent potentialities and to broaden his creative experiences.
> 4. To promote function wherever possible in the hope of counteracting atrophy from [muscle] disuse. (Korsen, 1974, p. 10)

I encourage the reader to re-read each of these goals with the following question in mind: Can this goal be achieved by music-making alone, or does it require something extramusical? A music-centered therapist would likely answer that the goals can be achieved with music alone, while Alexander's music *in* therapy approach would require a modification of extramusical behaviour to achieve the goal.

Behavioural psychology and psychology-centered approaches consider music to be a tool, whereas humanistic and music-centered approaches consider music to be an end. According to all three participants, the emphasis on humanistic and music-centered approaches was a key component of the early Canadian music therapy identity.

Diversity

> Bernadette: At that time, the [training] at Michigan State University was behaviourally oriented. . . I think people in Canada immediately began to develop music therapy in different ways. We had Carolyn Kenny and Nancy McMaster here . . . Carolyn and Nancy didn't do their training in behavior-oriented models. >> I don't know if they used the term "humanistic perspectives," but certainly, from a model perspective, their models were improvisatory. The model that I learned [at Michigan State] was more concrete. . . There was no such thing as improvisation. Never heard of the word when I was in that class. (B. Kutarna, personal interview, April 16, 2018)

Canadians had two options if they wanted to become an accredited music therapist in 1974: obtain a music therapy degree in the United States, or a "licentiate in music therapy" in England. Colleen and Susan elected to study at the Guildhall School of Music in London while Bernadette completed a National Association for Music Therapy (NAMT)-approved training in the United States. The difference between NAMT-approved trainings in the United States and the Guildhall School of Music in England mirrored the distinction between behavioural/psychology-based models and humanistic/music-centered models.

> Susan: I trained in England. The English training was much more musically, person-based. . . English training was very much based on improvisation. NAMT, I don't think they ever talked about improvisation. (S. Munro, personal interview, April 23, 2018)

NAMT-approved training programs required students to take 160 hours of courses in music, psychology, sociology, English, the biological sciences, and statistics (Schoenberger & Braswell, 1974). After finishing their coursework, students completed a six-month clinical internship in an NAMT-approved psychiatric hospital supervised by an approved music therapist. Bernadette completed her internship at the Douglas Hospital in Montréal under Canadian music therapist Bill Shugar, a member of the NAMT in 1974–75 (National Association for Music Therapy Inc., 1975; B. Kutarna, personal interview, April 16, 2018). Susan and Colleen described the Guildhall School of Music program as improvisation-based and heavily influenced by the Nordoff-Robbins method; they also mentioned that internships did not have to take place in psychiatric hospitals (S. Munro, personal interview, April 23, 2018; C. Purdon, personal interview, October 10, 2017). The difference between schools requiring students to intern in a hospital versus schools allowing flexible internship settings is significant and will be discussed in the following section.

Defining Music Therapy/Music Therapist

> Bernadette: [There was the idea of] *clinical* music therapy. "Oh, what *you do* is not music therapy, but working in a hospital *was.*" . . . There were lots of conversations

> about that. >> Doing performances as music therapy. . . lots of people said, "Oh that's not music therapy". . . Of course, Fran [Herman] was one of the *biggest* ones who did performances. . . her model [was] so clearly music therapy to me, and yet there was a whole whack of discussion [about whether it was] because it didn't look *clinical*. . . (B. Kutarna, personal interview, April 16, 2018)

At the time, it was difficult for music therapists to forge an identity that was distinct from that of a performer or educator. The clearest way to differentiate music therapy from performance was surely to eliminate the possibility of performance in treatment. Separating music therapy from music education was a subtler task. One might start by ensuring that music therapy took place in a setting—a hospital, for example—where healing takes priority over education. Colleen also spoke of the blurred lines between music therapy, performance, and education at that time.

> Daniel: Were music educators considered music therapists?
>
> Colleen: Well, everybody was. There was no accreditation. . . So, if you were doing music education, and doing it in a setting where you're working with say, handicapped kids, then you were a music therapist. (C. Purdon, personal interview, October 10, 2017)

Offering insight into the developing definition of "music therapist" in 1974–75, the list of active Canadian music therapists in 1975 (Canadian Association for Music Therapy, 1975) contains 31 names divided into nine categories, including the music education approaches Orff and Education Through Music (ETM). In the fall of 1974, the CAMT hired two music education specialists to offer workshops on using the Orff and ETM methods with "handicapped children" **(**Sharpe & Wright, 1974). Thus, there appears to have been significant overlap between the roles and definitions of music therapy and music education in 1975.

A 1975 newsletter published by the Ontario Music Therapy Association summarized a panel discussion the association had hosted to discuss the difference between music therapy and music education (Brooks, 1975). The panel concluded that "it is not what you do but

why you do it." The editor of the newsletter invited readers' input "regarding this somewhat controversial topic" and suggested that the next panel discuss the difference between music therapists' and music educators' intentions. Colleen echoed this foggy distinction.

> Colleen: I didn't really know what music therapy was, so how could I know about being a music therapist? I just knew that I had worked for years with music and people and really liked it, and it wasn't education. . . So, it was ~ it was *different,* but I didn't really know what the difference was. (C. Purdon, personal interview, October 10, 2017)

Two differences between music therapy and music education that Susan and Colleen mentioned were a heightened focus on the intention behind musical activities, and an emphasis on the importance of the person for whom the activity was planned, rather than the animator of the activity.

> Susan: The music therapist is not the most important person in the room. . . Yes, [the music therapist] will have skills and things, but how can [the music therapist] fit their skills to the [client] and the situation? (S. Munro, personal interview, April 23, 2018)
>
> Colleen: I remember *thinking* about. . . what we were doing with people. Before [the first music therapy conference] it was more like you're just thinking about what *you're* doing. ~ it was more focused on *us* or on the *mechanics* of the thing. (C. Purdon, personal interview, October 10, 2017)

The participants and primary source documents both suggested that the definitions of "music therapy" and "music therapist" were emerging during the CAMT's first year. At the time, the most salient discussions were about the differences between music therapists' and music educators' intentions and the distinction between clinical music therapy and music therapy that involved performance.

Emergence of an Alternative Profession

> Colleen: [Music therapy] was so ~ *new*. . . what was most important for me is that this is a *profession*. . . and that in Canada there was a group of people who were coming

> together to form an association to make it a reality. That was impressive to me. It gave some legitimacy to this whole thing, and it was something you could attach yourself to. (C. Purdon, personal interview, October 10, 2017)

Colleen's statement suggests that the CAMT's formation provided a boost to the public profile of music therapy in Canada. Universities seemed to be particularly aware of and involved in the development of Canadian music therapy. Colleen heard about the inaugural CAMT conference from a co-worker, who had heard about it on Western University's campus (C. Purdon, personal interview, October 10, 2017). Dr. Paul Green, chair of the Music Education Department at Western University at the time, attended the first CAMT conference and was involved in developing a never-to-be-realized undergraduate music therapy program at Western in the 1970s (Canadian Music Therapy Association, 1974; Smuckler, 1975). Bernadette also heard about music therapy through her university.

> Bernadette: I was in third year university, looking at what to do in my life with music. And a professor of mine. . . had gone to the first conference in St. Thomas, Ontario. . . And she called me [from the conference] to excitedly tell me about music therapy. . . She talked for a good hour about what she had heard and what was going on, and I think that's when I decided I would pursue music therapy. (B. Kutarna, personal interview, April 16, 2018)

The professor Bernadette referred to is Dr. Shirley Sproule, who was elected Second Vice President of the CAMT at the inaugural conference (Canadian Music Therapy Association, 1974). Evidently, Dr. Sproule and Dr. Green's involvement in the CAMT was helpful in spreading the word about music therapy to music students searching for alternative careers to performance or education.

> Colleen: I really wasn't sure what I wanted to *do* with music. I was not a performer. . . or a composer, so education was what was left. I liked teaching, but I wasn't sure if it was for me. . . and then I heard about a conference coming up in music therapy through my friend who worked with me. (C. Purdon, personal interview, October 10, 2017)

> Bernadette: I knew I couldn't be a teacher. . . I went into music education first and changed to performance because teaching didn't appeal to me. It still doesn't. (B. Kutarna, personal interview, April 16, 2018)

Music therapy offered Colleen and Bernadette a new option for a musical career outside of education or performance at a time when careers for women were proliferating. It seems likely that the participants' expanding career options reflected the effect of the second-wave feminist movement in the 1970s, a context that I was surprised they never mentioned. There was a significant increase in the percentage of Canadian women in the workforce in this era, including a 70% spike between 1965 and 1975 (Robbins, Luxton, Eichler, & Descarries, 2008). In 1971, 64.2% of working women were limited to twenty professions. Among these, teacher and nurse were the only professions in which employees had significant responsibility and upward mobility (Robbins et al., 2008). I imagine this context made music therapy—a profession with similarities to both teaching and nursing—an exciting new professional option, particularly for women.

While looking over the printed proceedings of the inaugural conference with Colleen during our interview, I noticed an advertisement for free childcare for conference attendees.

> Daniel: Babysitters on request!
>
> Colleen: Which is good! (C. Purdon, personal interview, October 10, 2017)

Colleen sounded surprised that I would find such an advertisement novel. This type of advertisement was not commonplace during the 1970s, as workplaces rarely offered support for childcare. It was common for women to withdraw from the workforce once they were married, or after their first pregnancy (Robbins et al., 2008). With this context in mind, of course babysitters needed to be available for attendees of a conference who were mostly women.

> Bernadette: I remember music therapists bringing their *babies*! Their babies were part of the conferences and the board meetings and stuff like that. (B. Kutarna, personal interview, April 16, 2018)

While Bernadette noticed that music therapists could participate in the profession while balancing family life, Colleen remarked that one of the profession's leaders chose to devote her life to her career rather than create a family.

> Colleen: And Norma [Sharpe]! . . . She was a real mover and shaker to get [the CAMT] organized. >> She was very *individual*. I don't think she had a husband, or children, or anything like that. Her life was *this.* (C. Purdon, personal interview, October 10, 2017)

Colleen and Bernadette were both attracted to a new profession that was led primarily by women, in which women could participate whether they had families or not, and in which childcare was already considered a legitimate concern. It is difficult to imagine such a profession being possible without the social and economic climate created by second wave feminism.

Discussion

Personal Perspectives

I noticed similarities and differences between my experiences as a new music therapist in the mid 2010's with those of the participants in 1974–75. My music therapy education reflected the music-centered, humanistic approach that the participants identified as an important part of early Canadian music therapy's identity. My training focused less on psychological theory than it did on clinical musicianship, clinical improvisation, self-reflection, and therapeutic relationship-building. My professors distinguished music therapy from music education by differentiating between musical activities intended to achieve non-musical goals versus musical goals. Based on the results of this study, it appears that the difference between music education and therapy has been elucidated since 1974–75, and that the humanistic, music-centered approach to music therapy continues to be emphasized in at least one of the Canadian music therapy training programs.

The third theme of the results, "Emergence of an Alternative Profession," remains an accurate description for Canadian music therapy. The adoption of music therapy into

mainstream Canadian culture is still nascent. It is more common for me to explain what music therapy is to people who have never heard of it than it is to meet people who have experience with or an understanding of it. During my training, significant time was devoted to discussing and practicing how to explain music therapy to people for whom it is unfamiliar. Although the music therapy community has solidified its definition of the profession since 1974–75, a broader, cultural understanding of it is still emerging.

Limitations

The historical literature on Canadian music therapy is mostly written by those with vested interest and longstanding involvement in the community. I was hoping my fledgling involvement in music therapy would allow me to approach this research with a less biased lens. However, I often considered how my music therapy colleagues would receive this research. My desire to create research that would be well-received by the community limited the degree to which I explored some of the more sensitive topics discussed during the interviews. For example, I decided not to address the conflicts between English-speaking and French-speaking music therapists, even though this topic was mentioned several times in the interviews. I did not consider the information in the interviews and the primary source documents adequate to tackle this issue with grace or precision.

I changed the eligible pool of participants and the primary research question midway through this study because I had difficulty recruiting participants with the original inclusion criteria. The original research question focused solely on the inaugural CAMT conference. When I was only able to recruit one eligible participant—Colleen Purdon—I decided to expand the inclusion criteria and adjust the research questions because I felt the historical narrative would be richer with multiple perspectives. I conducted Colleen Purdon's interview before the primary research question and inclusion criteria were changed, so we primarily discussed the inaugural CAMT conference. This likely limited the extent to which Colleen felt able to comment on her experience of the CAMT's inaugural year in its entirety, which was the focus

of this study. If I had interviewed each participant with the same research question in mind, it would have increased the validity of the data and the themes I identified from the interviews.

I identified significantly more material from the data that related to the first theme, "Development of Identity," than the other two themes. This discrepancy caused an imbalance in the results. Part of the reason for this imbalance is that I did not identify any material in Susan Munro's interview that related to the theme "Emergence of an Alternative Profession."

After having informal conversations with music therapists who were active in the 1970s, I began this project expecting to produce knowledge of the many conflicts and challenges of the CAMT's inaugural year. When participants brought up conflicts or challenges during their interviews, I pursued this material avidly. I believe this tendency affected the results of this study.

Recommendations for Future Research

While accumulating primary source documents from the CAMT archives, I found ample material about the development of the first Canadian music therapy programs, the establishment of the music therapy accreditation, and several of the CAMT's annual conferences. Historical research on any of these topics would be a valuable contribution to the literature.

Future historical research could explore the common historical narrative about the first university music therapy training in Canada. The literature routinely identifies Capilano's program as the first Canadian training (Alexander, 1993; Howard, 2009; Ivy, 1983; Moffitt, 1993). Corneille's (2008) article about the history of music therapy education in Québec, however, states that l'Université du Québec à Montréal offered a music therapy specialization as part of their music education degree in September 1975, one year before Capilano's program opened. While the definition of "music therapy training program" may come down to semantics in this case, a greater emphasis on French Canada's role in the development of early music therapy education would offer a necessary and overdue addition to the historical narrative. The history of music therapy training in Canada could be a starting point for

historical research examining the relationship between English-speaking and French-speaking music therapists in Canada.

Future research could examine the narrative of diversity in Canadian music therapy through a critical lens. This narrative could be nuanced by examining various elements of diversity among music therapists and music therapy clients, including neurodiversity, race, gender, (dis)ability, sexual orientation, and socio-economic status.

Although the participants did not name the connection between second wave feminism and the development of early Canadian music therapy, the data in this study suggests that further research on this relationship is needed.

Lastly, there are problems with relating a music therapy identity to a nation-state. Describing a music therapy identity as Canadian could exclude Indigenous communities of Turtle Island, as well as other communities who are excluded from or forced to assimilate to prevailing definitions of being Canadian. Can we find an alternative to emphasizing nation-states in our discussion of music therapy identities? If not, at the very least, we need to recognize how the violent, colonial legacy of this country affects the narratives through which we understand our profession. It would enrich future examination of music therapy identity and history if we were to explore how the discussion changes if we avoid using nation-states as the borders of our investigation.

Conclusion

This study identified three significant themes in music therapists' experiences of the CAMT's inaugural year in 1974–75: the development of identity, definitions of music therapy/music therapist, and the emergence of an alternative profession. The historical documents included in the study contain information related to each theme. The development of Canadian music therapy identity was characterized by debates around the validity of behavioural, humanistic, psychology-centered, and music-centered approaches to music therapy, from which the beginnings of a diverse clinical culture emerged. The primary

challenge in defining "music therapy" and "music therapist" was to separate music therapy from music education and performance. Music therapy provided an alternative profession for musicians who were not interested in pursuing a career in performance or education. Finally, music therapy developed in the context of the second-wave feminist movement in Canada. The historical narrative offered in this study should help music therapists and the Canadian public understand the history and identity of the profession. This study represents a small portion of the historical narrative of the therapeutic use of music in Canada. The value of this study will increase as future research highlights unexamined voices in the narrative, and as we explore identities outside of nation-state boundaries.

References

Agres, K. R., Foubert, K., & Sridhar, S. (2021). Music therapy during COVID-19: Changes to the practice, use of technology, and what to carry forward in the future. *Frontiers in Psychology, 12*, 1–17. https://doi.org/10.3389/fpsyg.2021.647790

Aigen, K. S. (2018). Community music therapy. In G.E. McPherson & G.F. Welch (Eds.), *Special needs, community music, and adult learning: An Oxford handbook of music education: Vol. 4* (pp. 138–154). Oxford University Press.

Alexander, A. (1974). Music in music therapy: Introduction of thesis. *Canadian Music Therapy Journal, 2*(2), 6–8.

Alexander, D. (1993). A reflective look at two decades in CAMT. *Canadian Journal of Music Therapy, 1*, 1–13.

American Music Therapy Association (2021). *Workforce analysis: A descriptive, statistical profile of the AMTA membership and music therapy community.* AMTA Bookstore.

Archibald, L., Dewar, J., Reid., & Stevens, V. (2012). *Dancing, singing, painting and speaking the healing story: Healing through creative arts.* Aboriginal Healing Foundation. https://viewer.canadacommons.ca/artifacts/1968941/dancing-singing-painting-and-speaking-the-healing-story/2720706/

Bibb, J. (2013). Professor Denise Grocke's contribution to the establishment of the music therapy profession in Australia: A historical research study. *The Australian Journal of Music Therapy, 24*, 3–13.

Brinkmann, S. (2013). *Qualitative interviewing: Understanding qualitative research.* Oxford University Press.

Brooks, P. (1975, January). *Ontario music therapy association newsletter.* Archives of the Canadian Association of Music Therapists, London, ON.

Buchanan, J. (2009). Fran Herman, music therapist in Canada for over 50 years. *Voices: A World Forum for Music Therapy, 9*(1). https://doi.org/10.15845/voices.v9i1.367

Canadian Association for Music Therapy. (1975). *Music therapists in Canada.* Archives of the Canadian Association of Music Therapists, London, ON.

Canadian Music Therapy Association. (1974). *Canadian music therapy conference.* Archives of the Canadian Association of Music Therapists, London, ON.

Canadian Music Therapy Association. (1974). *Delegates.* Archives of the Canadian Association of Music Therapists, London, ON.

Corneille, S. M. (2008). A page of history: The origins of teaching music therapy in Québec. *Canadian Journal of Music Therapy, 14*(1), 22–29.

Curtis, S. L. (2006). Feminist music therapy: Transforming theory, transforming lives. In S. Hadley (Ed.), *Feminist perspectives in music therapy* (pp. 227–244). Barcelona Publishers.

Curtis, S. L. (2015). Alike and different: Canadian and American music therapists' lives and work. *Canadian Journal of Music Therapy, 21*(1), 12–32.

Davis, W. B. (2012). The first systematic experimentation in music therapy: The genius of James Leonard Corning. *Journal of Music Therapy 49*(1), 102–117. https://doi.org/10.1093/jmt/49.1.102

Davis, W. B., & Hadley, S. (2015). A history of music therapy. In B. L. Wheeler (Ed.), *Music therapy handbook* (pp. 17–28). The Guilford Press.

de L'Étoile, S. K., & Lagasse, A. (2013). Music therapy and neuroscience: From parallel histories

to converging pathways. *Music Therapy Perspectives, 31*(1), 6–14. https://doi.org/10.1093/mtp/31.1.6

Dibble, C. L. A. (2010). *An inquiry into the collective identity of music therapists in Canada* (Unpublished master's major research paper). Wilfrid Laurier University.

Garrido, S., & Davidson, J. (2013). Music and mood regulation: A historical enquiry into individual differences and musical prescriptions through the ages. *The Australian Journal of Music Therapy, 24*, 89–109.

Gouk, P. (2000). *Musical healing in cultural contexts.* Ashgate Publishing. https://doi.org/10.4324/9781315090719

Gross, E., & Young, L. (2014). Canadian music therapists' perspectives on the current state of music therapy as a profession in Canada. *Canadian Journal of Music Therapy 20*(2), 102–133.

Green, J. P., Charboneau, E. A., & Gordon, Beth. (2014). Music Therapy. In *The Canadian Encyclopedia*. Historica Canada. https://www.thecanadianencyclopedia.ca/en/article/music-therapy-emc

Herman, F. (2017). Profile 17: Fran Herman: Canada. In J. J. Moreno (Ed.), *The lives of music therapists: Profiles in creativity: Vol. 1* (pp. 249–263). Barcelona Publishers.

Horden, P. (Ed.). (2000). Music as medicine: The history of music therapy since antiquity. Ashgate Publishing. https://doi.org/10.4324/9781315090894

Howard, M. (2009). An interview with two pioneers of Canadian music therapy: Carolyn Kenny and Nancy McMaster. *Voices: A World Forum for Music Therapy 9*(2). https://doi.org/10.15845/voices.v9i2.351

Hryniw Beyers, K. L. (2016). *A history of the music therapy profession: Diverse concepts and practices.* Barcelona Publishers.

Im, H. J. (2015). *Norma Sharpe; Pioneer music therapist: Her contribution to music therapy in Canada* [Unpublished master's major research paper]. Wilfrid Laurier University.

Im, H. J., & Lee, C. A. (2017). Profile 37: Norma Sharpe (1907-1996). In J. F. Mahoney (Ed.), *The lives of music therapists: Profiles in creativity: Vol. 2* (pp. 382–388). Barcelona Publishers.

Intveen, A., & Edwards, J. (2012). The history and basic tenets of anthroposophical music therapy. *Voices: A World Forum for Music Therapy, 12*(2). https://doi.org/10.15845/voices.v12i2.646

Ivy, V. (1983). The Canadian association for music therapy: Our first decade. In F. Herman & S. Munro (Eds.), *Kaleidoscope: Perspectives on music therapy practice in Canada* (pp. 1-12). Ontario Institute for Studies in Education for the Canadian Association for Music Therapy.

Jackson, N. A. (2016). Phenomenological inquiry. In B. Wheeler & K. Murphy (Eds.), *Music Therapy Research* (3rd ed.). Barcelona Publishers.

Kern, P., & Tague, D. B. (2017). Music therapy practice status and trends worldwide: An international survey study. *Journal of Music Therapy*, *54*(3), 1-32. https://doi.org/10.1093/jmt/thx011

Kim, S. J. (2009). Historical investigation regarding the perception of music therapy among Korean medical professionals as seen in medical journal articles. *Music Therapy Perspectives, 27*(2), 122–129. https://doi.org/10.1093/mtp/27.2.122

Mahoney, J. F. (Ed.). (2017). *The lives of music therapists: Profiles in creativity: Vol. 2.* Barcelona Publishers.

McMaster, N. (2017). Profile 21: Nancy McMaster: Canada. In J. J. Moreno (Ed.), *The lives of music therapists: Profiles in creativity: Vol. 1* (pp. 308–326). Barcelona Publishers.

Moffitt, E. (1993). Music therapy in Canada. In C. D. Maranto (Ed.), *Music therapy: International perspectives* (pp. 131–155). Jeffrey Books.

Moore, K. S. (2015). Music therapy advocacy for professional recognition: A historical perspective and future directions. *Music Therapy Perspectives, 33*(1), 76–85. https://doi.org/10.1093/mtp/miu043

Moreno, J. J. (Ed.). (2017). *The lives of music therapists: Profiles in creativity: Vol. 1*. Barcelona Publishers.

National Association for Music Therapy, Inc. (1975, February 24). *1974–75 Membership Directory.* Archives of the Canadian Association of Music Therapists, London, ON.

Register, D. (2013). Professional recognition of music therapy: Past, present, and future. *Musical Therapy Perspectives 31*(2), 159–165. https://doi.org/10.1093/mtp/31.2.159

Reschke-Hernández, A. E. (2011). History of music therapy treatment interventions for children with autism. *Journal of Music Therapy, 48*(2), 169–207. https://doi.org/10.1093/jmt/48.2.169

Robbins, W., Luxton, M., Eichler, M., & Descarries, F. (Eds.). (2008). *Minds of our own: Inventing feminist scholarship and women's studies in Canada and Québec, 1966-76.* Wilfrid Laurier University Press.

Ruud, E. (2000). Music therapy: History and cultural contexts. *Nordic Journal of Music Therapy, 9*(2), 67-76. https://doi.org/10.1080/08098130009478003

Schoenberger, L., & Braswell, C. (1974). Music therapy in rehabilitation. *Canadian Music Therapy Journal, 2*(2), 20-22.

Sharpe, N., & Wright, B. (1974). *ETM and Orff workshops.* Archives of the Canadian Association of Music Therapists, London, ON.

Sharpe, N. (1975). Canadian music therapy association. *Canadian Music Therapy Journal, 3*(1), 2-4.

Sharpe, N. (1977). The history of the Canadian Association for Music Therapy. *The Journal: Canadian Association for Music Therapy, 5*(2), 2.

Shugar, B. (2009). An interview with Susan Munro-Porchet. *Voices: A World Forum for Music Therapy, 9*(3). https://doi.org/10.15845/voices.v9i3.334

Smuckler, B. (1975, January). *The status of music therapy in Ontario.* Archives of the Canadian Association of Music Therapists, London, ON.

Solomon, A. L., & Davis, W. B. (2016). Historical research in music therapy. In B. L. Wheeler & K. Murphy (Eds.), *Music therapy research* (3rd ed., pp. 2412–2448). Barcelona Publishers.

Solomon, A. L., & Heller, G. N. (1982). Historical research in music therapy: An important avenue for studying the profession. *Journal of Music Therapy, 19*(3), 161-178. https://doi.org/10.1093/jmt/19.3.161

Summers, S. (2019). *Government regulation-overview.* https://www.musictherapy.ca/about-camt-music-therapy/government-regulation/

The academy of neurologic music therapy. (2016). International training institutes in NMT. https://nmtacademy.co/training-opportunities/nmt-training-institute/

Wheeler, B. L., & Bruscia, K. E. (2016). Overview of music therapy research. In B. L. Wheeler & K. Murphy (Eds.), *Music therapy research* (3rd ed., pp. 3–19). Barcelona Publishers.

Author Information

Daniel Kruger (MTA, MA) is an improviser, guitarist, composer, and music therapist living in Tio'tia:ke/Montréal, Québec. His clinical work takes place at the Douglas Mental Health University Institute, where he accompanies children and adolescents as they strive to achieve their mental health goals. Daniel is also an active performer and composer in the creative/improvised music scene.

daniel.kruger.comtl@ssss.gouv.qc.ca

Reflections on the Canadian Music Therapy Podcast: The First 40

[Réflexions sur le balado *Canadian Music Therapy Podcast* : Les 40 premiers épisodes]

Adrienne Pringle, BA, BMT, MMT, RP, MTA

Cathy Thompson, BA

Abstract

The Canadian Music Therapy Podcast celebrated two years of episodes in February 2023. Hosted by music therapist Adrienne Pringle (AP) and business leader Cathy Thompson (CT), the bi-weekly podcast shines a bright light on the impact and work of music therapists across Canada. This reflective article features Adrienne's and Cathy's personal explorations of themes and ideas that emerged from a close examination of the podcast transcripts from the first 40 interview-based episodes.

Keywords: podcast, music therapy, advocacy, music as catalyst, connection, collaboration, adaptability

Sommaire

Le balado Canadian Music Therapy Podcast a célébré son deuxième anniversaire en février 2023. Animé par la musicothérapeute Adrienne Pringle (AP) et la cheffe d'entreprise Cathy Thompson (CT), le balado a lieu toutes les deux semaines et met en lumière l'influence et le travail des musicothérapeutes de toutes les régions du Canada. Dans cet article de réflexion, les autrices discutent des thèmes et des idées qui sont ressortis d'un examen minutieux des transcriptions des entrevues présentées dans les 40 premiers épisodes du balado.

Mots-clés : balado, musicothérapie, défense des droits, la musique comme catalyseur, connexion, collaboration, adaptabilité

Beginnings

AP: When Cathy first suggested the concept of the podcast, I was reluctant to embark on the project. I didn't know anything about the podcast world and there was a steep learning curve to understanding *why* and *how* we would do this. I was intimidated by the undertaking. Cathy was reassuring, and I quickly learned that we wouldn't be doing this alone—thanks to our team, Stacy Maynard (editor), Lindsey Jacobs (graphic design) and Julie Pickett (social media), it turned out to be simpler than I had anticipated. Cathy is an innovative business leader and brave risk-taker; she also brings experience as a TV host and, most importantly, a constant curiosity about people. Since we had collaborated so successfully for *Beyond the Studio* (www.beyondthestudio.ca) and *Sing it Girls* (www.singitgirls.ca), knowing that I would be working with Cathy made it possible to take the leap and say yes.

Once we began planning the *why* of the podcast and developing our understanding of how it could represent our unique Canadian voices and identities, our reasons to move forward became evident. My personal mission to advocate for music therapy could be realized through the podcast in a whole new way. I would get a chance to talk to my heroes, friends, inspirational colleagues, and, equally as important, give our listeners a chance to hear their stories, experiences, and perspectives. I also realized that this would be an opportunity to highlight Canadian music therapists' identities, and the strong work that they are doing across the country. We need to celebrate and support one another. The geographical breadth of our country often limits us from gathering in the way that we could in a smaller territory. The podcast gives us a platform to acknowledge and create awareness of one another, as well as to grow pride in our national identity as a profession.

As we have heard on the podcast, our work can be isolating: we are often the only music therapist in our facility or in our community. One of the reasons that we end up with attrition in our profession is because of this feeling of isolation. Hearing others speak about their clinical work and lived experiences helps us to feel connected. Importantly, through our podcast, a music therapist may see themself or relate to the experience of another music therapist that

they may never have the chance to meet. My hope is that the podcast works to inform those who may be interested in learning more about music therapy, to inspire students to study music therapy, and to help professionals to feel seen and proud of the powerful work they are doing.

When I was on the Canadian Association of Music Therapists' (CAMT) board for a term as President, one of our board members, Jeffrey Hatcher (Winnipeg-based MTA and counselor), said: "The CAMT is the long thread that connects music therapists across this vast country" (2016). With such a wide geographical spread across varied provincial health-care landscapes, we need to be conscious of staying connected as a professional body. The CAMT offers us this sense of connection, and the podcast gives us another platform to hear one another's voices and stories from coast to coast. It has been a powerful experience for me to take this time to reflect on what has been shared on the podcast over these past two years.

CT: The idea of hosting a music therapy podcast came to me one day after I had finished producing and hosting three seasons of a local cable TV show, *Beyond the Classroom.* What I loved about the TV show was that I had the privilege of interviewing people and sharing their areas of expertise and stories as they related to learning in childhood. I had also begun to understand more about the business utility of a podcast as a way of sharing stories and information more widely. With the advancement of tools and technology in the podcast field, I felt that it could be something Adrienne and I could do together to create more awareness of our company, *Beyond the Studio.* But, more importantly, I envisioned the podcast as a means of highlighting the amazing work of music therapists across Canada. When I approached Adrienne about creating a podcast, she liked the idea but was hesitant. I felt that, with Adrienne's gift for connecting people, her ability to create a warm environment for sharing, and her extensive relationships with music therapists, we would make a great team for producing the podcast. After some convincing, she was prepared to give it a try with an open mind and heart, and a willingness to learn along the way.

I had built effective systems to produce the TV show, which I knew we could translate to podcast production. So we weren't starting from scratch, even though neither of us had hosted a

podcast before. We hired a podcast editor, graphic designer, and social media consultant and, in February 2021, the *Canadian Music Therapy Podcast* was launched. The guests that Adrienne has invited to the podcast are amazing and the experiences they have shared have been compelling. I believe that one of the reasons why people who aren't music therapists listen to the podcast is because of the stories. Storytelling attaches emotion to concepts and, through this, music therapists can articulate the impact of their work with clients. One of the challenges that music therapists have identified is that the public often does not fully understand what they do. I have heard this for at least eight years in a variety of ways at meetings, events, and throughout interviews on the podcast. After co-hosting this show as a non-music therapist, I believe that the stories are what hits home with the public. The stories give listeners a sense of what music therapists can do.

The Process

In preparation for this piece, we chose 40 podcast episodes to review in order to identify themes that emerged in the first two of years of the show. We decided on the first 40 interview-based episodes, and transcribed them using a transcription service. Based on several thorough reviews of the transcriptions, we each highlighted prominent themes that emerged from interviewees' responses to questions we asked during the shows. We compiled, reflected upon, and discussed areas of crossover and similarity, leading us to identify five overarching themes: connection, collaboration, adaptability, advocacy, and using music as a catalyst.

Next, we engaged independently in reflective writing, considering each theme alongside relevant direct quotes from podcast interviews, following the practice articulated by Artioli et al: "The reflective approach of reflective writing allows oneself to enter the story, becoming aware of our professional path, with both an educational and therapeutic effect" (2021). From this thematic reflection, ideas emerged as we immersed ourselves in the stories and made connections between interviewees' lived experiences and our own lives.

For this article, we each wrote about select themes: Adrienne wrote about the themes of advocacy and using music as a catalyst, while Cathy wrote about the themes of connection, collaboration, and adaptability.

Thematic Discussion

Connection

CT: The theme of connection was prevalent in most episodes. Specifically, guests spoke about the connection between members of the provincial organizations, connection to other music therapists in the field, and music as a connector between therapist and client, as well as between therapist and staff, caregivers, or client family members. In addition, guests spoke about connection to the music itself, between voices and to their voice, to oneself (mind and body), to memories, to the environment, and to music in their own childhoods.

We interviewed all of the provincial associations' presidents as well as the CAMT leaders on the podcast. The provincial associations' presidents often mentioned their focus on ensuring that membership connections stayed strong despite pandemic lockdowns. Staying connected helps music therapists energetically, in job support, and in growing our profession. Leaders touched upon the unique challenges faced by music therapy in their area, speaking about the influences of culture, socioeconomics, and geography. In some cases, they made a concerted effort to bring different learning opportunities to their associations to promote community connections and to support ongoing education. Guests spoke about creative initiatives, including surveying members, strengthening policies and operations, and bringing people together through in-person and online events. The CAMT conferences in 2020 and 2021 continued as scheduled, but were moved online. Maintaining this opportunity for members to meet, share experiences, and work together to problem-solve issues during COVID-19 lockdowns was critical. Members felt supported by each other and by CAMT during a very stressful time, furthering existing connections.

The podcast was launched in February 2021 when lockdowns across Canada were still prevalent due to the pandemic. The early podcast episodes often echoed the need to stay connected during a time when the government asked that we socially distance—from both colleagues and clients. Music therapists articulated a desire to continue to connect virtually with other MTAs (Certified Music Therapists) to avoid loneliness, and to get support and ideas from one another.

The guests on the podcast shared their personal connections to music, as well as their clients' connections to music through therapy sessions. From my perspective, music therapists have an innate ability to clinically connect to music in a way that gives others access to musical connection, regardless of their current musical capacities. It's like the music is inside of the MTAs, ready to support those who need it through a variety of mediums and instruments. Ruth Roberts shared one of her experiences in oncology with a family on episode 45:

> So, in oncology, I supported families and children going through various stages of treatment from their diagnosis. Could be through lengthy chemo or radiation through complications and sometimes at end of life and music was really an ally for the kids. I remember one mom saying, *"I knew when he spent time with you, he could just be a little boy again."* (Thompson & Pringle, 2022)

As guests shared their experiences on the show, I was struck by the fact that music itself was a huge connector. I knew from the research behind the Sing it Girls!® program that the act of making music together connects people and can have a positive impact on an individual's mental health and well-being (Pringle & Thompson, 2022). Music therapists have the benefit of using music as a connective tool when talking might not be a preferred option in the therapy sessions. Naomi Ben-Aharon explained this eloquently in episode 22: "I felt really alive. I felt really in connection with being a human. And the people who were at hospice taught me a lot about what it meant to be in the moment with somebody, what it meant to be present, the importance of planning and also *not* planning in music therapy work" (Thompson & Pringle, 2021).

Alexandra Moir spoke about her experience in palliative care of feeling connected by being present on episode 34: "I ended up going into palliative care and just being struck by the difference that I could make just via my presence and my music . . . music is one of those, you know, huge connectors, so when you bring presence and music together, just something so amazing can happen that I just feel invigorated during so much of my time at work" (Thompson & Pringle, 2022). On episode 24, Elaine Cheung underlined this idea of connection to others in the work of music therapy:

> I think a person's individual preferences for music is a way to communicate their identity, to connect with another person, and to make meaning out of whatever they're experiencing. The reason that I got into music therapy was wanting that deeper and more personal level of connection with people. (Thompson & Pringle, 2021)

We asked many guests on the podcast about their journeys to become music therapists, and the stories are amazing. One of the common threads we have heard is the connection to music as a child. Often, our guests have witnessed first-hand how music has positively impacted someone's life and, because of this experience, they have chosen to follow the path to becoming a music therapist. On one of our first episodes (episode 3), Noreen Donnell spoke about her childhood experiences with music:

> I would have to give a nod to my early love of music, starting with piano lessons at age eight. I quickly realized this was something that I not only loved to do, but it was something I was naturally good at. I have to give a shout out to one of my favourite piano teachers, Mrs. Lachine. I totally credit her with bringing the music out in me—I think she knew on some level that music was bubbling inside of me. I feel like she freed my musicality. So I'd often go onto these musical tangents. For example, if I made an error when I was playing classical music and I liked the sound of it, I would start composing a different song based on that. So I kind of think that was my creativity coming out and probably why I continue to love to write songs. Music was a very present force in my home growing up, and I'm really thankful for that. (Thompson & Pringle, 2021)

Kaitlyn Kasha, on episode 46, also relayed her musical journey:

> So my journey to music therapy was actually quite organic. I grew up in a very musical household and I'm really thankful to my parents for a really encouraging music education. I started in Kindermusik when I was very young, and after I graduated from that program, my parents encouraged me to take lessons. They basically said to pick an instrument and I said, "I want to sing, my voice is an instrument too." (Thompson & Pringle, 2022)

Hearing the "journey" stories of "how I got here" helps music therapists re-connect to their roots, their reason for doing this work. Our hope for listeners is that this is inspiring, refueling, and sustaining because they can relate, they feel "seen," and they can connect these stories to their own "why" and journey story.

Adaptability

CT: When speaking with podcast guests, the theme that permeates most episodes is the adaptability of music therapists. Just like an educator in the classroom, MTA's must be flexible and adaptable during their music therapy sessions with clients and groups. I think this speaks to client-led care in the sense that, if something is not working to help with the therapeutic goals, the therapist switches their techniques or pacing to move the session forward. Each client has individual needs during music therapy, so finding a match between the therapist and client is critical to meeting therapeutic goals.

On our second episode, Susan LeMessurier-Quinn shared her music therapy experiences in different settings:

> Well, I think music therapists have this very unique position in that music can be so adaptable for a variety of situations that allows us to work in different areas in different population areas, and also with different age groups. So, for example, for a pediatric hospital to be able to spend maybe one day working in children's rehabilitation and perhaps the next day working in pediatric intensive care, or a neonatal intensive care, is really for me a blessing and a privilege because of this unique ability to use different musical resources and approaches to work within each situation. And so, whether it's choosing the right instrument for that right moment, or the most appropriate type of music or style of music for that moment, and then that unique ability to be able to respond within the moment to the music that you're creating, but also the music that the patient is creating . . . we can do anything, we're adaptable and we can make this happen because the most important thing at the end of the day is that you're maintaining that connection with your patient and with their families and caregivers. So how do we do that? We figure that out and we look for ways to make that happen." (Thompson & Pringle, 2021)

Guests have also noted the need to trust their gut in situations to get the most out of their time with the client or group. They must also be innovative, be flexible, and bring a diverse range of skills to their work.

Collaboration

> *We can learn so much about how music can help people from a health and wellness perspective. By not only collaborating with other healthcare professionals, but other music practitioners and other people that swim around in music and human relationships all the time.* —Liz Mitchell, Thompson & Pringle, episode 12, 2021

CT: One of the things that we hear continuously from music therapists on the podcast is the importance of collaboration. This can take the form of collaborating with others within a facility, collaborating at the provincial level as colleagues, or collaborating in an interdisciplinary way within organizations and in the community. As an entrepreneur and business leader for over 25 years, what has struck me in speaking with music therapists is that outright competition for business opportunities is frowned upon. Rather, ethical music therapy practice calls for professionalism and collaboration. This is a notable difference compared to traditional business culture, despite the very real issues music therapists face of limited contracts, positions, and integration into the health-care systems across Canada. The Canadian Association of Music Therapists Code of Ethics (2023) Item II.37 Responsible Practice, Ethical Business Practice states: "The MTA will demonstrate respect for other Certified Music Therapists by ensuring they do not intentionally undermine existing therapeutic relationships by engaging in deliberate solicitation of clients who are receiving services from another Certified Music Therapist" (CAMT, 2023).

Peer support is part of the fabric of music therapy and we have categorized it under the theme of collaboration. Guests of the show have identified that they seek opportunities to connect with others in the field to receive mentorship, guidance, and supervision. In episode 25, Mackenzie Costron explained the links between mentorship and a broader integration of the profession: "We have a vision to provide brave spaces for students, interns, and certified music therapists. We also have an interest in music therapy to be accessible, recognized, and

integrated into all healthcare systems at both the macro and the micro level" (Thompson & Pringle). There is mutual respect and a coming together to help bring all certified music therapists to the same level to make music therapy accessible to all. Many MTAs found the opportunity to connect virtually with teams within their own practices, with their provincial associations, and with the Canadian Association of Music Therapists particularly helpful during the pandemic.

Amanda Schenstead (episode 28) was excited to share the ways they brought unique educational opportunities to members of the provincial association in Saskatchewan: "This year, we decided to branch out to include education sessions, which featured professionals outside of the membership and from other disciplines . . . And so that was kind of nice to like collaborate and have voices from other disciplines coming in" (Thompson & Pringle, 2022).

We also heard from many guests about the need to collaborate to overcome workplace isolation. Reflecting on her time as the first music therapist working alone at Sick Kids in Toronto, Ruth Roberts shared: "For a lot of us as music therapists going into situations, the work itself can be isolating, and so I relied heavily on my colleagues in the profession. I didn't have colleagues in the hospital, but I became involved provincially and through the national organization. And it was so enriching to me personally and professionally" (Thompson & Pringle, 2022).

When Miya Adout was asked about her advice for new music therapists on episode 35, she offered: "I think probably to seek out a mentor, whether it's the supervisor, a friend who, you know, has been in the field for some time. I think just communicating with someone who's been there can go a long way" (Thompson & Pringle, 2022). On podcast episode 3, Noreen Donnell told us more about the impact of collaboration and connection when sharing her recommendations for other music therapists: "Probably a final recommendation is just connect with other music therapists. These are your people. We have so many ways to do this. We have our provincial conference, we have national conferences and, I've always said, when I go to these conferences, I feel like I'm coming home" (Thompson & Pringle, 2021).

One of the things I have noticed about many of the music therapists I have met is their passion for learning and the need for interprofessional collaboration to learn from other disciplines for client-centred care. As Elaine Cheung explained: "I know that many music therapists work in complex care and are in collaboration with other healthcare professionals" (Thompson & Pringle, episode 24, 2021).

I believe that educating professionals in different disciplines about what music therapy can do for their patients/clients, along with the role of music therapists on teams, will help advance client care. Also, informing those individuals needing therapy that music therapy is a potential treatment option may create a push upwards to management as a form of patient advocacy. Clients asking specifically for music therapy will draw the attention of management to potentially allocate a budget for this position on all healthcare teams.

Music therapy is not only helpful in healthcare settings, we have also heard about successful music therapy programs in jails and schools. On episode 4, Jennifer Buchanan related how other professionals work with music therapists to co-treat patients:

> What does it really mean to co-treat with others and recognize that yes, it's all that list, but it is also working with the chaplains in spiritual care. It's also working with the many recreation therapists who have advocated for our work across Canada. I mean, it's all these pieces. It's also working with families. We can see all the layers of networks that people are working in. (Thompson & Pringle, 2021)

Music As a Catalyst for Change

> *There is a profound sense of grounding when we can show why what we do works from a very evidence-based perspective. However, this does not take away from the mystery and the magic and the intuition of why music is so important.* —Dr. SarahRose Black, Thompson & Pringle, episode 10, 2021

AP: The impact and role of the "music" in music therapy is a strong theme in each episode. In episode 47, Melissa Jessop recounted the words of my supervisor, Caryl Ann Browning: "You have to trust the music, let the music do the work" (Thompson & Pringle, 2022). As music therapists, we search for the words to describe *the work* that the music does. We study all of this as musicians and have in-depth understandings of how to use music in a wide range of clinical applications. Music therapists use the elements of music in varied applications in the context of therapeutic relationship. Podcast guests have spoken about these relationships through stories of lived experiences of music in action, stories that speak to the heart of this work. As Noreen Donnell explained, "These stories, I've always said, provide that 'aha' moment for others to get what music therapists do" (Thompson & Pringle, 2021).

In episode 11, Paul Lauzon spoke about how Howard Gardner's theory of multiple intelligences highlights an area that deserves more emphasis and recognition: musical intelligence (Gardner, 1983). Paul reminded us: "Music is a part of what makes us human and each one of us has a music child within" (Thompson & Pringle, 2021). As a former student of Paul's at Acadia, Yasmin Kawar—who went on to complete her graduate studies at Concordia University—summed it up succinctly while discussing her work in mental health and addictions, saying: "Music is inherently humanizing" (Thompson & Pringle, episode 22, 2022).

Rachael Finnerty (episode 21) described music as a natural, engaging intervention that allows a space for mental health goals to be achieved proactively. Through Rachael's current research with university students, she advocates for music therapy to be recognized as a standard of care. Elizabeth Eldridge (episode 5) described the natural power of music therapy as the creation of a comforting, safe space, without feeling "like therapy." This music space gives a sense of agency, empowerment, and hope for the future. Dr. Elizabeth Mitchell spoke of this as well, saying, "I love the paradox that was this idea that their clients identified that music therapy was helpful in their treatments because they didn't perceive it to be treatment" (Thompson & Pringle, episode 12, 2021). Similarly, in reflecting upon her work at Sick Kid's Hospital, Ruth Roberts spoke about music as an "ally for kids," sharing how music helped

a mom to regulate her emotional response, which, in turn, helped her child to be soothed. These strong examples give life and understanding to the work of music.

Dr. Susan Summers (episode 6) shared her learnings about her own intuitive knowing, supported in findings from her PhD research on the uniqueness of the human voice as a valued and audible expression of our identities (Baker & Uhlig, 2011). Susan explained further that vocal expression through singing is a powerful non-verbal means of accessing our subconscious and healing capacities. What happens when we are singing and connecting in music therapy is that the experience of engaging in music "takes the lid off" and gives the participant access to themself as a whole person:

> Their voice freed them and it released emotions. It spoke for them. It said things in song and in vocalization, in different ways than a verbal statement would have done. They talked about the physical healing that can come from that and the emotional release that they were able to facilitate for their clients. (Thompson & Pringle, 2021)

In popular culture, we hear this described as "the power of the music," a descriptor used by music therapists in several podcast interviews (Thompson & Pringle, episode 17, 2022; episode 31, 2022); Music makes us feel deeply and has properties that integrate us and connect directly to emotions and our physical bodies (McFerran et.al, 2020). Music facilitates the mind-body connection, drawing upon our musical intelligence (Gardner, 1983), our inner "music child" (Aigen, 2014)—"inherently humanizing" us.

Advocacy

> *I think that one of the main things that I came away with is just the amount of obstacles that the people who I interviewed had to get through just to be able to establish and to have a career as a music therapist.* —Dan Kruger, Thompson & Pringle, episode 41, 2022

AP: If there is one distinct theme that comes up in every interview on the podcast, it is advocacy. I love hearing the excitement, passion, and dedication that Canadian music therapists share when we ask the (often final) question: "what is your vision for the future of music therapy in Canada?" Susan Summers, for instance, shared:

> I think if I had a crystal ball and if I had anything to say about how we would progress, it would be that music therapists and music therapists' work are understood for what it is as the ethical professional depth approach that we are hired everywhere that every hospital ward, every school, every community agency, every mental health treatment centre, every long-term care home across Canada and beyond have a music therapist. And that actually we would be in short supply then, because there's not enough of us. (Thompson & Pringle, 2021)

I recognize now that if there is one purpose alone for the podcast, it is this: to keep that inspiration and passion alive in each one of us, so that we continue to be pioneers and trailblazers in moving this healthcare profession forward. As Dr. SarahRose Black explained:

> When we talk about the future of music therapy what I envision is this: may music be a standard of healthcare. So of course music therapy is a standard. May there be a music therapist in every facility, in every community, may people have access. I am fierce about access and I hope it is not difficult to access a music therapist and that it becomes so common that no one is surprised. Like when I introduce myself as a music therapist, well, of course there'd be a music therapist here, as opposed to, I can't believe this hospital has a music therapist. I'm looking to switch that narrative. And I know so many of my colleagues and friends are doing the same thing. (Thompson & Pringle, 2021)

Music therapists recognize the value of their work; however, there are barriers that limit access to music therapy services. Music therapy is generally not included in most public (government) or private (insurance) funding models. Health-care policy is regulated provincially, and the number of practising music therapists is too small to gain enough traction to lobby at each provincial level. When we band together at the national level, we need to be able to access and target the audiences that can influence policy change that is both challenging to identify and to target without the means for a lobbying effort.

Another barrier to services can be inadequate numbers of music therapists available in certain regions to meet demands. Further, there continues to be a general misconception about what music therapy is and who is qualified to provide it—and this can cause frustration and a path to burnout for some MTAs. I recall a clever tag line on the radio a few years ago that went like this: "(radio station name) . . . music therapy for your ears." Of course, there is nothing wrong with saying that the music played on the radio may be therapeutic for many. This language, however, can be discouraging for music therapists who have been advocating together for almost 50 years to clarify that the term "music therapy" refers specifically to clinical interventions offered in the context of a therapeutic relationship by a certified music therapist.

I have three degrees and studied for seven years, plus a 1000-hour internship, alongside hundreds of continuing education course hours and certifications—extensive training that I know many of my colleagues share. As Susan Summers commented, because music therapists begin their studies as children in music lessons, a four-year Bachelor of Music Therapy is more like 15 years of training. The misconceptions that we are entertainers, that any amateur musician could do our job, and that our work is fun and easy can be difficult to tolerate on a day-to-day basis, especially when we may feel misunderstood by our colleagues. We understand the effort, time, resources, and dedication that is required to train to become a certified music therapist, and the need to explain this endlessly can be a challenge. As Fleur Hughes stated in episode 30: "I don't want people to think we show up with a guitar and sing" (Thompson & Pringle, 2022).

On the podcast, music therapists have explained that advocating can be challenging within their personal workplace. To have retention in our field we need to have more options for "good" jobs, meaning full-time employment with benefits and vacation pay so that MTAs feel supported and can focus singularly on providing the excellent services that they are trained for. We talk with a lot of different MTAs on the podcast from across the country, and many ideas and initiatives are shared. The podcast helps us to strategically create a common language for talking about our work, to build towards collective pursuits, and to align advocacy goals.

For instance, Julia Kowaleski (episode 23), current past President of the Music Therapy Association of Ontario, spoke about the need to increase awareness of funding to provide more music therapy services, the need to educate the public, the constant demand to validate what we do, and the need for more "good" MTA jobs. As Elaine Cheung contends, at the local level this can mean having strong messaging and material shared on accessible websites (Thompson & Pringle, episode 24, 2022). Elaine Cheung also spoke about increasing research that validates music therapy services, aligning with other provincial health-care services, working towards provincial regulation, and ensuring "secure" employment for music therapists as current needs in Alberta. In Quebec, provincial leaders from the Association québécoise de musicothérapie spoke to us about the need to educate the public, that there are not enough MTAs to meet the demand and need, that the credibility of music therapists needs to be increased, and that the overarching goal is to be able to provide access to music therapy for everyone (Thompson & Pringle, episode 35, 2022).

Recent graduates have also articulated the importance of advocacy on our podcast. Yasmin Kawar spoke to music therapy education as an important consideration in professional retention and growth: "how we teach music therapy is a huge part of the profession." As a newer graduate who has completed both undergraduate and graduate studies in music therapy, Yasmin shared her hope, saying that she wanted "music therapy to be a very normal part of health care" (Thompson & Pringle, 2022). Dan Kruger conducted interviews as part of his MA thesis, learning about the first years of the CAMT. He discovered that the women

who started the CAMT were fighters and passionate, tireless trailblazers. He noted that our advocacy initiatives today still need to focus on educating people on what a music therapist does and how that differs from the role of a music educator.

These issues have a long history. Ruth Roberts recently retired from her position at Sick Kids in Toronto, where she was the first music therapist hired in the late 1990s. Ruth shared stories of the deep impact of her work with us on the podcast. She also shared: "those initial years really involved being the person for music therapy when it came to advocacy, securing funds, public relations, clinical work, and trying to promote the profession within the hospital" (Thompson & Pringle, 2022).

Important groundwork has been laid by the first music therapists who created the CAMT in 1976 and by music therapists like Ruth Roberts who left a legacy of her clinical work and built a program that employs a team of music therapists. My hope is that the demand for advocacy of the nature that Ruth describes is going to change and that we will see music therapists who are able to focus most of their effort on the service they are providing, just as allied health professionals, physicians, nurses, and many of the other health-care colleagues are able to do.

I currently sit on the advocacy committee for the CAMT, a group that includes past presidents and vice presidents of the CAMT and provincial associations, as well as a growing number of professionals new to our field, representing as many provinces as possible. I suppose you could call this committee a think tank, and we talk strategically about the issues that we have discussed above so that we can make suggestions to the CAMT Board of Directors about where our attentions and resources might be directed. Over the years, I have come to understand that unity and strong links between the provincial and national bodies are essential to our growth. The CAMT strives to understand the changes and differences within each province as music therapists (counseling therapists/psychotherapists) become regulated by provincial colleges. Kiki Chang and Joel Klassen spoke to this and to the necessary understanding of the role the CAMT will play in continuing to support, advocate,

and connect members as these changes unfold (Thompson & Pringle, episode 7, 2021). The CAMT also plays a role in understanding how services are accessed and provided from province to province and how the CAMT can help connect and communicate nationally in supporting advocacy efforts.

Implications for Practice and Education

AP: There is much to be learned from the advice, stories, and wisdom shared by guests on the Canadian Music Therapy Podcast. Our hope is for the podcast to be used to gather information about our collective voice as music therapists across Canada and to apply that learning to advance the profession. Our vision is to continue to share the information from these and upcoming podcasts through a variety of mediums, including this article and potential educational materials for new music therapists. We also want to capture the stories that are so powerful and share them more broadly across other professions and the non-music therapy community. Collaborating in these efforts allows us to continue to advocate for integration into health-care systems, for wellness initiatives, and for making music therapy accessible to all.

Final thoughts

CT: I love that part of the fabric of the music therapy profession that relates to innovation and continuous learning. I have learned an incredible amount of information from our guests and, after doing more than 50 interviews, I feel like I am a part of this community. I respect and admire the work and advocacy that is being done across Canada to raise the profile of music therapy to hopefully integrate it across all health-care teams and increase its accessibility. We will continue to highlight the incredible work of music therapists through this podcast in hopes of being a strong part of the advocacy efforts needed to create awareness and access across Canada.

AP: Working with Cathy on the podcast to shine a bright light on Canadian music therapists has been a true highlight of my career. Identifying and reflecting on these five themes has provided me with deeper insight and purpose for our podcast journey. I am so proud of our community and am inspired and moved by each interview. Listening to the podcast, you will hear us laugh, and you will hear me moved to tears because this is what music therapy stories do—they move me. Amplifying the voices of music therapists to describe music doing the work is truly a gift. CAMT's first Executive Director Jennifer Buchanan shared a saying borrowed from JFK that we might anchor ourselves to in our work: "a rising tide lifts all boats." There are common threads that connect us to one another from coast to coast, and when we collaborate, connect, and advocate together, everyone wins.

References

Aigen, Kenneth. (2014). Music-Centered Dimensions of Nordoff-Robbins Music Therapy. *Music Therapy Perspectives, 32*, 18–29. DOI:10.1093/mtp/miu006

Artioli, G., Deiana, L., De Vincenzo, F., Raucci, M., Amaducci, G., Bassi, M.C., Di Leo, S., Hayter, M., & Ghirotto, L. (2021). Health professionals and students' experiences of reflective writing in learning: A qualitative meta-synthesis. *BMC Med Educ, 21* (394). https://doi.org/10.1186/s12909-021-02831-4

Baker, F. & Uhlig, S. (2011). Voicework in Music Therapy: Research and Practice. Jessica Kingsley.

Canadian Association of Music Therapists. (2023, May 15). CAMT Ethics. https://www.musictherapy.ca/wp-content/uploads/2022/11/CAMT-Code-of-Ethics-FINAL-2022-EN.pdf

Gardner, Howard. (1983). *Frames of Mind: The Theory of Multiple Intelligences*. Basic Books.

Hatcher, J. (2016, June 1).

Canadian Association of Music Therapists board member biographies. https://www.musictherapy.ca/about-camt-music-therapy/board-of-directors/

McFerran, K., Lai, H., Chang, W., Acquaro, D., Chin, T., & Stokes, H. (2020). Music, rhythm and trauma: A critical interpretive synthesis of research literature, *Frontiers in Psychology,*

2(11). https://doi.org/10.3389/fpsyg.2020.00324

Pringle A. & Thompson C. (2022). Sing it girls: Facilitator manual. Beyond the Studio.

Thompson, C. & Pringle, A. (Executive Producers). (2021, February 15). The Versatility of Music Therapy with Children and in Remote Settings (No. 2) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/0gLHUQ33bBb

Thompson, C. & Pringle, A. (Executive Producers). (2021, February 15). Becoming a Music Therapist: A 30-year journey (No. 3) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/hT9DkQ33bBb

Thompson, C. & Pringle, A. (Executive Producers). (2021, March 3). Trailblazing the Field of Music Therapy (No. 4) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/mthAHO33bBb

Thompson, C. & Pringle, A. (Executive Producers). (2021, March 17). Innovation, Mental Health and Resilience (No. 5) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/K98O7N33bBb

Thompson, C. & Pringle, A. (Executive Producers). (2021, March 31). Embracing Voice for Healing (No. 6) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/WY5lwN33bBb

Thompson, C. & Pringle, A. (Executive Producers). (2021, April 14). The Pandemic, Leadership and Access to Music Therapy (No. 7) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/tOO76AZ47Bb

Thompson, C. & Pringle, A. (Executive Producers). (2021, May 26). Oncology, Palliative Care and the Changing Health Care System (No. 10) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/mAbZTK33bBb

Thompson, C. & Pringle, A. (Executive Producers). (2021, June 9). Challenging our Beliefs (No. 11) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/UVFTu926bBb

Thompson, C. & Pringle, A. (Executive Producers). (2021, June 23). Access, Collaboration and Unlearning: A Music Therapist's Journey (No. 12) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/jyISoM66bBb

Thompson, C. & Pringle, A. (Executive Producers). (2021, September 1) Connecting with Children with Autism & Diverse Needs through Music (No. 17) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/uYGdfvZ47Bb

Thompson, C. & Pringle, A. (Executive Producers). (2021, November 10). Becoming a Music Therapist: Leaning into Discomfort, Emotion and Intensity (No. 22) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/sceoSra7bBb

Thompson, C. & Pringle, A. (Executive Producers). (2021, November 24). Connection and Support in the Ontario Music Therapy Community (No. 23) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/KK6Uira7bBb

Thompson, C. & Pringle, A. (Executive Producers). (2021, December 8). The Alberta Music Therapy Community: Identity, Relationships and Leadership (No. 24) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/3FvqJqa7bBb

Thompson, C. & Pringle, A. (Executive Producers). (2021, December 22). The Impact of Heart Centered Leadership (No. 25) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/HU3u23k7bBb

Thompson, C. & Pringle, A. (Executive Producers). (2022, March 16). The Saskatchewan Music

Therapy Community: Innovation and Connection (No. 28) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/3Hy0KBm7bBb

Thompson, C. & Pringle, A. (Executive Producers). (2022, April 13). Music Therapy in Elementary Education: A Humanistic, Improvisation based approach (No. 30) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/axJZJAm7bBb

Thompson, C. & Pringle, A. (Executive Producers). (2022, April 27). The Atlantic Music Therapy Community: Presence + Music = Impact (No. 34) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/SotNaAm7bBb

Thompson, C. & Pringle, A. (Executive Producers). (2022, May 11). Passion, Innovation and Resilience in the Business of Music Therapy (No. 35) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/N3vkBzm7bBb

Thompson, C. & Pringle, A. (Executive Producers). (2022, September 28). The Fascinating History of the CAMT (No. 41) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/qItpcwm7bBb

Thompson, C. & Pringle, A. (Executive Producers). (2022, October 12). Cultivating a Trauma Informed Practice (No. 42) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/rfHODvm7bBb

Thompson, C. & Pringle, A. (Executive Producers). (2022, November 23). Poignant Stories from a Passionate Music Therapist (No. 45) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/7OwKgtm7bBb

Thompson, C. & Pringle, A. (Executive Producers). (2022, December 7). The Winding Path of a New Music Therapist (No. 46) [Audio podcast episode]. In Canadian Music Therapy

Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/SAjprtB7bBb

Thompson, C. & Pringle, A. (Executive Producers). (2022, December 21). Music Therapy Assisted Childbirth (No. 47) [Audio podcast episode]. In Canadian Music Therapy Podcast. Beyond the Studio. https://spotifyanchor-web.app.link/e/RZDlRsB7bBb

Author Information

Adrienne Pringle brings over 20 years of experience as a Certified Music Therapist, Registered Psychotherapist and clinical supervisor. She serves as a board member for the Canadian Music Therapy Fund, is a past President of the CAMT, co-founder and co-owner of Beyond the Studio and the Sing it Girls! program and co-host of The Canadian Music Therapy Podcast. Adrienne supervises undergraduate and graduate students at Wilfrid Laurier University and is Part-time Faculty (adjunct) at Concordia University.

Cathy Thompson is a Canadian business leader and author, spending the past 30 years creating companies from the ground up including sole proprietorships, partnerships, corporations, franchises and licensing. She is the co-founder and co-owner of Beyond the Studio and the Sing it Girls! program and co-host of The Canadian Music Therapy Podcast.

beyondthestudiomusic@gmail.com

Book Review

Developing Issues in World Music Therapy Education and Training: A Plurality of Views

Karen D. Goodman (Editor)

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A timely resource, *Developing Issues in World Music Therapy Education and Training: A Plurality of Views* is the second international volume edited by Karen D. Goodman dedicated to music therapy education and training. This newest book promises a multitude of perspectives on "current and/or necessary changes in training that come about as a result of history, society, economy, generational shifts and the workplace" (p. xi). In these 347 pages, nineteen contributing authors representing eight countries share ideas that inspire, highlight challenges and differences in training programs, offer helpful resources, and ask thought-provoking questions of the ever-evolving profession of music therapy. While the plurality of perspectives that emerges in this book makes it particularly relevant for educators, the volume would also appeal to experienced music therapists with interests in these topics. Students might find most of the content to be beyond their current experiences, but this does not discount its value. I remember being similarly overwhelmed by Dileo's *Music Therapy International Perspectives* (1993) as an undergraduate student 30 years ago—but it also provoked useful questions and provided helpful information.

Developing Issues in World Music Therapy Education and Training is effectively structured into a stand-alone chapter, followed by five parts:

- Chapter 1
- Part 1, "Some New Frameworks and Content for Music Therapy Education and Training" (Chapters 2–5)

- Part 2, "Online Formats for Music Therapy Education and Training" (Chapters 6–7)
- Part 3, "Inclusivity in Music Therapy Education and Training" (Chapters 8–9)
- Part 4, "Professional Opportunities in Music Therapy Education, Training and Development" (Chapters 10–13)
- Part 5, "Ongoing Issues and Possibilities in Music Therapy Education and Training" (Chapters 14–15)

Chapter 1 provides a substantial, ambitious, and complex conceptualization of transversality as both a way of rethinking our current understandings of music therapy and as a means of integrating transversality into music therapy education. This chapter is an intense and challenging entryway into what follows in Part 1. Chapters 2 and 3 of Part 1 resemble each other in their descriptions of the development of music therapy in their respective countries, acknowledging the pioneers of the profession, the evolution of training programs, and other cultural, social, and political influences. Chapter 2 explores the theme of change, reviewing the last two decades of music therapy training in Israel and describing these changes through a "growing tree" metaphor. Similarly, Chapter 3 provides an overview of Germany's music therapy history and education programs and, as its title suggests, it focuses primarily on the Institute for Music Therapy at the Hamburg University of Music and Drama, where psychodynamic music therapy is taught through free improvisation. Chapter 4 begins with a clear professional case example that introduces the subject of interprofessional practices in the workplace, providing a refreshing reminder of the necessity of teaching practical skills to students. This chapter includes good visual aids including graphs, tables, and a Venn diagram, as well as a helpful checklist at the end, which could be especially beneficial for educators. Chapter 5 advocates for music therapists to have knowledge and understanding of "music and the brain" concepts and research, recommending that educators include current brain research in their curricula.

Unsurprisingly, Part 2 was dedicated to the use and integration of virtual technology and delivery in music therapy education. Prior to COVID-19, some academic programs had already begun to offer virtual options, realizing the competitive advantage of remote undergraduate- and graduate-level training possibilities. Chapter 6 highlights some familiar challenges with engaging virtual learners, focusing on the significance of offering meaningful learning experiences to students through strong online learning communities. Chapter 7, on the other hand, shares international survey results of eight music therapy educators' perceptions of their respective online/hybrid graduate programs and poses possible implications for the profession moving forward.

Part 3 includes two compelling chapters—both a must-read—pertaining to inclusivity in music therapy education. Chapter 8 describes sources of both implicit and systemic ethnic and racial bias, making suggestions to overcome the effects of bias on students, clinicians, and clients. The time is now to reimagine music therapy education, and Chapter 9 presents the concept of queering the curriculum. This approach to teaching and learning challenges assumptions and societal norms through lenses of queer, feminist, sociological, and anti-oppressive orientations. Additionally, there are calls for deep and reflective action towards decolonization through the deconstruction of heteronormativity, towards the goal of preparing students to work competently in the real world.

Part 4 groups together a broad range of topics that are presented as professional opportunities. Chapter 10 is a highlight of Part 4, as an informative chapter that both makes a case for and describes a framework of professional supervision developed in Australia. In fact, given the strengths of this chapter, a section dedicated entirely to supervision might have been a worthwhile consideration. The content of Chapter 10 is contrasted by that of Chapter 11, an introductory overview of a few popular advanced music therapy trainings that could provide prospective students with a helpful comparative reference. This content flows smoothly into Chapter 12, which presents another interesting historical review, this time of Nordoff Robbins music therapy from its formative years to its developments, evolutions, and

at times uncomfortable growth to meet societal and economic demands. This chapter might have been included with the historical perspectives of Chapters 2 and 3, but its detail about masters of music therapy training and supervision also locates it within the career scope of Part 4. Chapter 13 moves from explaining the many meanings of aloha to exploring the concept of "growing aloha" through the linkages that developed between the members of a community ukulele group—both older adults and music therapy students.

Part 5 concludes the book with two final chapters that discuss ongoing professional issues and struggles inherent to our work. Chapter 14 explores reasons why music therapists "cross-train" to backfill gaps in training, counteract disrespect, and gain increased recognition as professionals. Interspersed with protestations about job dissatisfaction, burnout, and poor remuneration, this chapter gives somewhat of a bleak view of the profession. Similarly, Chapter 15 describes music therapy in the United States, gaps in training, and challenges in its competency-based training and credentialing process. A substantial effort was made to provide a history of medical/health-care certification boards and practice entry requirements of other professions with comparisons to therapeutic recreation, child life, occupational therapy, and speech therapy. While interesting, this space in the book might well have been filled by some material that was more relevant to our current concerns in the profession. Through a comparison of international practices of credentialing, this chapter makes one last nod to the global community.

An Afterword might have been a more satisfying way to conclude this book, leaving the reader with an inspired sense of positivity for the future of our profession. Although Goodman justifies the organization of the book in the Preface, she might have positioned Chapter 1 at the end instead. A second edition to this book could rectify the surprising number of editorial or typographical issues littered throughout the chapters, from small typos, to an entire duplicated section in Chapter 13, a misprinted table in Chapter 15, incorrect spelling of a cited author, and mistakes in listed references. The voices of music therapist contributors representing South America and Asia were most noticeably absent from the

chapters and, as a Canadian reviewer, I was surprised that there were no full-time tenured professors from at least one of the six Canadian university music therapy programs weighing in on the education and training discussions.

With 40 years of teaching experience, Karen D. Goodman has made it her mission to cultivate the music therapy education and training literature, inviting international representation and voices into this book. Overall, *Developing Issues in World Music Therapy Education and Training* reflects a cross-section of international perspectives and an interesting collection of chapters designed to share successes, learn and reflect on challenges, and remind us of our own desires to move this profession forward with conviction and grace.

References

Dileo Maranto, C. (Ed.). (1993). *Music therapy international perspectives*. Jeffrey Books.

Reviewed by Melissa Jessop, RP, MMT, MTA

Melissa Jessop completed both undergraduate and graduate music therapy degrees from Wilfrid Laurier University (1994, 2003) and is an experienced practicum and internship supervisor. She operates a music therapy business in the Waterloo Region, continues to practice music therapy in long-term care settings, and is a Registered Psychotherapist.

Critique de livre

Developing Issues in World Music Therapy Education and Training: A Plurality of Views

[la pluralité des points de vue sur l'évolution des enjeux en matière d'enseignement et de formation en musicothérapie dans le monde]

Karen D. Goodman (éditrice)

Charles C Thomas Publisher Ltd., 2023

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Une ressource qui vient à point, *Developing Issues in World Music Therapy Education and Training: A Plurality of Views* est le second volume international édité par Karen D. Goodman sur l'éducation et la formation en musicothérapie. Ce nouveau livre présente une multitude de points de vue sur « les changements récents et nécessaires dans la formation, pour des raisons historiques, sociétales, économiques, générationnelles ou relevant de l'évolution du milieu du travail » (p. xi). Au fils des 347 pages de l'ouvrage, dix-neuf auteurs collaborateurs provenant de huit pays présentent des idées inspirantes, mettent en lumière les distinctions entre les programmes de formation et les enjeux liés à chacun, proposent des ressources utiles et posent des questions qui donnent à réfléchir sur la perpétuelle évolution de la profession de musicothérapeute. Alors que les multiples des points de vue émergeant de l'ouvrage rendent sa lecture particulièrement pertinente pour les éducateurs, ce livre intéressera également les musicothérapeutes d'expérience qui s'intéressent aux sujets touchés. Les étudiants peuvent aussi y trouver leur compte, même si la majorité des questions traitées dépasse le cadre de leur expérience. Je me rappelle qu'au cours de mes études de premier cycle, il y a 30 ans, je me suis sentie dépassée à la lecture de *Music Therapy International Perspectives* (1993) de Dileo, mais l'ouvrage m'a poussée à me poser des questions et m'a appris des choses utiles.

Bien conçu, *Developing Issues in World Music Therapy Education and Training* s'ouvre sur un chapitre distinct, suivi de cinq parties :

- Chapitre 1
- Partie 1 : *Some New Frameworks and Content for Music Therapy Education and Training* [nouveaux cadres et contenus pour l'enseignement et la formation en musicothérapie] (chapitres 2 à 5)
- Partie 2 : *Online Formats for Music Therapy Education and Training* [modèles en ligne pour l'enseignement et la formation en musicothérapie] (chapitres 6 et 7)
- Partie 3 : *Inclusivity in Music Therapy Education and Training* [l'inclusivité dans l'enseignement et la formation en musicothérapie] (chapitres 8 et 9)
- Partie 4 : *Professional Opportunities in Music Therapy Education, Training and Development* [perspectives professionnelles touchant l'enseignement, la formation et l'évolution de la musicothérapie] (chapitres 10 à 13)
- Partie 5 : *Ongoing Issues and Possibilities in Music Therapy Education and Training* [enjeux actuels et possibilités en matière d'enseignement et de formation en musicothérapie] (chapitres 14 et 15)

Le chapitre 1 propose une conceptualisation substantielle, ambitieuse et complexe de la transversalité, à la fois comme un moyen de repenser notre conception de la musicothérapie et pour intégrer la transversalité à l'enseignement de la musicothérapie. Ce chapitre est une introduction intense et exigeante à ce qui suit dans la partie 1. Les chapitres 2 et 3 de la première partie présentent des descriptions similaires des progrès de la musicothérapie dans les pays respectifs de leurs auteurs. Ils rendent hommage aux pionniers de la profession et dépeignent l'évolution des programmes de formation, de même que des facteurs culturels, sociaux et politiques qui ont pesé dans la balance. Le chapitre 2 explore le thème du changement, en faisant un retour sur vingt ans de formation en musicothérapie en Israël, dont l'évolution est décrite métaphoriquement comme un arbre en croissance. De même, le chapitre 3 présente un aperçu de l'histoire de la musicothérapie

et des programmes d'éducation en Allemagne. Comme le suggère son titre, il se concentre principalement sur l'Institut de musicothérapie de l'Université de musique et de théâtre de Hambourg, où l'on recourt à l'improvisation libre pour enseigner la musicothérapie psychodynamique. Le chapitre 4 s'ouvre sur un exemple de cas qui introduit clairement le thème des pratiques interprofessionnelles en milieu de travail et nous rappelle la nécessité d'enseigner des compétences pratiques aux étudiants. La présentation visuelle efficace de ce chapitre comprend des graphiques, des tableaux et un diagramme de Venn, de même qu'une liste de vérification qui sera particulièrement utile aux éducateurs. Le chapitre 5 incite les musicothérapeutes à approfondir leur connaissance et leur compréhension des concepts et de la recherche sur les effets de la musique sur le cerveau, recommandant aux éducateurs d'intégrer un tour d'horizon de l'état de la recherche à leur programme d'enseignement.

Comme on pouvait s'y attendre, la partie 2 porte sur l'utilisation et l'intégration des technologies virtuelles à l'enseignement de la musicothérapie. Avant la COVID-19, conscients des avantages concurrentiels de l'enseignement en ligne, certains établissements d'enseignement avaient commencé à offrir des options virtuelles pour les programmes d'études de premier et de deuxième cycles. Le chapitre 6 fait le point sur quelques enjeux récurrents relatifs à l'engagement des apprenants en mode virtuel. Il souligne l'importance d'offrir aux étudiants des expériences pédagogiques marquantes en formant de solides communautés d'apprentissage. Dans un autre ordre d'idées, le chapitre 7 présente les résultats d'un sondage international mené auprès de huit enseignants en musicothérapie pour évaluer leur perception de leurs programmes d'études supérieures en ligne ou hybrides, et soulève ensuite les incidences possibles de cet enseignement sur l'avenir de la profession.

La partie 3 comprend deux fascinants chapitres sur l'inclusion dans les programmes d'enseignement de la musicothérapie. Le chapitre 8 décrit les sources implicites et systémiques de la discrimination ethnique et raciale et présente des suggestions pour surmonter les effets de la discrimination sur les étudiants, les cliniciens et les clients. Le temps étant venu de réimaginer l'enseignement de la musicothérapie, le chapitre 9 présente le concept de la « queerisation des

programmes d'enseignement ». Fondée sur les perspectives queer, féministe, sociologique et anti-oppressive, cette approche de l'enseignement et de l'apprentissage remet en question les idées reçues et les normes sociales. Par ailleurs, des voix s'élèvent pour réclamer que l'on mette en place un processus de décolonisation en profondeur par la déconstruction de l'hétéronormativité afin de préparer les étudiants à travailler de façon compétente dans le monde réel.

La partie 4 couvre un vaste éventail de sujets, qui sont présentés comme des avenues de perfectionnement professionnel. Le chapitre 10, très informatif, est l'un des points forts de lla partie. Il decrit un cadre de supervision professionnelle élaboré en Australie et en établit le bien-fondé. En fait, compte tenu des idées fortes abordées dans ce chapitre, il aurait peut-être été utile de consacrer une section entière à la supervision. En contraste avec le chapitre 10, le chapitre 11 propose plutôt un aperçu de quelques programmes de formation avancée prisés en musicothérapie pouvant offrir aux étudiants potentiels de précieux points de repère. Sur la même lancée, le chapitre 12 présente une autre rétrospective historique, celle-là portant sur la méthode Nordoff Robbins, et examine ses débuts, son évolution et les malaises occasionnellement soulevés par les attentes économiques et sociétales. Ce chapitre aurait pu être intégré aux perspectives historiques des chapitres 2 et 3, mais les renseignements détaillés sur les études de maîtrise en musicothérapie et la supervision le placent aussi dans le champ des perspectives professionnelles du chapitre 4. Le chapitre 13 s'amorce par l'explication des multiples significations du terme *aloha*, et poursuit par une exploration du concept de « aloha évolutif » (*growing aloha*) en examinant les liens tissés entre les membres d'un groupe communautaire de ukulélé constitué d'aînés et d'étudiants en musicothérapie.

Concluant l'ouvrage, les deux chapitres de la partie 5 traitent des enjeux posés à la profession et des luttes qui s'y rattachent. Le chapitre 14 examine les raisons pour lesquelles les musicothérapeutes recherchent des compléments de formation pour combler les lacunes dans leurs apprentissages, gérer le manque de respect et se sentir davantage reconnus en tant que professionnels. Parsemé de doléances sur l'insatisfaction au travail, l'épuisement professionnel et la faible rémunération, ce chapitre brosse un portrait plutôt sombre de

la profession. De même, le chapitre 15 décrit la situation de la musicothérapie aux États-Unis, les lacunes en matière de formation et les défis posés par le processus de formation et d'accréditation axé sur les compétences. On remarque un effort important pour présenter un historique des comités d'agrément et des exigences d'entrée en exercice d'autres professions, notamment les loisirs thérapeutiques, la psychoéducation, l'ergothérapie et l'orthophonie. Le chapitre n'est pas sans intérêt, mais il aurait peut-être été plus pertinent de consacrer ces pages à des questions plus proches des préoccupations actuelles au sein de la profession. Cette comparaison des pratiques internationales en matière d'agrément est un dernier clin d'œil à la communauté mondiale de la musicothérapie.

Une postface offrant des perspectives plus optimistes quant à l'avenir de la profession aurait constitué une conclusion plus satisfaisante pour les lecteurs. Bien que Karen D. Goodman justifie l'organisation de l'ouvrage dans sa préface, elle aurait peut-être dû placer le contenu du chapitre 1 à la fin du livre. Dans la seconde édition, il y aurait lieu de rectifier le nombre surprenant d'erreurs de rédaction et de typographie qui jonchent l'ouvrage : les coquilles, la section qui apparaît deux fois dans le chapitre 13, le tableau mal imprimé au chapitre 15, le nom mal orthographié d'un auteur cité et les erreurs dans la liste des références. L'absence de contributeurs de l'Amérique du Sud et de l'Asie est flagrante. Par ailleurs, du point de vue canadien, j'ai été surprise que l'on n'ait pas songé à inclure les opinions sur l'enseignement et la formation d'au moins un des professeurs titulaires des six programmes universitaires canadiens de musicothérapie.

Forte de 40 années d'expérience en enseignement, Karen D. Goodman 'est donné pour mission de faire avancer la recherche sur l'enseignement et la formation en musicothérapie, notamment en intégrant les voix de représentants de la communauté internationale dans ce livre. Dans son ensemble, *Developing Issues in World Music Therapy Education and Training* reflète la diversité des perspectives internationales et offre une intéressante collection de chapitres conçus pour faire valoir les réussites, réfléchir aux enjeux et nous rappeler notre volonté de faire avancer la profession avec grâce et conviction.

Références

Dileo Maranto, C. (Ed.). (1993). *Music therapy international perspectives*. Jeffrey Books.

Un compte rendu de Melissa Jessop, RP, M. MT, MTA

Melissa Jessop détient un baccalauréat (1994) et une maîtrise (2003) en musicothérapie de l'Université Wilfrid-Laurier et possède une vaste expérience dans la supervision d'internats et de stages. Psychothérapeute autorisée, elle exploite une entreprise de musicothérapie dans la région de Waterloo tout en continuant d'exercer la musicothérapie dans des centres de soins de longue durée.

Book Review

Sociocultural Identities in Music Therapy

Susan Hadley (Editor)

Barcelona Publishers, 2021

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Sociocultural Identities in Music Therapy, edited by Susan Hadley, continues Barcelona Publishers' series that explores social themes such as racism and colonialism in music therapy. The series began in 2006 with another collection edited by Hadley, *Feminist Perspectives in Music Therapy*. As Hadley explains in her introduction, *Sociocultural Identities in Music Therapy* elaborates one of her final assignments for the Master of Music Therapy Students at Slippery Rock University in Pennsylvania. The invited authors in this new book courageously share explorations of their sociocultural identities through personal histories and experiences in music therapy education and practice.

Sociocultural Identities in Music Therapy is a lengthy and powerful publication that includes 18 chapters by individual authors, as well as an introduction and afterword by Hadley. In the introduction (pp. 3–25), "Conceptual Origins and Theoretical Framing," Hadley invites readers to participate in their own critically reflexive process, to journey alongside the authors on their pathways towards personal awareness and social justice. Hadley writes eloquently about the complexities involved in group membership, timing, multiple relationships, connecting through music, patriarchy, culture, norms, and pedagogy. She concludes the introduction with a section called "What Lies Ahead?," in which she invites readers to critically engage with the book's stories by noting their responses to each chapter, whether positive or negative. This provides readers the opportunity to consider their personal values and beliefs as they relate to the book's content.

While the focus of individual chapters is clearly conveyed through their titles, each chapter must be read to truly understand the significance of each story. The amalgam of these stories invites readers to experience the field of music therapy through the lives of writers who have been and continue to be systemically oppressed. These experiences offer readers an entry point to consider inclusive pathways forwards for music therapy by generating increasingly equitable, accessible, inclusive, and diverse representation across the field.

In her conclusion, "Afterword: Reflections and Strategies" (pp. 399–413), Hadley invites readers to further our critically reflexive journeys, as informed by the book's content. She provides opportunities and processes for continued learning through exercises that she calls "Strategies for Cultivating Sociocultural Reflexivity," including: (a) I Am, (b) Softening Exercise, (c) Values Inventory, (d) Recognizing Microaggressions, (e) Cultural and Critical Genograms, (f) Artistic Cultural Reflexivity, and (g) Preparing for Difficult Dialogues.

In the final reflections of her "Afterword," Hadley offers three quotes that the collections' authors shared with her after they had read the book. These reflections, which describe how reading *Sociocultural Identities in Music Therapy* furthered authors' critical reflexivity, resonated profoundly with me in terms of my experience reading and working through the contents—an experience I imagine most readers will echo.

Even though the authors come from distinct backgrounds and experiences, the book has an American context: 16 of the authors study and/or work in the United States, one author is an American living in Germany, and the final author lives in Japan. This American focus could have limited the value of these stories for people living outside of the United States; instead, the critically reflexive narratives reveal common human truths. For example, the theme of recommending ongoing critical self-reflection towards increased ethicality and social justice in music therapy runs throughout the book. Further, the authors offer a strong critique of their Eurocentric music therapy education for its reliance on privilege, alongside its denial of systemic oppression. The authors question who gets to define "better" and how that is manifested in music therapy, from questions of pedagogy and curriculum, research

methods, and models of practice, to normalization rather than maximization goals. Overall, the contributors to this volume deserve our respect for having the courage to publish their stories and experiences for the purpose of moving towards a more socially just future in the field of music therapy and beyond.

Despite their primary ties to the United States, the authors' diverse contexts give the book breadth and depth. As I read each chapter, I found myself immersed in each author's personal history and music therapy story, and their experiences have enriched the context in which I practise music therapy. These readings and processes will prove useful to all music therapy students, educators, researchers, and practitioners, offering contemporary and much needed self-reflexive social justice learning across our field. At 442 pages, the book is well-designed and easily accessible, particularly due to a helpful index. I highly recommend this book.

References

Hadley, S. (Ed.). (2006). *Feminist perspectives in music therapy.* Barcelona Publishers.

Reviewed by Sue Baines, PhD, MTA, FAMI

Sue Baines is a music therapy scholar/practitioner, author, and speaker, and a professional musician. She practices in long-term care, is an instructor in the Bachelor of Music Therapy program at Capilano University, and researches Anti-Oppressive Music Therapy theory, practice, pedagogy, education, and curriculum. Sue is a graduate of the University of Calgary (BMus, 1984), Wilfrid Laurier University (BMT, 1989), New York University (MA, 1992) and the University of Limerick (PhD, 2014). She serves on the review boards of the *Canadian Journal of Music Therapy and The Arts in Psychotherapy* and is a member of the Canadian Association of Music Therapists' Equity, Diversity, and Inclusion Committee.

Critique de livre

Sociocultural Identities in Music Therapy

[identités socioculturelles en musicothérapie]

Susan Hadley (éditrice)

Barcelona Publishers, 2021

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Édité par Susan Hadley, *Sociocultural Identities in Music Therapy* s'inscrit dans la série publiée par Barcelona Publishers qui explore des enjeux sociaux comme le racisme et le colonialisme en musicothérapie. La série a commencé en 2006 avec un autre ouvrage collectif édité par Susan Hadley, *Feminist Perspectives in Music Therapy* [perspectives féministes en musicothérapie]. Comme l'explique Susan Hadley dans son introduction, *Sociocultural Identities in Music Therapy* fait suite à l'un des travaux finaux qu'elle assigne à ses étudiants de maîtrise en musicothérapie à l'Université Slippery Rock de Pennsylvanie. Les autrices et auteurs invités à collaborer à ce nouveau livre explorent courageusement leur identité socioculturelle par le biais d'anecdotes et d'expériences liées à l'étude et à la pratique de la musicothérapie.

Sociocultural Identities in Music Therapy est une publication aussi volumineuse qu'édifiante comprenant 18 chapitres, écrits par différents auteurs, de même qu'une introduction et une postface de Susan Hadley. Dans son introduction (p. 3 à 25) intitulée *Conceptual Origins and Theoretical Framing* [origines conceptuelles et cadre théorique], Susan Hadley invite les lecteurs à entreprendre leur propre processus de réflexion critique et à suivre le parcours des auteurs vers la conscience de soi et la justice sociale. Elle décrit avec éloquence les questions complexes qui entourent l'appartenance à un groupe, le choix du moment opportun, les relations multiples, les échanges musicaux, le patriarcat, la culture, les normes et la pédagogie. Elle conclut son introduction par une section intitulée *What Lies Ahead?* [que

nous réserve l'avenir?], dans laquelle elle invite les lecteurs à poser un regard critique sur les récits contenus dans l'ouvrage en notant leur réaction, positive ou négative, à chacun des chapitres, les poussant ainsi à examiner leurs valeurs et leurs convictions personnelles à la lumière de leur lecture.

Si le sujet principal de chaque chapitre est clairement précisé dans son titre, il faut lire le chapitre en entier pour bien comprendre la signification du récit qu'il présente. L'amalgame des récits invite les lecteurs à appréhender la musicothérapie selon le point de vue d'auteurs et d'autrices qui ont vécu — et continuent de vivre — l'oppression systémique. Ces expériences fournissent aux lecteurs un point de départ pour envisager des démarches plus inclusives de la musicothérapie en favorisant l'équitabilité, l'accessibilité, l'inclusivité et la diversité dans l'ensemble du domaine.

Dans sa conclusion, *Afterword: Reflections and Strategies* [postface : réflexions et stratégies, p. 399 à 413], Hadley nous invite à pousser plus loin notre réflexion critique à la lumière de l'ouvrage. Elle propose des moyens et des processus de formation continue sous forme d'exercices qu'elle appelle « stratégies de développement de la réflexivité socioculturelle », notamment : (a) Je suis; (b) Exercice de décontraction; (c) Inventaire des valeurs; (d) Reconnaître les microagressions; (e) Génogrammes culturels et critiques; (f) Réflexivité artistique et culturelle; et (g) Se préparer à des dialogues difficiles.

Dans les observations finales de sa postface, Hadley cite les réflexions que lui ont faites trois des auteurs du collectif après avoir lu le livre. Ces réflexions, qui décrivent à quel point la lecture de *Sociocultural Identities in Music Therapy* a fait progresser leur réflexivité critique, ont profondément influencé ma réaction au contenu de l'ouvrage, une expérience que partageront sans doute la plupart des lecteurs.

Même si le parcours et l'expérience des auteurs sont propres à chacun, le livre s'inscrit dans un contexte états-unien : 16 des auteurs étudient ou travaillent aux États-Unis, un des contributeurs est un États-Unien qui vit en Allemagne et un autre réside au Japon. Ce point de vue aurait pu limiter la pertinence de ces récits pour ceux qui vivent hors de ce pays. Or

ces témoignages sur la réflexivité critique révèlent des vérités humaines universelles. Ainsi, le thème de l'autoréflexion critique axée sur le développement de l'éthique et de la justice sociale en musicothérapie est présent tout au long de l'ouvrage. Par ailleurs, les auteurs critiquent vivement le caractère eurocentrique de leur formation en musicothérapie reposant sur le privilège et occultant l'oppression systémique. Les auteurs remettent en question qui peut définir ce qui est « mieux » et comment cette définition se manifeste en musicothérapie, qu'il soit question de pédagogie et de programme, de méthodes de recherche et de modèles de pratique, ou encore de viser de normalisation plutôt que d'optimisation. Dans l'ensemble, les contributeurs de cet ouvrage méritent notre respect pour avoir eu le courage d'exprimer publiquement leurs récits et expériences personnelles dans le but de progresser vers la justice sociale dans le domaine de la musicothérapie et au-delà.

En dépit de la prévalence de la perspective états-unienne, la diversité des contextes dans lesquels évoluent les auteurs donne de l'ampleur et de la profondeur à l'ouvrage. À chaque nouveau chapitre, je me suis trouvée baignée dans le récit personnel de l'auteur et dans son parcours en musicothérapie, et chaque expérience a enrichi ma propre pratique. Ces lectures et les processus que l'on en tire seront utiles à tous les étudiants, éducateurs, chercheurs et praticiens du milieu, car elles proposent une prise de conscience contemporaine et opportune sur les enjeux de justice sociale au sein de notre profession. Ce livre de 442 pages est bien conçu et facile d'accès, particulièrement en raison d'un index très utile; je le recommande chaudement.

Références

Hadley, S. (Ed.). (2006). *Feminist perspectives in music therapy*. Barcelona Publishers.

Critique par Sue Baines, Ph. D., MTA, FAMI

Sue Baines est chercheuse, praticienne, autrice et conférencière en musicothérapie et musicienne professionnelle. Elle exerce dans le secteur des soins de longue durée, enseigne au programme de baccalauréat en musicothérapie de l'Université Capilano, et son travail de recherche porte sur la théorie, la pratique, la pédagogie, l'éducation et les programmes d'enseignement en musicothérapie anti-oppressive. Sue est diplômée des universités de Calgary (B. Mus., 1984), Wilfrid Laurier (B. MT, 1989), de New York (M. A., 1992) et de Limerick (Ph. D., 2014). Elle siège au comité de lecture de la *Revue canadienne de musicothérapie* et de la revue *The Arts in Psychotherapy*, et est membre du comité d'équité, de diversité et d'inclusion de l'Association canadienne des musicothérapeutes.

Book Review

Trauma-Informed Music Therapy: Theory and Practice

Laura E. Beer and Jacqueline C. Birnbaum (Editors)

Routledge, 2022

ISBN 9781032061269

At the time of writing this review, the last book about music therapy and trauma was published in 2013. Moreover, considering recent global tragedies, such as the deadly flooding in Pakistan, the war in Ukraine, and the COVID-19 pandemic, *Trauma-Informed Music Therapy: Theory and Practice*, edited by Laura Beer and Jacqueline Birnbaum, is a much-needed addition to the present catalogue of literature on music therapy and trauma. Previous books on the topic have mostly presented case studies, with some exposition of their underlying theories (Birnbaum, 2013; Bruscia, 2012; Stewart, 2010; Sutton, 2002). This book stands out for its aim of providing multiple theoretical perspectives on how trauma-informed practice (TIP) can be incorporated into music therapy clinical practice. This volume features authors who come from diverse cultural backgrounds, have varied experiences with trauma, and use different clinical approaches. The diversity of voices and clinical insights position this book as an invaluable resource to both experienced and early-career music therapists interested in applying TIP principles to their clinical work.

The book contains 16 chapters that are divided across three main parts. Chapters are loosely structured, allowing authors to present their ideas in a manner suited to their topic. While this might make the book less cohesive as a whole, it means that each chapter stands on its own and readers need not read the entire book sequentially to understand its content. If one is strapped for time, readers could navigate to their topic of interest using the contents page or the chapter-specific DOI. In general, most chapters contain three sections: a theoretical framework or background information, case examples or clinical vignettes, and recommendations for clinical practice.

Jennifer Sokira, Joy Allen, and Heather Wagner start off the first part, "Theories and Perspectives," by delineating a broad conceptual understanding of trauma and introducing the resilience framework as a guide for TIP in music therapy. Barbara Else and Mireya González present psychological first aid as another perspective within the context of natural disasters and global crises. Jasmine Edwards offers a cultural perspective, highlighting cultural humility as an imperative within trauma-informed music therapy. Elly Scrine and Asami Koike critique the prevailing trauma paradigm and challenge us to reconsider safety as a relational practice that requires continuous negotiation and co-construction. Overall, this part offers valuable insights into what is and how to practise trauma-informed music therapy from different theoretical perspectives. I found the chapters by Edwards as well as Scrine and Koike to be especially relevant, given broader contemporary discourse surrounding social justice (Leonard, 2020) and anti-oppressive music therapy (Baines, 2021). My biggest takeaway from this part is that cultural humility and "structuring safety" (p. 42) are vitally important to trauma-informed music therapy practice.

The second part of the book takes a deeper dive into several trauma contexts experienced by "Children and Adolescents." Olivia Yinger introduces readers to Adverse Childhood Experiences (ACEs) and offers practical strategies when working with children who have experienced trauma. She suggests Perry's sequence of engagement (regulate, relate, reason) and child-directed musical play using PRIDE skills (praise, reflect, imitate, describe, enthusiasm). Stephanie Holly presents a practical application of cultural humility by describing how therapeutic songwriting can be especially valuable for adolescents dealing with race-based traumatic stress. Cindybet Pérez-Martínez expands on Else and González's chapter and shares music therapy interventions that can be used with children who have experienced trauma due to a natural disaster. Tracie Sandheinrich and Jaime Kennington closes this part by exploring how therapeutic songwriting can be used with children within the context of traumatic and life-threatening illnesses, such as cancer. This part offers practical suggestions for TIP in music therapy with children and adolescents. I particularly appreciated Yinger's

analysis from a developmental systems perspective because it reminds us not to quickly assume that all children are weak and vulnerable, but to recognize each individual's unique capacities and strengths.

The third part of the book covers trauma contexts experienced by "Adults." Rachel Ebeling and Sarah Michaelis write about The Angel Band Project that works with survivors of sexual violence/intimate partner violence. Nadine Cadesky describes music therapy groupwork in short-term inpatient psychiatric care and recovery. Gillian Langdon also describes groupwork but within the context of complex trauma. Andrew Rosetti shares how he uses the Trauma, Resilience, Safety model in radiation oncology settings. Jenny Fu discusses how vocal psychotherapy can help individuals work through developmental trauma. Joanne Loewy explores the unique traumatic events experienced by musicians and examines trauma-informed music psychotherapeutic approaches. From an analytical music therapy perspective, Brian Harris shares his work regarding trauma experienced by the LGBTQAI+ community. Finally, Moshe Bensimon concludes this part by presenting five mechanisms of change in trauma-informed music therapy: relaxation, playfulness, super-expressive emotions, agency, and interpersonal synchronization. This part weaves together myriad theoretical frameworks with wonderful case examples that make the theory accessible and applicable. Personally, I found Loewy's chapter to be a gentle reminder for me to engage in "play" to maintain my own musical health and creativity.

Overall, I believe that Beer and Birnbaum met their objective of combining theoretical perspectives on TIP with real-life applications in music therapy practice. The diverse theoretical frameworks coupled with the wide range of topics make this book extremely valuable to experienced and early-career music therapists alike. As Julie Sutton writes, "we are all susceptible to trauma" (p. xviii), and this book serves as an excellent resource to anyone interested in applying TIP principles in their clinical practice. However, one limitation is that most of its content is situated within the U.S. context, which can exclude international readers. The book is available in paperback, hardback, and e-book formats. Despite having

a penchant for reading physical books, I found the e-book format surprisingly pleasant. The e-book is highly accessible: one can read the e-book via the VitalSource Bookshelf application on any device; highlight, annotate, bookmark, and make flashcards; and customize reading preferences through functions such as text size, font, and "read aloud." The e-book format may be suitable for individuals with sensory, visual, and/or other needs. I look forward to an updated edition that explores intersectionality and more nuanced approaches to trauma-informed music therapy work to meet the challenges of the increasingly complex world that we live in.

References

Baines, S. (2021). Anti-oppressive music therapy: Updates and future considerations. *The Arts in Psychotherapy*, *75* Article 101828. https://doi.org/10.1016/j.aip.2021.101828

Birnbaum, J. C. (2013). *Healing childhood trauma through music and play (with DVD excerpts): The Nordoff-Robbins music therapy monograph series* (Vol. 6). Barcelona Publishers.

Bruscia, K. E. (Ed.). (2012). *Case examples of music therapy for event trauma.* Barcelona Publishers.

Leonard, H. (2020). A problematic conflation of justice and equality: The case for equity in music therapy. *Music Therapy Perspectives*, *38*(2), 102–111. https://doi.org/10.1093/mtp/miaa012

Stewart, K. (Ed.). (2010). *Music therapy & trauma: Bridging theory and clinical practice.* Satchnote Press.

Sutton, J. P. (Ed.). (2002). *Music, music therapy and trauma: International perspectives* (Illustrated ed.). Jessica Kingsley.

Reviewed by Jonathan Tang, PhD

Jonathan Tang is a PhD researcher at the University of Sheffield in the UK. He has worked internationally in Singapore, the United States, and the UK, and has clinical experience in medical, mental health, and special education settings. His research interests include music therapy and rehabilitation, as well as the intersections between culture, music, and health. Correspondence concerning this article should be addressed to Jonathan Tang, Department of Music, Jessop Building, 34 Leavygreave Road, Sheffield, S3 7RD. Email: jwltang1@sheffield.ac.uk.

Website: https://orcid.org/0000-0002-8352-4066.

Critique de livre

Trauma-Informed Music Therapy: Theory and Practice

[la musicothérapie tenant compte des traumatismes : théorie et pratique]

Laura E. Beer et Jacqueline C. Birnbaum (éditrices)

Routledge, 2022

ISBN 9781032061269

Avant la parution de cet ouvrage, le livre le plus récent sur la musicothérapie et les traumatismes avait été publié en 2013. De plus, dans la foulée des récentes tragédies mondiales comme les inondations meurtrières au Pakistan, la guerre en Ukraine et la pandémie mondiale de COVID-19, *Trauma-Informed Music Therapy: Theory and Practice*, édité par Laura Beer et Jacqueline Birnbaum, est un ajout indispensable au corpus de la littérature sur la musicothérapie et les traumatismes. Les précédents ouvrages sur le sujet sont principalement des études de cas comprenant de brèves explications des théories sous-jacentes (Birnbaum, 2013; Bruscia, 2012; Stewart, 2010; Sutton, 2002). Cet ouvrage se distingue parce qu'il vise à présenter de multiples perspectives théoriques sur les façons d'incorporer les pratiques tenant compte des traumatismes (PTCT) à la musicothérapie clinique. Il regroupe des auteurs et autrices provenant de contextes culturels diversifiés ayant un vécu qui leur est propre en matière de traumatismes et utilisant différentes approches cliniques. En raison de la diversité des voix et des expériences cliniques présentées, ce livre est une ressource précieuse pour les musicothérapeutes d'expérience tout autant que pour les novices qui souhaitent appliquer les principes de la PTCT dans leur travail clinique.

L'ouvrage comporte 16 chapitres répartis en trois grandes parties. Les chapitres sont structurés de façon souple, ce qui permet aux auteurs de présenter leurs idées de la façon qui convient le mieux au sujet traité. Si cela réduit la cohésion de l'ouvrage dans son ensemble, chaque chapitre se suffit à lui-même et le lecteur n'a pas besoin de lire tous les chapitres dans

l'ordre pour comprendre le contenu. Le lecteur pressé peut se rendre au sujet qui l'intéresse à l'aide de la table des matières ou de l'identificateur d'objet numérique (DOI) particulier à chaque chapitre. La plupart des chapitres comportent trois sections : un cadre théorique ou un contexte, des exemples de cas ou des vignettes cliniques et des recommandations visant la pratique clinique.

Jennifer Sokira, Joy Allen et Heather Wagner amorcent la première partie (Theories and Perspectives) en définissant le concept général du traumatisme et en introduisant la théorie de la résilience comme guide à la PTCT en musicothérapie. Barbara Else et Mireya González présentent ensuite leur perspective des premiers soins en psychologie dans le contexte des catastrophes naturelles et des crises mondiales. Jasmine Edwards propose une perspective axée sur la nécessité de l'humilité culturelle dans l'exercice de la musicothérapie tenant compte des traumatismes. Elly Scrine et Asami Koike examinent le paradigme actuel du traumatisme et invitent le lecteur à remettre en question la sécurité comme pratique relationnelle nécessitant une négociation soutenue dans le cadre d'un processus de co-construction. Dans son ensemble, cette partie offre de précieuses réflexions sur plusieurs approches théoriques du concept de la musicothérapie tenant compte des traumatismes et de sa mise en œuvre. J'ai trouvé les chapitres écrits par Edwards et Scrine particulièrement pertinents dans le contexte du discours contemporain sur la justice sociale (Leonard, 2020) et de la musicothérapie anti-oppressive (Baines, 2021). Ce que je retiens surtout de cette première partie, c'est que l'humilité culturelle et la « sécurité structurante » (p. 42) sont d'une importance vitale dans l'exercice de la musicothérapie tenant compte des traumatismes.

La seconde partie du livre analyse plus en profondeur plusieurs contextes dans lesquels évoluent les enfants et les adolescents traumatisés. Olivia Yinger présente le concept des expériences négatives durant l'enfance (ENE) et propose des stratégies pratiques pour le travail auprès des enfants ayant vécu un traumatisme. Elle suggère le recours à la séquence d'engagement de Perry (réguler, établir la relation, raisonner) et le concept PRIDE (en anglais : praise, reflect, imitate, describe, enthusiasm; en français : féliciter, réfléchir,

imiter, décrire, enthousiasmer) de l'interprétation musicale dirigée par l'enfant. Stephanie Holly présente une application pratique de l'humilité culturelle en décrivant les bienfaits de l'écriture de chansons dans une perspective thérapeutique auprès d'adolescents ayant vécu des traumatismes raciaux. Cindybet Pérez-Martínez ajoute au propos du chapitre d'Else et González en décrivant les interventions de musicothérapie indiquées pour les enfants traumatisés par une catastrophe naturelle. Tracie Sandheinrich et Jaime Kennington concluent cette partie en explorant les applications de l'écriture de chansons à des fins thérapeutiques dans le contexte des traumatismes et des maladies potentiellement mortelles, comme le cancer. Cette partie offre des suggestions pratiques pour intégrer les PTCT à la musicothérapie auprès d'enfants et d'adolescents. J'ai particulièrement aimé l'analyse de Yinger selon la perspective des systèmes de développement; elle nous rappelle qu'il ne faut pas simplement supposer que tous les enfants sont faibles et vulnérables, mais plutôt tenir compte des aptitudes et des forces uniques à chacun.

La troisième partie du livre porte sur les traumatismes vécus par les adultes. Rachel Ebeling et Sarah Michaelis traitent de The Angel Band Project, qui s'adresse aux personnes survivantes de violences sexuelles ou conjugales. Nadine Cadesky décrit la musicothérapie de groupe auprès de patients hospitalisés pour des soins psychiatriques de courte durée. Gillian Langdon aborde aussi le travail en groupe, mais dans le contexte des traumatismes complexes. Andrew Rosetti explique comment il emploie le modèle traumatisme-résilience-sécurité en radio-oncologie. Jenny Fu explique en quoi la psychothérapie vocale peut aider certaines personnes à surmonter des traumatismes de croissance. Joanne Loewy examine les événements traumatiques particuliers que vivent les musiciens et les démarches musicales en psychothérapie tenant compte des traumatismes. Dans la perspective de la musicothérapie analytique, Brian Harris décrit son travail auprès des membres de la communauté LGBTQAI+ qui ont subi des traumatismes. Enfin, Moshe Bensimon conclut cette partie en présentant cinq mécanismes de changement en musicothérapie tenant compte des traumatismes : détente, esprit ludique, émotions super-expressives, agentivité et synchronisation interpersonnelle.

Cette partie illustre une myriade de cadres théoriques à l'aide de merveilleux exemples qui facilitent la compréhension de la théorie et son application. Personnellement, le chapitre de Loewy m'a rappelé qu'il faut que je continue à « jouer » pour maintenir ma santé musicale et ma créativité.

Dans l'ensemble, je crois que Beer et Birnbaum ont atteint leur objectif, qui était de combiner des perspectives théoriques sur les PTCT et des applications concrètes dans l'exercice de la musicothérapie. Ce livre abordant divers cadres théoriques et un vaste éventail de sujets est un outil très précieux aussi bien pour les musicothérapeutes chevronnés que pour ceux qui sont en début de carrière. Comme l'écrit Julie Sutton, « nous sommes tous sensibles aux traumatismes » (p. xviii), et cet ouvrage est une excellente ressource pour toute personne souhaitant intégrer les PTCT à sa pratique clinique. Ma seule réserve est que la plus grande partie du contenu s'inscrit dans un contexte états-unien, ce qui pourrait être moins pertinent pour les lecteurs d'autres pays. Le livre est offert en formats de poche, relié et numérique. Même si je préfère généralement les livres physiques, j'ai trouvé la lecture du format numérique étonnamment agréable. Le livre numérique est très accessible : on peut le lire à l'aide de l'application VitalSource Bookshelf sur n'importe quel appareil; surligner, annoter, marquer des pages, créer des fiches et personnaliser ses préférences de lecture à l'aide des fonctions de réglage de la taille du texte, de la police et de « lecture à haute voix ». Le format numérique peut convenir aux personnes qui ont des besoins particuliers, entre autres du point de vue sensoriel ou visuel. J'attends impatiemment la parution d'une édition augmentée qui pourrait traiter de l'intersectionnalité et offrir des démarches plus nuancées de la musicothérapie tenant compte des traumatismes pour répondre aux défis que pose notre monde de plus en plus complexe.

Références

Baines, S. (2021). Anti-oppressive music therapy: Updates and future considerations. *The Arts in Psychotherapy, 75* Article 101 828 https://doi.org/10.1016/j.aip.2021.101828

Birnbaum, J. C. (2013). *Healing childhood trauma through music and play (with DVD excerpts): The Nordoff-Robbins music therapy monograph series* (Vol. 6). Barcelona Publishers. https://barcelonapublishers.com/e-books/healing-childhood-trauma-music-play-nordoff-robbins-monograph-series-volume-6

Bruscia, K. E. (Ed.). (2012). *Case examples of music therapy for event trauma.* Barcelona Publishers. https://barcelonapublishers.com/case-examples-music-therapy-event-trauma

Leonard, H. (2020). A problematic conflation of justice and equality: The case for equity in music therapy. *Music Therapy Perspectives, 38*(2), 102–111. https://doi.org/10.1093/mtp/miaa012

Stewart, K. (Ed.). (2010). *Music therapy & trauma: Bridging theory and clinical practice.* Satchnote Press.

Sutton, J. P. (Ed.). (2002). *Music, music therapy and trauma: International perspectives* (Illustrated ed.). Jessica Kingsley.

Critique par Jonathan Tang, PhD

Jonathan Tang (PhD) est chercheur à l'université de Sheffield, en Grande-Bretagne. Il a travaillé à l'international à Singapour, aux États-Unis et au Royaume-Uni. Il possède une expérience clinique en médecine, en santé mentale et en éducation spécialisée. Ses domaines de recherche comprennent la musicothérapie et la réadaptation, de même que les intersections entre la culture, la musique et la santé. Toute correspondance concernant cet article doit être adressée à Jonathan Tang, Department of Music, Jessop Building, 34 Leavygreave Road, Sheffield, S3 7RD. Courriel : jwltang1@sheffield.ac.uk. Site Web : https://orcid.org/0000-0002-8352-4066.

Notes

Canadian Association
of Music Therapists
Association canadienne
des musicothérapeutes

Canadian Association of Music Therapists /
Association canadienne des musicothérapeutes
info@musictherapy.ca | 1-800-996-2268
PO Box 103 | Hensall, ON N0M1X0