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MEDICAL MUSIC: ANTHROPOLOGICAL PERSPECTIVES ON MUSIC THERAPY

by

STEPHEN McMASTERS

Under the Direction of Steven P. Black, PhD

ABSTRACT

Music-based healing is utilized as a healing tool in many cultural contexts around the world. This thesis examines the cultural practice of music therapy in the context of the larger discipline of medicine in the United States through an ethnographic study of music therapists in the Greater Atlanta area. It contextualizes this data with research in medical ethnomusicology that explores cross-cultural traditions of music in healing rituals. It also connects music therapy to the observation that forces of globalization are strongly correlated with an increase in rates of inequality, poverty, stress, and disease. This thesis discusses how Atlanta-area music therapists use music healing with patients suffering from physical and mental disease and how economic stratification impacts access to music therapy. It is concerned with deeper and not immediately evident processes taking place in music therapy, such as the role of music as a medium and facilitator in healing.

INDEX WORDS: Medical anthropology, Medical ethnomusicology, Medical pluralism,

Embodiment, Medical discourse, Mental illness

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STEPHEN McMASTERS

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2015

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2015

MEDICAL MUSIC: ANTHROPOLOGICAL PERSPECTIVES ON MUSIC THERAPY

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December 2015

DEDICATION

I dedicate this thesis to my mother, the strongest and most generous person I know, and my sister, whose fortitude and courage inspires me every day. Thank you both for supporting me in my aspirations and endeavors.

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I would like to thank the members of my committee: Dr. Black, for keeping me calm and focused in guiding me through this process; Dr. Guano, for providing me with feedback to help me become a better writer; and Dr. Patico, for helping me keep things in perspective. I would also like to thank the music therapists who enthusiastically gave their time and energy to share their lives and experiences with me, and especially Jamie, for meeting with me multiple times and allowing me to spend a day at The George Center for Music Therapy.

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1 INTRODUCTION

I begin my day at the George Center for Music Therapy in Roswell, Georgia, a small city located north of Atlanta within the Metro Atlanta area. The population of Roswell is approximately 90,000, but the clinic treats people from all over the Greater Atlanta area, which has a population of about 5.5 million. The center is located in Sweet Apple Village across the street from Sweet Apple Elementary School in a middle to upper class area of Roswell, grass manicured and buildings new. Driving through the office complex, I see restaurants, shops, and other offices before finally locating The George Center. I walk in and am greeted by Jordan, a young woman who recently graduated from the University of Georgia with a degree in Music Therapy. The center is noticeably empty. It later dawns on me that many of the clients at The George Center are children and adolescents, and since it is August, they are back in school for the new school year. Jordan informs me I will be accompanying her to a group music therapy session at the Academy at North Fulton for children with disabilities. While the session was informative, the data will not be discussed here since patients are outside of the scope of this study, which focuses on music therapists only.¹

Upon returning to the center, I am greeted by Jamie, the owner and director of The George Center for Music Therapy. Jamie is in her mid 30s. She wears glasses and has a bubbly personality, what I might imagine a music therapist to be. We are finishing up an interview we began a month prior in July. The clinic is very much a state of the art facility. Specific rooms are designed with noise absorbing panels and specialized lights to minimize their effect on patients with epilepsy. There are approximately five rooms designed for individual sessions, and each room is equipped with a piano, drums, and a guitar that hangs on the wall. There is one large

¹ Patients and children are vulnerable populations and were not included in this study to avoid the ethical complications involved in overcoming perceived coercion to participate. Parent or guardian permission was also required for children under 18, and I was only communicating with music therapists.

room for group sessions, a conference room, a break room, and a reception area filled with games, toys, and magazines to occupy waiting patients and children. Walking around the clinic, it is hard to believe that Music Therapy has been an organized professional discipline in the US since only the late 20th century. After the interview, I was able to observe Lana, a music therapist with a couple of years of experience under her belt, work with an autistic patient, followed by Madison, another young therapist, giving a session to a teenager with severe depression and anxiety. The session with Madison piqued my interest as I assumed most patients suffered from depression and anxiety, but this was not to be the case.

1.1 Purpose

The purpose of this thesis is to examine music therapy as cultural practice. It will draw from theorization of medical pluralism and embodiment to analyze how music therapy exists at the fringes of established biomedicine. It will rely on previously published research as well as data from my own ethnographic fieldwork with music therapists. When I began this study, one primary objective was to examine the use of music therapy with mental illnesses, specifically stress and depression, utilizing research and interviews with music therapists. The National Institute of Mental Health states that 9.5% of the US population suffers from depression (NIMH 2010). Armed with this data, I was under the incorrect assumption that music therapy mostly treated stress and depression. However, upon interviewing music therapists for the study, I quickly learned that music therapy is used to treat a wide range of both mental and physical diseases, from Autism to Alzheimer's to Cerebral Palsy. While this study still examines stress and depression, the focus has shifted to American mainstream understandings of illness, the role of music in healing, how clinical discourse impacts access to alternative treatment methods, and efforts of music therapists to incorporate mind-body healing into a biomedical culture.

The healing powers of music and other forms of ritual performance are utilized in many cultural contexts around the globe (Koen 2008). This thesis will examine the cultural practices of Music Therapy as a professional discipline in the United States, contextualizing it with research in medical ethnomusicology that explores cross-cultural traditions of music in healing rituals (Roseman 2008). In addition, this thesis connects music therapy to the observation that forces of globalization such as neoliberalism are strongly correlated with an increase in rates of inequality, poverty, stress, and disease (Farmer 1997; 1999). Neoliberal agendas have shifted responsibility for mental health care from the state to the individual through deinstitutionalization, making access challenging for some populations (Desjarlais 1997). This thesis draws from Foucault's (1973) discourse on the clinic, which explores the development of the clinic in Western societies and has implications for biomedicine and music therapy. Analyzing medical discourse helps to explain the marginal role of music therapy in current mental health practice as well as work done by practitioners to legitimize this alternate form of mind-body healing and integrate it with biomedicine, which focuses on treating the visible body. Despite obstacles presented by biomedical discourse and neoliberal deinstitutionalization, music therapy is expanding in the US for those seeking alternatives to traditional psychotherapeutic treatments.

The fieldwork for this thesis took place between June and October of 2015 in the Metro Atlanta area. Semi-structured interviews and analysis of interview data were the two primary anthropological methods used throughout the duration of the project. These methods were used with music therapists only and not patients. A total of ten music therapists were interviewed, some in person, and some online via email. One full day was spent at The George Center for Music Therapy as described in the opening ethnographic vignette. This study seeks to answer the following questions: What brought Atlanta music therapists into the profession? What mental

and physical disorders do music therapists treat, and what methods and techniques do they employ? What is the role of music in healing? Who has access to music therapy, and how do historical and cultural factors impact this access? How does discourse surrounding scientific medicine impact access to music therapy? The following section gives a brief description of the chapters in this thesis.

1.2 Chapter Summaries

Chapter 2 examines theoretical principles in medical anthropology and medical ethnomusicology. Medical pluralism provides a foundational theory for this study in acknowledging alternate frameworks of illness and healing seen in cultural systems across the globe (Johannessen & Lázár 2006). Medical ethnomusicology embraces this theory in analyzing the power of sound and music in cross-cultural healing rituals (Koen 2008; Roseman 2008). This chapter discusses the development of the clinic as a cultural framework and the history of Music Therapy as a professional discipline within and at the margins of this framework (Foucault 1973; Peters 2000). Western discourses on biomedicine have implications for access to music therapy in the US. Embodiment, or culturally elaborated ways of experiencing the world with the body (Desjarlais 1992; Howard 2000), rejects the mind-body dichotomy in healing rituals (Csordas 1993; Fassin 2007), and this theory aids in explaining music therapy as a valid cultural system of healing, but on the fringe of biomedicine (Foucault 1973). This chapter then explores the use of narrative and music central in healing for many cultures around the world (Barz 2008; Black 2013; Hinton 2008; Olsen 2008). Finally, it examines structural violence, which involves large-scale forces such as racism, poverty, and inequality (Farmer 1997, 1999; Hunter 2007; Briggs et al 2003). These are strongly correlated with the disease and illness music therapy often treats.

Chapter 3 discusses background information and research methods. It outlines the research objective and questions to understand various ways music therapists in Atlanta treat mental and physical diseases embodied in individuals, often through structural violence and inequality. Research methods and ethnographic methodology are discussed, including interviews and participant observation. The background information places myself in the study. It provides an understanding of my interests in music, illness, and healing, and why my research is focused in the areas of ethnomusicology, medical anthropology, and psychological anthropology. My early connection to music, musicianship, and experience with family illness lays the foundation for my interests in this study.

Field research took place in the Metro Atlanta area, and chapter 4 elaborates on this. It describes the details of the study, including music therapy clinics where interviews took place, the interview process, and background information of the music therapists interviewed. Having musical backgrounds, most of the therapists knew early on they wanted a career in music, and many were exposed to music therapy through a personal illness experience. These personal experiences made strong practitioners and believers of music healing. However, the research participants feel they must constantly legitimate music therapy to skeptics. Music therapy focuses on mind-body healing in a culture fixated on the biomedical model, and music therapists struggle to reconcile these perspectives. Finally, this chapter reviews methods and techniques.

Chapter 5 begins with a broad overview of illnesses and interventions. It analyzes theoretical principles of use and the role of music in therapy and healing as perceived by Atlanta music therapists. Roles of music include treating the mind and body as one, creating community, connecting to memories, and acting as a medium and facilitator. Then the chapter explores music therapy interventions for stress, depression, and anxiety with patients, the family, and in the

context of mourning and birth (Hanser 1999; Sekeles 1999). Finally, it describes the use of music therapy in treating Alzheimer's disease and various physical disabilities due to traumatic injury and terminal illness (Brummel-Smith 2008; Clair 2008).

Chapter 6 explores the recent growth of music therapy in Metro Atlanta, including the socioeconomic and demographic makeup of a sample of patients in the area. It discusses the politicizing of medical knowledge and its institutionalization, followed by its subsequent deinstitutionalization, i.e. the way neoliberal and capitalist policies and agendas shifted responsibility of psychological care from the state to the individual (Foucault 1973; Desjarlais 1997). This has created problems in funding and access to music therapy. Then various avenues and obstacles to accessing music therapy are described, including insurance, waivers, grants, and nonprofits. The research participants must incorporate mind-body connectedness and spiritual healing in music therapy within a biomedical model focused on treating the body in order to qualify for insurance and receive accreditation for state licensure, and this has altered the practice in terms of documenting outcomes and changing clinical terminology. Finally, this chapter explores praxis solutions for creating more access to music therapy for low-income populations, which includes following the University of Kentucky model and state regulation.

Chapter 7 summarizes the thesis, presents theoretical conclusions, and evaluates the significance of the study. Music Therapy is marginalized in terms of biomedicine, occupational gender, and socioeconomic status. It emphasizes music therapy as a viable healing method in a culture in which access has been limited due to its marginalization through Western discourses on biomedicine and the deinstitutionalization of mental healthcare through neoliberal policies.

2 MEDICAL ANTHROPOLOGY, MUSIC, AND THE CLINIC

This thesis synthesizes ideas from a number of topics and theories in medical anthropology, cultural anthropology, and medical ethnomusicology. It unifies work with scholarship on medical pluralism and embodiment in recognizing and understanding the use of narrative and music in health and healing. This chapter first examines medical pluralism as an overarching theory that recognizes alternate frameworks of illness and healing seen in cultural systems across the world (Johannessen & Lázár 2006). Medical ethnomusicology, which studies the cross-cultural use of sound and music in healing rituals, embraces the theory of medical pluralism in understanding this phenomenon (Koen 2008; Roseman 2008). Next, the development of the clinic and the history of Music Therapy in the US are discussed (Foucault 1973; Peters 2000). Medical discourse, central in the creation of the modern biomedical model, has implications for music therapy in the US in terms of which populations have access to treatment and how that treatment occurs.

This chapter analyzes the theory of embodiment, an idea that goes beyond the mind-body dichotomy in healing rituals (Csordas 1993; Fassin 2007). Embodiment is defined as culturally elaborated ways of experiencing the world with the body (Desjarlais 1992; Howard 2000), and this theory aids in explaining music therapy as a cultural system of healing that is on the fringe of biomedicine (Foucault 1973). While music, and the narrative within music, is central in healing for many cultures around the world (Barz 2008; Black 2013; Hinton 2008; Olsen 2008), it has only recently gained in popularity in mainstream US contexts. Finally, this chapter ties music therapy, used to treat mental illnesses embodied in individuals, to inequality. Global forces of neoliberalism and resultant inequality shape the ways disease becomes embodied by individuals all over the world. Structural violence involves large-scale forces, such as racism, poverty, and

inequality. These forces are strongly correlated with disease and illness (Farmer 1997, 1999; Hunter 2007; Briggs et al 2003). This thesis is ultimately interested in the healing method of music therapy to treat mental and physical disease, and the ways neoliberal policies and medical discourse impact this treatment option.

2.1 Medical Pluralism & Medical Ethnomusicology

The Western biomedical model focuses on biomedicine and treating the body, the visible, and the defined (Foucault 1973). Medical pluralism, on the other hand, recognizes the validity of multiple medical frameworks for treating both the mind and body, noting that no single framework is fully consistent, coherent, or complete (Johannessen & Lázár 2006). The theory of medical pluralism provides a strong foundation for medical anthropology and medical ethnomusicology in observing and recognizing multiple cultural systems of illness and health by taking into account the importance of context. It not only explains the various ways cultural practices visualize and perceive disease and healing around the world, but also it aids in understanding music therapy as a valid alternative healing method in the US.

In studying witchcraft amongst the Azande, Evans-Pritchard (1976) provides an early example of anthropological research on thought and motivation for action. Azande use witchcraft in diagnosing injuries, illness, and healing. It is a medical framework for explaining misfortune. For example, if a boy stubs his toe, it is because he was blinded by witchcraft (Evans-Pritchard 1976:20). If a granary collapses with people underneath, witchcraft is responsible for the timing. Azande people are aware termites caused the structure to rot, but the “second spear” of witchcraft is responsible for the timing of the event (Evans-Pritchard 1976:23-25). If a man becomes ill, he seeks the poison oracle and outcomes are based on taboos and witchcraft (Evans-Pritchard 1976:28). This belief system is perfectly logical under Azande rules.

Medical ethnomusicology embraces medical pluralism in evaluating cultural music meaning and understanding cross-cultural music healing (Koen 2008; Roseman 2008). Medical ethnomusicology seeks to understand the power and role of music and sound in health and healing across all cultures, and this requires an understanding and application of medical pluralism. Examining music, health, and healing through multiple disciplines offers new insights into improved life quality, illness and disease prevention, and even curing (Koen 2008:3). In the 1900s, anthropologists and musicologists embraced medical pluralism when they became increasingly interested in the music and healing of diverse cultural practices resulting in the field of medical ethnomusicology (Koen 2008:6). Practices include not only therapy, but also the actual healing and curing of disease. It usually involves spiritual and religious rituals or ceremonies, meditation, and preventative methods (Koen 2008:6). Rather than the strict biomedical model, medical ethnomusicology incorporates “the neural, psychological, emotional, and cognitive processes, sociocultural dynamics, spirituality, belief, and the metaphysical as central concerns and modes of action that play critical roles in achieving and maintaining health” (Koen 2008:7). Just as in medical anthropology, the cultural context must not be neglected when analyzing the role of music in healing across cultures (Koen 2008:12).

In order to understand music healing in various cultural practices, one must understand cultural music meaning and embrace multiple belief systems. A fourfold framework for cross-cultural engagement in research on music and therapy was developed to understand music healing embedded in various cultures and apply that knowledge to other contexts (Roseman 2008:24). The fourfold approach includes the musical, sociocultural, performative, and biomedical, thereby emphasizing multiple frameworks and medical pluralism. The musical axis is concerned with sound structures (pitch, tone, tempo), the sociocultural axis involves culturally

relevant musical metaphors, the performative axis examines how music healers convey sound, and the biomedical axis focuses on the psychophysiological transformation (Roseman 2008:29). This approach has been used to study music therapy in the US. Music is analogous to emotions and creates an affective environment of joy or pain through duration, pitch, tempo, rhythm, and melody (Roseman 2008:29). Medical pluralism recognizes music therapy as a valid healing method by taking into account cultural context.

2.2 Discourse & The Clinic

While music is commonly used in healing rituals across the globe, it is not common in biomedicine. Many cultures focus on mind-body connectedness in healing rituals, whereas in Western cultural practices, medicine places a heavy emphasis on the biomedical model. Foucault (1973) analyzes the development of the clinic in Western societies, providing insight as to why this might be the case. During the 18th century, the narrative surrounding disease discourse changed from a language of fantasy to a language of visibility, or from using words like “damp parchment” to “red membrane” in describing disease (Foucault 1973:xi). The relationship between the visible and invisible changed, revealing through observation and language what had previously been beyond perception. A different type of alliance between words and the objects they describe was developed, “enabling one to *see* and to *say*” (Foucault 1973:xii). In clinical experience, the body was exposed to the “language of rationality” (Foucault 1973:xv). In the 18th century, the clinic yielded a system of reorganizations. “What is the matter with you?” was replaced with “Where does it hurt?” emphasizing the importance of the physical location of disease. The clinic owes its importance not only to the reorganization of medical discourse, but also to the possibility of discourse about disease at all (Foucault 1973:xix).

Disease became spatialized and localized within the body, though configuration cannot necessarily be demonstrated geometrically (Foucault 1973:3). Instead it is described using relations of envelopments, subordinations, divisions, and resemblances (Foucault 1973:5). The endless exchange between doctor and patient takes place until the disease reveals its true nature (Foucault 1973:9). Here, tertiary spatialization refers to the ways in which disease is circumscribed, isolated, divided into regions, or distributed in cure facilities by society in the most favorable manner in order to protect itself and establish assistance. It is on the basis of tertiary spatialization that “the whole of medical experience was overturned and defined for its most concrete perceptions, new dimensions, and a new foundation” (Foucault 1973:16). The medicine of space disappeared, and it was given legal protection, new status, and medicine became institutionalized (Foucault 1973:20). These perspectives have profound implications for Western discourses surrounding medicine, and by extension, for alternative healing methods such as music therapy. Music therapy is used to treat both mental and physical illnesses. The relatively new field struggles to justify treating the mind and body as one in societies that place such heavy emphases on the biomedical and treating only the visible while giving little weight to the invisible, i.e. the realm of the psyche.

2.3 Music Therapy

This section explores how the origins of the clinic are related to the history of Music Therapy in the US. According to Foucault (1973), medicine found the possibility of origin in the clinic. Historically speaking, medicine was simply the relationship between illness and alleviating it. It was not based on theoretical knowledge as in the hospital. Acts to alleviate pain were not even necessarily conscious; they were performed “immediately and blindly” (Foucault 1973:55). The knowledge was not recorded and concealed for future use. The decline of the

clinic began when knowledge was no longer available for immediate use. It was made secret, politicized, and concentrated in privileged groups (Foucault 1973:55). Music Therapy is typically administered in the clinic, a place where individuals go to seek treatment to simply feel better. Western clinical discourse impacts our understanding of music therapy in the US.

Peters (2000) is a music therapist who provides an emic perspective on music therapy. Music therapy has many definitions, but most recognize it as the role of music and sound in attaining goals in mental and physical health (Peters 2000:2). Peters (2000) provides a descriptive and in depth definition of music therapy:

Music therapy may be defined as a planned, goal-directed process of interaction and intervention, based on assessment and evaluation of individual clients' specific needs, strengths, and weaknesses, in which music or music-based experiences (e.g., singing, playing musical instruments, moving or listening to music, creating or discussing songs and music) are specifically prescribed to be used by specially trained personnel (i.e., music therapists or those they train and supervise) to influence positive changes in an individual's condition, skills, thoughts, feelings, or behaviors (Peters 2000:2).

Music therapy is often an individual process between therapists and patient that takes place over a long period of time; there is no simple or instant cure. It involves careful planning and methodical steps that include musical, artistic, therapeutic, interpersonal, and behavioral elements. A trusting and caring atmosphere between therapist, client, and music is vital and necessary as the primary interaction is within the music experience beyond verbal expression. Music experience can be active or passive, and includes playing instruments, singing, listening to music, feeling music vibrations, and responding emotionally to music (Peters 2000:3-5).

Medical and psychiatric journals began publishing articles on the use of music in treating physical and mental disorders in the early 19th century (Peters 2000:26). Psychiatric intervention began in the 19th century, when mentally ill patients could be removed from their environment and placed in "morale custody" where they underwent therapeutic programs that involved the arts, museums, and music listening (Wigram et al 1999:7). It was believed that listening to music

could ease and pacify an afflicted and disturbed mind. Harmonious music was thought to bring the disarray of the mind into harmony (Wigram et al 1999:7).

In the early 20th century, studies demonstrated the psychological effects of and physiological responses to music, especially its influence on mood and mental health (Peters 2000:29). The invention of the phonograph allowed for the use of music in hospitals during medical operations, to induce sleep, to calm fears, and as an aid to anesthesia. During the inter-war period, music therapy as a psychiatric intervention continued to grow, and music therapy programs were implemented in mental hospitals and prisons (Peters 2000:29). Early institutions and foundations were developed to train students in music therapy, and after WWII, music as medicine skyrocketed in psychiatric and veterans' hospitals (Peters 2000:33). Many of the music therapists in this study cited the rise of PTSD or Post Traumatic Stress Disorder after WWII as the official beginning of professional music therapy. By the late 20th century, music therapy had become an organized professional discipline with the founding of The American Music Therapy Association in 1996 (Peters 2000:40). Music therapy is now a recognized profession in approximately 50 countries (Wigram 1995).

2.4 Embodiment: Healing

This chapter has thus far analyzed the role of medical pluralism in medical anthropology and medical ethnomusicology in taking into account cultural contexts and multiple frameworks for illness and healing. It examined the development of Western biomedical discourse and the history of Music Therapy in the US. It now shifts gears to explore the various ways both illness and healing are embodied cultural experiences. Embodiment is useful for understanding music therapy and its marginalization in biomedical discourses. Embodiment is a theory that rejects the mind-body dichotomy of biomedicine. This perspective is significant in understanding how

illness becomes embedded as individual experience through history and culture. Theorization of embodiment describes the historical, sociopolitical, and socioeconomic forces that structure illness and become embodied in individuals (Fassin 2007).

Embodiment describes the social construction of not only disease and illness but also health and healing. Csordas (1993) describes embodiment as ways of experiencing the world through practice and perception. Practice involves ingrained, internalized, and habitual ways of thinking, feeling, and acting with the body. Here, Csordas (1993) uses embodiment to move beyond a traditional mind-body dichotomy. Practice shapes our perception, which is always cultural. Attention to or constitution of an object is termed somatic modes of attention, which are “culturally elaborated ways of attending to and with one’s body to surroundings that include the embodied presence of others” (Csordas 1993:138). Embodiment helps understand how healing practices unfold in various cultural patterns, including Catholic Charismatic healers, Puerto Rican spiritist mediums, and nonreligious healing in Siddha medicine and contemporary psychotherapy.

2.4.1 Shamanism & Trance

Other examples of the culturally shaped embodiment of healing include shamanism and trance. Many cultural practices today embody healing in music through shamanic rituals or shamanism (Howard 2000:354). The word “shamanism” was first applied to religious activities of Siberian people more than 200 years ago (Howard 2000:354). Definitions describe the shaman as healer or seer traveling to the spirit realm through trance and acting out stages of the journey (Howard 2000:355). Shamanism, and specifically healing through shamanism, is a phenomenon seen across the globe. However, the practice, concepts, and descriptions vary greatly amongst

distinct social groups (Howard 2000:355). Though shamanism is not common in the US, we embody music in healing through music therapy, the focus of this thesis.

Examples of shamanism and music healing can be seen in Venezuela, Peru, the Middle East, and Nepal. In South America, shamanism employs music healing when a shaman enters the spirit realm. Many indigenous tribes of South America attribute illness to evil spirits, imbalance with nature, and the supernatural (Olsen 2008:331). The Warao of Venezuela and desert people of northern Peru utilize music in healing rituals. Shamans are spiritual specialists that enter trance states through music to contact or embody the supernatural (Olsen 2008:332). Both groups have three types of shamans that perform healing rituals using specialized rattles and songs. The process requires belief from both healer and patient. Music therapy is an important element in Islamic cultures of the Middle East. Research in Iran and Central Asia demonstrates the influence of trance states, the hypnotic effect, and the power of music to alter consciousness. Significantly, Westerners cannot embody trance unless they understand the cultural context. For example, a Swedish woman was only able to experience trance upon marrying a Muslim, following the proverb, “The one who does not know the *tarab* (musical ecstasy), he does not belong to Arab people” (During 2008:381). Though the practice of shamanism varies cross-culturally, music is an integral part of many distinct healing traditions.

Trance or ecstasy is a key element of shamanism, and music assists in entering trance (Howard 2000). Becker (2000) explains that a particular kind of selfhood is required to enter trance, which may explain why the practice of trance is not as common in the US, and even looked down upon. Western perspectives have historically emphasized selfhood as bounded, innate, and the essence of an individual (Lutz 1988:4). This view of the self may affect the openness to emotional responses to music stimulation that nearly always accompanies trance-

based rituals (Becker 2000:26). To participate in a trance ceremony is to enter into a community narrative and become a certain kind of person that is not one's own (Becker 2000:27). In US mainstream contexts, we do not easily accept trance because of our views of selfhood. In order to experience trance, there must be no distance between the ritual and self, and if integrity feels challenged, trance cannot occur (Becker 2000:30)

Trance has many distinct characteristics. Healer and patient must embody trance to achieve the healing experience. Two distinct physical states of embodiment can be differentiated: one characterized by noise, hyperactivity, loss of control, loss of knowledge, and dissociation, and the other with silence, calm, regained control, intuitive knowledge, and increased awareness, with many states in between (Howard 2000:363). It is seen as an expression of hysteria or mental illness, a reflex to cultural stimuli, hyperventilation, body disorientation, and heightened awareness due to drugs, foods, music, dance, and repeated actions (Howard 2000:363). Music is the most plastic of the arts in that it is most open to and needy of interpretation (Howard 2000:364). Music is a trigger for embodying the trance state: it blocks out surroundings and thoughts, regulates or destabilizes the body, and focuses or stunts the senses (Howard 2000:364). Shamans use drum rhythms, bells, and the voice during healing rituals to aid in embodying a trance or altered state of consciousness to facilitate resolution and healing (Peters 2000:21). Sound serves as a distraction allowing the mind to enter a different state.

An example of the use of drums in trance and healing can be seen in the Yolmo Sherpa of Tibet. People in the region practice Buddhism and shamanism and are influenced by both Tibet and Nepal (Desjarlais 1992:7). Shamans perform oracular divination or *mo* using drums to induce trance states so a deity can enter the body to reveal the patient's illness. During ethnographic fieldwork, Desjarlais (1992) attempts to embody trance by following the beating

drum, shaking body, and crescendo of the music. Music is a stimulus that promotes embodiment of the trance state because of the social coding of meaning (Howard 2000:364). As Desjarlais picked up cultural nuances, he was better able to embody the trance state, even to the point that he was trusted with playing the drum. The drum rhythm produces “auditory driving, matching brainwaves, and leads to sensory bombardment and convulsions” (Howard 2000:365). Though his trance experience was not the same as Yolmo states, Desjarlais’ experience became a hybrid, “betwixt and between” two worlds, a mix of shamanistic practice and embodied knowledge (Desjarlais 1992:19). The imagery of his trance state may have been a therapeutic or transcendent experience resulting from his transformation in the field.

Desjarlais accompanied a shaman on house visits to perform healing rituals, and he interviewed patients after treatment on body, pain, and emotions (Desjarlais 1992:13). Music is very important during this shamanic healing ritual. Pain occurs with “soul loss” when the soul leaves the body to wander the country and talk to ghosts and demons resulting in sorrow, despair, and anxiety (Desjarlais 1992:13). The shaman is summoned to find the soul and bring it back. In Yolmo wa culture, people do not typically show or express emotions. Soul loss is similar to grief, sadness, and anxiety, and shaman-healing rituals “appear to offer an indirect medium through which this private distress is voiced, fashioned, and potentially transformed” (Desjarlais 1992:22). For example, a young bride lost her spirit. She was upset, confused, and cried, and the shaman’s diagnosis lifted blame legitimizing her feelings (Desjarlais 1992:22). Her feelings, described as sadness or malaise, were likely due to cultural tensions in the house between men and women (Desjarlais 1992:23). The author alludes that “soul loss” is loosely translated as “depression.” Just as illness is culturally shaped and embodied, healing is culturally shaped and embodiment is key to healing experiences. This indicates the importance of cultural context in

medical ethnomusicology (Koen 2008), and the utility of the fourfold framework in understanding medical pluralism and music healing in cultural practices (Roseman 2008).

2.4.2 Narrative & Music

Medical pluralism examines alternative frameworks of healing and disease where biomedical models prove inadequate in explaining cultural practices surrounding health and illness. Explanatory frameworks for health and illness are often constituted in narrative and music. Narrative aids in reframing the past to make sense of disease that disrupts normal life and in telling fragile stories stigmatized by culture. Music aids in healing experience through entering trance and altered states of mind and self. Both narrative and music, and the narrative within music, help make sense of illness, facilitate psychological flexibility, and promote healing through the embodiment of ritual transformation.

The use of narrative and music in healing rituals is present in African songs (Barz 2008; Black 2013) and cross-cultural music therapy (Hinton 2008). Narrative within song changes the cultural memory of HIV/AIDS in Uganda. It explains how Ugandans are “living positively” with HIV, shifting the language from the stigmatized label “HIV positive” to manipulate cultural memory (Barz 2008:164). A primary method for shifting cultural memory is through the songs of AIDS support groups. Through the aid of healthcare workers, the language of these songs changed from death and dying to hope and empowerment to change memories and shift attitudes of AIDS sufferers from disease and death to living positively and life (Barz 2008:165). This method actively seeks to align the positive message of traditional healers, medical doctors, and religious institutions. Traumatic injury and serious illness changes ordinary experience into extraordinary experience, and people use narration to make sense of this disruption to normal life (Ochs 2004:271). “Traumatic rememorying” through music refers to a process where traumatic

memories are legitimated and incorporated into narratives to relieve victims of the past (Barz 2008:167). HIV/AIDS has become ingrained in African psyches, and song and narrative are effective tools in changing perspectives of illness.

Narrative and music used in HIV/AIDS disclosure is evidenced in South Africa with a Zulu gospel choir (Black 2013). Choir members disclosed status and spread awareness through performance narrative, which aided in seeking treatment and healing. The choir provided a foundation for a narrative event embedded in a larger context resulting in a coherent narrative (Black 2013:359). Structural violence and the unequal distribution of HIV/AIDS became embodied in choir members, and narrative allows them to embody living positively. Performance and art allows for discourse on subjects otherwise difficult to talk about due to dominant ideals (Black 2013:363). Through the choir and music, they were able to see the context of their disenfranchised position, make sense of their illness, and achieve healing.

One way to understand the role of narrative and music in healing is the concept of flexibility. Hinton (2008) is interested in how rituals, and specifically music healing rituals, instill qualities in individuals deemed valuable by society by presenting flexibility primers that promote psychological flexibility. Flexibility is both physical and psychological. In other words, it is embodied. Muscle and joint flexibility is similar to psychological flexibility in bringing about a relaxation response. Psychological shifts consist of disengaging from an emotion and choosing a new emotion or psychological “set” (Hinton 2008:124). Pathology may be defined as the inability to change psychological sets and adapt a new mindset. Psychological and emotional flexibility is the ability to shift these sets and adapt to the new situation (Hinton 2008:125). Somatic flexibility includes joints, nervous systems, and the brain. Increasing flexibility in these systems increases psychological flexibility by decreasing tension, stress, and anxiety priming

psychological flexibility (Hinton 2008:129). Culture promotes flexibility through simultaneous patterns and sequential patterns. Music has simultaneous patterns that can be attended to at once or separately, and sequential patterns, including shifts in harmony, melody, and rhythm, and these patterns promote psychological shifting and flexibility (Hinton 2008:134). Music healing traditions are embedded in cultural contexts and function as primers for healing.

Societies across the globe improve social health through flexibility primers that facilitate psychological flexibility. Cultural practices teach how to control attention and shift emotional states. Pathologies can be attributed to a lack of flexibility, such as inability to be flexible resulting in stress and anxiety or inability to focus attention resulting in ADD (Hinton 2008:143). Psychological illnesses are due to inflexibility of the mind. Music healing traditions within cultures function as “ritualized cures” by instilling happiness and adjustment techniques, thereby promoting psychological flexibility through music and dance (Hinton 2008:149). In Isan culture in Thailand, the music healing ritual promotes flexibility through multiple means, including pattern shifts in music and kinesthetic dance. Flexibility becomes embodied, a part of a “flexible memory network” that can be recalled in difficult situations requiring a change in perception (Hinton 2008:158). Music healing rituals promote healing through the embodiment of flexibility primers that shift psychological mindset. These music rituals are embedded in cultural contexts and help make sense of illness.

2.5 Neoliberalism & Structural Violence

Music therapy is one among a number of options for people struggling with mental or physical illness. This section discusses neoliberalism and structural violence because illness and inequality are closely correlated. Structural violence involves large-scale forces, such as racism, poverty, and inequality, which are highly correlated with disease and illness (Farmer 1997;

1999). Structural violence is prevalent all over the world, from Haiti to South Africa to Venezuela. In Haiti, for instance, economic patterns are correlated with disease distribution, structural inequality, and structural violence (Farmer 1997). Personal distress, poverty, racism, and suffering become embodied as individual experience (Farmer 1997:262). Structural violence is embedded in the larger matrix of culture, history, and political economy (Farmer 1997:273). As the world becomes increasingly interconnected, globalization shapes historical, political, and economic forces that structure violence and suffering. Structural violence is rampant in Haiti. In global terms, the US government funds the Haitian military that enforces unfettered political violence. In historical terms, Haitians are the descendants of slaves kidnapped from Africa to produce sugar, coffee, and cotton, and these Haitians suffer a disproportionate share of inequality (Farmer 1997:274). In nations across the world, global forces induce inequality, poverty, and higher mortality rates (Farmer 1997:276).

Farmer (1999) examines how these large-scale social forces unequally impact particular populations in spreading and preventing disease. Suffering is often blamed on cultural differences rather than the result of the globalization that facilitates inequality. For example, people in Haiti frequently die of tuberculosis, a treatable disease, due to a structure that impedes access to resources. Three million people die every year from tuberculosis, and infectious diseases are the most common cause of death in the world (Farmer 1999:3). The unequal distribution of these infections is due to social inequalities (Farmer 1999:4). Rather than blame victims of AIDS and the poor, the structure of poverty, social conditions, and access to prevention and treatment needs evaluation (Farmer 1999:9). Standards of care need to be questioned since all need access to quality healthcare.

Another example of the connections between illness and inequality can be found in South Africa. The structural violence of colonialism and apartheid have led to racialization and a dramatic rise in the rate of AIDS in South Africa between 1990 and 2005 from 1% to 29% (Hunter 2007:689). Causes responsible for the large increase in the pandemic include an increase in inequality, poverty, and specifically, the political economy of sex and money exchange (Hunter 2007:690). The adoption of neoliberal policies has led to increased marginalization of women, declining marriages, female circular migration, and a sex economy. Informal settlements known as *imijondolos* have HIV rates twice that of rural and urban settings (Hunter 2007:690). The people that live there are young, unemployed, poor, and have multiple sex partners (Hunter 2007:691). The poor are and remain sicker in both rich and poor countries (Farmer 1999:12). Wealth inequality equals health inequality and a lack of social cohesion.

Venezuela provides a third example of the impact of structural violence on health and access to medicine. Briggs and Martini-Briggs (2003), an anthropologist and a doctor, respectively, discuss how structural violence facilitated an outbreak of cholera in the Delta Amacuro region of Venezuela in the nineties. In the most remote regions of the delta, there are no clinics, schools, or stores, and local people blamed the deaths of villagers on sorcery and attempted traditional medicines such as *hoarotu* and *wisidatu* (Briggs et al 2003:3). The proportion of those who died was disproportionately indigenous people because they lacked access to government services, healthcare, clean water, and water treatment. Health officials and authorities used language to control information and define populations in Venezuela. *Sanitary citizens* were defined as individuals who possess modern medical understandings of the body, health, hygiene, and go to the doctor when sick, and those incapable of adopting this relationship

as *unsanitary subjects* (Briggs et al 2003:10). This created the catalyst for implementing unequal health policy that led to the outbreak.

During the cholera outbreak in Venezuela, the media sought to link cholera to poverty, the poor, and indigenous people. Media images fortified the dominant narrative of “space versus race” and “us versus them,” with authorities in suits juxtaposed to images of diseased bodies (Briggs et al 2003:104). Stories of indigenous people becoming infected due to their own agency were presented to the press before fully investigating the situation (Briggs et al 2003:200). Officials explained how the disease started and spread in racial terms before the pandemic even began, and it was immediately linked to the favorite foods of indigenas (Briggs et al 2003:200). When this no longer held water, the argument shifted to lack of hygiene, migration habits, healing beliefs, biological susceptibility, and geographic location. If anything, industrialization brought cholera through transportation, colonization, and exploitation, i.e. through structural violence (Briggs et al 2003:296).

In conclusion, this chapter examined medical pluralism as an overarching theory of medical anthropology that recognizes alternate frameworks of illness and health. It explored musical ethnomusicology in the context of medical pluralism in understanding the use of narrative and music in healing across cultures. It discussed the development of the clinic, Western discourses on biomedicine, and Music Therapy as a professional discipline in the US. This chapter then analyzed the theory of embodiment in rejecting the mind-body dichotomy in healing rituals. This theory is useful in illustrating reasons why music therapy is on the fringe of biomedicine. Next, the use of narrative and music in various healing rituals and cultural practices was examined, and finally, this chapter linked illness to inequality. Structural violence involves forces such as inequality and poverty strongly correlated with the illnesses and disease music

therapy often treats. The following chapters explore Music Therapy in the US by examining music therapists, the role of music in healing, who has access, and how to make this alternative healing method more available to populations that could use it.

3 RESEARCH METHODS AND BACKGROUND

3.1 Research Objectives & Questions

This chapter lays the foundation for the focus of this study and purpose of this thesis. It begins by outlining the research objective, which is to explore anthropological perspectives of music therapy and examine its use in Atlanta as a treatment option for mental and physical illnesses. This is followed by a discussion of the research, including where the research took place, who was involved, and which anthropological research methods were employed throughout the duration of the project. Next, it provides my own music and illness experiences and background that led me to my interests in ethnomusicology, medical anthropology, and thus, the subject matter of this thesis, music therapy. Finally, it analyzes ethics and potential obstacles encountered in the study.

The primary ethnographic objective is to develop an anthropological perspective on music therapy. This is informed by Foucault's (1973) discourse on the clinic and its development as an institution in Western medicine. Music therapy underscores mind-body connectedness and holistic healing (Koen 2008). Clinical discourse was reorganized around treating the visible (Foucault 1973), placing music therapy on the periphery of Western notions of biomedicine. I explore the circumstances surrounding one's decision to become a music therapist, methods and techniques used by music therapists to treat mental and physical disorders, and the role of music in healing. Methodologically, this study utilizes participant observation and interviews with music therapists. This study seeks to answer the following questions: What brought Atlanta

music therapists into the profession? What mental and physical disorders do music therapists treat, and what methods and techniques do they employ? What is the role of music in healing? Who has access to music therapy, and how do historical and cultural factors impact this access? How does discourse surrounding Western medicine impact access to music therapy? Through interviewing music therapists in Atlanta, this study seeks to understand the local culture of music therapy, and how we as a society conceptualize illness and the role of music healing in the US.

This study examines the way music therapists in Atlanta treat the mental and physical diseases that become embodied in individuals, often due to inequality and poverty. Although some persons are more prone to mental stress than others, mental illness occurs in all types of people regardless of age, class, or ethnicity, and the impact can be frustrating at the least, and debilitating at the worst. Some people turn to healthy outlets, such as exercising, meditation, or immersion in a hobby. Others turn to substance abuse to “self-medicate,” using drugs and alcohol to escape reality and the stress that can complicate and compound life. Still others seek professional help from psychiatrists, psychologists, counselors, and therapists. Psychiatrists may prescribe antidepressants or other medications, while psychologists may examine an individual’s past in an effort to dissect what plagues the mind. Counselors and therapists help develop activities and goals for working through stress and depression, and they may administer various therapies, including psychotherapy, aromatherapy, dance therapy, art therapy, and music therapy. Music therapy is growing as an option for those seeking alternatives to pharmaceutical and psychological treatments, although access is still limited for certain populations.

3.2 Research Methods

Evaluation Research examines the cultural environment of an existing program (Trotter & Schensul 1998:692). In my case, I examined Atlanta atmospheres of music therapy through

therapists' perspectives. The applied setting involved four clinics and offices in Atlanta that administer music therapy, which required identifying a network of people who regularly employ music therapy. I utilized social cognitive theories, which focus on thought processes and cultural beliefs (Trotter & Schensul 1998:697). These theories come from an interaction between cognitive psychology and psychological anthropology. I employed ethnographic research methods, including participant observation, semi-structured interviews, and data analyses. Participant observation and interviews took place in music therapy offices and clinics in the Atlanta area with music therapists only. This project did not include patients or clients. With many private practices in the Greater Atlanta area, it was not difficult to locate experts in musical therapy within the community whom I could interview. I used targeted sampling in looking for individuals who are avid practitioners (Trotter & Schensul, 1998:707).

Interviews with therapists were in person or online through email if unavailable or preferred. Interviews began with an explanation of the consent procedures and the signing of the consent form. At the beginning of interviews, I read the consent form to the participants and sent a digital copy after the interview. For online interviews, I sent the consent form via email, and they scanned the signed copy and emailed it back. I received verbal confirmation of consent on audio recording for in person interviews. Interviews lasted between one and two hours, and ten therapists were interviewed. Participants were informed they could end the interview at any time without consequence. First names and contact information were collected for communication purposes and stored digitally in a password-protected computer. Participants had the option to choose pseudonyms linking them to their information in this record, but none chose to use a pseudonym. Audio recording was used only after gaining explicit permission. Files are also stored on a password-protected computer, and print versions of data are stored in a locked space.

Only the Principle Investigator and myself have access to the data. Upon completion of the study, all data will be physically or digitally destroyed.

3.3 Music Background

Now that the research objectives, questions, and methods have been addressed, my background with music and illness informing the research questions will be discussed. My interest in this study is based on my early connection to music, musicianship, and experience with family illness. Music has always played a large role in my family. My brother has been playing drums since he was five and currently plays in two bands, while my sister and I both began playing piano at young ages. I mostly learned to play by ear and by watching others play. In grade school, I took band and played many instruments, from clarinet to trombone to tuba. My first declared major in college was music. I took guitar classes in addition to piano and music theory classes. I even entertained the idea of applying to Berklee School of Music. Though I ultimately changed my major, I still received an Outside Concentration in Music, and I am an avid guitar player today. I also had many early experiences with the emotional power of music and dance. After watching a movie in the theatre, I would leave thinking about the score of the movie rather than the movie itself. I remember seeing movies and picking out the score on piano, demonstrating an early ear. I began thinking about the powerful role of music in the movies, so much so that I thought I might pursue a career in it one day.

I also connected to dance at an early age, and I was interested in different styles of dance, such as hip-hop, salsa, breaking, and krumping. I see dance as one of the most visual expressions of human emotion, and krumping completely represents and expresses affect through body movement. I have personally experienced positive mental benefits from music. If I am stressed, I can pick up my guitar and after playing for a bit, I “zone out” and feel as though a weight has

been lifted off my chest. Or, if I take time out and listen to music for just thirty minutes, I notice a marked improvement in my mood. Though I never went to Berklee School of Music or became a movie score composer, the emotional power of music continues to intrigue me, and this project focuses that energy on medical ethnomusicology and the role of music in healing.

3.3.1 Music is “My Jam”

In my interviews with music therapists in the Metro Atlanta area, many of the research participants pointed out the impact of music on our mood and emotions. Though it was never an interview question, the topic of personal connection to music came up in most of the interviews. For instance, Sarah at Metro Music Therapy feels music is very personal to people, and she suggests that, “people identify with the music that they choose to listen to.” Jamie, owner of The George Center for Music Therapy, states we all use music therapeutically everyday. When angry, a song may serve as a mantra, when sad it may soothe the soul, or a summer jam may cause one to roll down the car windows and throw on some shades exclaiming, “that’s my jam!” I had often wondered if we as a culture use music more to change our moods or to match our moods. For example, if someone is down, does he or she listen to an upbeat song, maybe Michael Jackson to lift his or her mood? While music therapists may use music to lift mood, most of us, according to the research participants in this study, use music to match our mood.

If we go to a wedding, we hear happy music that matches the environment. When depressed, we listen to depressing music. If I am feeling down, I might listen to someone like Elliott Smith who uses minor chords and depressing lyrics in his music. Beth, owner of Music Therapy Services of Greater Atlanta, picks music based on her mood. She argues she does so “because sometimes music can be annoying, and sometimes music can be energizing, and sometimes music can be calming.” Lana of The George Center concurs, stating music that does

not match her mood often irritates her, but music that matches her mood helps her feel heard and understood. Jennifer, owner of Therabeat, listens to upbeat music when she is working out, and “coffeehouse music” when she is looking to chill. Like me, all of the research participants were in tune with their emotional connection to music and its impact on their mood. But my interest in music therapy extends beyond the music element. I became curious about mental illness and the structures that surround disease because of personal family experiences.

3.4 Illness: Aplastic Anemia & Beyond

In 1997, and again in 2004, my sister was diagnosed with Aplastic Anemia. Aplastic Anemia is an extremely rare disease in which the bone marrow quits producing red blood cells, white blood cells, and platelets. Basically, the blood dies. The disease is so rare that hospitals see about one case a year, and the only treatment is a bone marrow transplant. Even with a donor, chances of survival are still not 100%. Fortunately, I was a match for my sister. Throughout both transplants, she had to undergo chemotherapy, hospital isolation, and months of recovery before returning to her normal life. The first transplant was done with baby stem cells, a process in which doctors drilled into my pelvis through my lower back to extract the marrow. However, the first transplant failed. The second transplant was done through apheresis, a process in which the adult stem cells were filtered from my blood after my bones were stimulated to produce surplus stem cells. Miraculously, the second transplant was successful and her counts remain normal, but she suffers from graft versus host disease. Her body is constantly at war with my bone marrow causing painful side effects. She took cancer-causing immunosuppressant drugs to suppress her immune system so her body would not reject my bone marrow, but she was able to come off those drugs. This type of illness experience has not only done tremendous damage to her body, it has wreaked havoc on her mind.

For years, my sister has felt like she will not live passed 40, and living with a terminal illness for half of her life has resulted in chronic stress, clinical depression, and severe anxiety. As a young adult, her way of dealing with the condition was not to be emotional or vulnerable, and she facilitated this process through substance addiction. Despite the obstacles, my sister moved forward with her life, graduating from law school amidst the second transplant, graduating from cosmetology school, and eventually opening her own business. She dealt with her illness by pushing it aside and pursuing her academic and career goals. However, her past continues to haunt her, and her mental illness has manifested into new diagnoses as she comes to terms with her past illness experiences that she kept bottled up for so long. It has been difficult on both her and our family. Music and dance has played a significant role in my sister's illness. She views dance as her personal therapy, and she was a research participant in my project in 2014. She ties her connection to music and dancing directly to her medical history. "I think it's because [of] everything I've gone through, and finally making that connection for myself, for what it does for me, that I can now recognize it in others."

Often closing her eyes on the dance floor, she once opened them and her close friend was just staring at her and proclaimed that dance was indeed her meditation. When I play guitar, I frequently close my eyes to better hear and connect with the music, so these details made complete sense to me. According to Foucault (1973), medical discourse focuses on treating the visible, and perhaps by closing our eyes, we are able to experience a different type of healing within the invisible mind aided by our aural senses. She summarized what dance does for her:

It's where problems don't exist. When you're not thinking of everything else going on in your life, therefore your anxiety is reduced. Moving and dancing to music makes you happy. You're not feeling depressed. It's all about the whole getting lost in the moment. That's a lot of what Buddhist practice is, staying in the present.

This echoes sentiments expressed by ancient Chinese philosopher Lao Tzu in the 6th century.

“If you are depressed, you are living in the past. If you are anxious, you are living in the future. If you are at peace, you are living in the present.” My sister seems to have found peace in those moments of presence on the dance floor. She also copes with her illness through narrative. As previously noted, narrative helps individuals makes sense of traumatic illness, which disrupts normal life (Ochs 2004). She writes in a journal nearly every day about her life and experiences. I believe that through her writing, she is trying to make sense of her past and her experience with illness.

3.5 Ethics & Obstacles

Potential obstacles and ethical issues exist in any project. The American Anthropological Association blog on ethics lists seven principles of professional responsibility in anthropology. I applied these ethical principles to this study. This first is do not harm, particularly important when working with vulnerable populations. No vulnerable populations are involved in the study. The second is honesty regarding work. Open and honest communication regarding purpose, methods, and goals of research took place with music therapists in a transparent atmosphere. The third is obtaining informed consent. Informed consent was obtained from all research participants involved in the project. The fourth is weighing competing ethical obligations with all parties involved, including music therapists, the primary research participant. The fifth is making results accessible. The information obtained through this study will be available to the public or upon request. The sixth is protecting and preserving records. This principle was followed as described in the research methods. Finally, the seventh principle is maintaining ethical and respectful professional relationships, which this study seeks to achieve.

A potential obstacle lies in one theoretical foundation of this study, which looks at neoliberalism, structural violence, poverty, and inequality. One concern prior to beginning this

project was that those living in poverty and suffering from stress and associated diseases may have limited access to alternative and complementary medicine, such as music therapy, much less access to medications or support systems due to lack of insurance or other resources. While the study does imply individuals of a higher socioeconomic status do have more access to music therapy, lower socioeconomic populations do indeed have avenues for access as well. This study seeks to gain insight into the cultural environment of music therapy by understanding what populations in the area receive it and why.

As long as we participate in social systems we don't get to choose whether to be involved in the consequences they produce. We're involved simply through the fact that we're here. As such, we can only choose *how* to be involved, whether to be just part of the problem or also to be part of the solution. That's where our power lies, and also our responsibility (Johnson 2005:89, *from the AAA website*).

Thinking about my past experiences with music and illness, I believe music has a great capacity for treating disorders of the mind and body. This study explores praxis solutions with the aim of contributing to greater access to music therapy for low-income populations.

This chapter discussed background information and research methods. It outlined the research objective and questions, which is to understand various ways music therapists in Atlanta use music to treat mental and physical diseases. It presented the research methods and ethnographic methodology, including interviews and participant observation, utilized throughout the study. The background information places myself in the study. It did this by discussing my interests in music, illness, and healing, and why my research is focused in the areas of ethnomusicology, medical anthropology, and psychological anthropology. My early connection to music, musicianship, and experience with family illness lay the foundation for my interests in this study. It concluded with the seven ethical principles that guided the study.

4 THE FIELD RESEARCH

4.1 Music Therapy in Atlanta

This study takes place in Greater Atlanta, also known as Metro Atlanta, an area with a population of approximately 5.5 million people. It seeks to understand the cultural elements surrounding the field of Music Therapy, including the correlation between inequality, health, and access to alternative and complementary healing methods such as music therapy. It seeks to understand the role and utilization of music in healing in the US through interviewing ten music therapists in the Metro Atlanta area who work at one of following four music therapy clinics: The George Center for Music Therapy, Therabeat Inc., Music Therapy Services of Greater Atlanta, and Metro Music Therapy. The clinics are all located North of Atlanta's city center. All music therapists interviewed for this study are female. Music Therapy in the US is marginalized in terms of its relation to biomedicine (Foucault 1973) and occupational gender (Hochschild 1983). Perhaps women largely represent music therapists due to the feminization of caretaker roles and the emotional labor it often requires (Hochschild 1983). One male therapist was contacted but eventually became unresponsive. Seven of the interviews were done in person, and three of the interviews took place via email. The George Center for Music Therapy yielded the most data with five therapists interviewed for the study. The George Center music therapists include Jamie, Andrea, Jordan, Lana, and Madison. Two therapists interviewed from Therabeat, Inc. are Jennifer, the owner, and Chelsea. Therapists interviewed from Metro Music Therapy include Kally and Sarah. Finally, Beth was interviewed, music therapist and owner of Music Therapy Services of Greater Atlanta. The discussion below is my analysis of commonalities found across interviews, supplemented by my participant-observation and personal experiences described in chapter 3, and contextualized within the literature discussed in chapter 2.

4.1.1 Music Therapists of Atlanta

As previously stated, a total of ten therapists were interviewed. Jamie is the owner of The George Center for Music Therapy and in her mid-thirties. She was born in Chattanooga and grew up in Detroit, graduating from Western Michigan University with a degree in Music Theatre. She moved to Orlando to perform for Disney, then to New York to perform in theatre, and then got her Masters in Music Therapy in 2004. She worked as an Assistant Director at a private practice before starting The George Center in 2010. Jamie grew up singing and playing piano and violin. Andrea has been the Assistant Director at The George Center since 2012. She was born in North Carolina and moved to Powder Springs near Atlanta when she was four. She graduated from Georgia College and State University in Milledgeville in 2009 with a degree in Music Therapy. Her main instrument is the cello.

Jordan, Lana, and Madison are the other three therapists from The George Center that were interviewed. Jordan was born and raised in McDonough near Atlanta and graduated from the University of Georgia with a degree in Music Therapy. She grew up singing at an early age and has been practicing for two years. Lana was born in Alabama before moving to Georgia when she was nine, and she received degrees in Music Education and Music Therapy from Samford University and Appalachian State University, respectively. She has been singing in choirs since she was three, and played a variety of instruments growing up. Finally, Madison was born and raised in Atlanta and received a degree from Florida State University in Music Therapy. She has been at The George Center for less than a year.

Jennifer and Chelsea are the music therapists interviewed from Therabeat, and they have some interesting similarities. They both received degrees in Music Therapy from UGA. Jennifer was born in Texas and lived there for six months before moving to Canton just north of Atlanta,

while Chelsea was conversely born in Atlanta living there for six months before moving to Texas and eventually back to Atlanta. Voice was their principle instrument in college, as all Music Therapy majors must specialize as part of the UGA program. Jennifer started Therabeat in 2006 and opened up her current clinic in 2012. She has been practicing for twelve years while Chelsea has been practicing for three. Beth, owner of Music Therapy Services of Greater Atlanta, was born and grew up in Ohio. She got her Music Therapy degree from Eastern Michigan University and received her Masters in Neurologic Music Therapy from Colorado State University. Moving to Atlanta in 1998, Beth immediately began her company, which is the oldest music therapy clinic in Atlanta. She is an accomplished pianist.

Kally and Sarah are the final two music therapists to be introduced, and both work for Metro Music Therapy. Kally was born in Maryland, grew up in Atlanta, and graduated from Georgia College and State University in Milledgeville with a degree in Music Therapy. She did an internship in Dallas before moving back to Atlanta one and half years ago to begin practicing. She started on piano but mostly plays guitar now. Sarah was born in Charlotte, North Carolina and grew up in Roswell just outside of Atlanta. Like Kally, she received a degree in Music Therapy from Georgia College and State University and has been practicing in Atlanta for three years. Sarah began playing piano at a young age, but voice was her primary instrument in college. She primarily works with substance abuse patients, while Kally primarily works with hospice patients.

4.1.2 Musical Backgrounds

Greater Atlanta is made up of people from all around the world. While none of the music therapists interviewed was born outside of the country, they collectively represent different regions of the Eastern US. None of the music therapists were an only child growing up, all

having at least one sibling, and two, Andrea and Sarah, were homeschooled during high school. All of the therapists interviewed had a degree in Music Therapy, and most went to one of the two main schools that offer a Music Therapy degree in the state: Georgia College and State University and the University of Georgia. Two owners received degrees in Michigan. The three owners interviewed had either a Masters in Music Therapy or received specialized training in Neurologic Music Therapy. All of the music therapists were extremely willing to give an interview, eager to spread the word about music therapy, and most of them were young professionals excited to be working in a relatively new field. Two items stood out regarding how they became interested in music therapy. Having musical backgrounds, most of them knew from an early age they wanted a career in music, and they came to learn about music therapy through a sick loved one or being sick themselves. It may be that these special connections to music and music therapy are linked to the marginalized position of music therapy with respect to biomedicine, as mentioned in chapter two. Those without such connections might either not know about this career option or understand it within traditional biomedical discourses.

Ask many high school seniors what they want to study in college, and most will give more than one answer or no answer at all. Indeed, most college students change their major at least once in college. However, in the case of the participants interviewed for this study, most knew early on they wanted to do music therapy. One explanation for this is that they all had musical backgrounds and came from musical families, and so they knew they wanted to do something with music. Only Beth, the owner at Music Therapy Services of Greater Atlanta, came from a nonmusical family. Even looking at my own music background, I always wanted incorporate music into my life, hence the subject of this thesis. All of the therapists took to singing and playing musical instruments early in life, starting from age 3 to 10. The music

therapists play a variety of instruments, including piano, guitar, cello, violin, and clarinet, with the top two instruments being piano and guitar. Jamie, the owner of The George Center, remarked that all board certified music therapists must be proficient in piano, guitar, drums, and voice. All have enjoyed listening to music since childhood, and tastes include classic rock, Christian rock, gospel, classical, and popular music from the 60s, 70s, and today.

In addition to having musical backgrounds, many participants were exposed to music therapy early in life. During her homeschooled years, Andrea met a music therapist who works at Children's Healthcare of Atlanta (CHoA) while performing with a community orchestra. Her father, who was also in the orchestra, knew this therapist and set Andrea up with her to learn more about music therapy. Chelsea witnessed music therapy while working at a summer camp in high school and was hooked. Beth wrote a career paper her sophomore year of high school, and a teacher who knew she was the school accompanist suggested music therapy. Also in high school, Beth observed a music therapist at the city hospital and thought, "holy cow, this is real, this is cool." She was already interested in being a special education teacher and felt Music Therapy was a good marriage of the two. Jordan also took a career test. Music Therapy was one of her top career suggestions, and she "never looked back." Kally knew before going to college that she wanted to help people, and music had always been a big part of her life. She declared Music Therapy as her first and only major in college.

4.1.3 Experiences with Music Healing

Another factor that drew the research participants into music therapy was having a close friend or family member with an illness, or having an illness themselves, and then finding healing in music. As stated in the previous chapter, I became interested in the role of music in healing due to my own family background with illness. It is no surprise that some of the music

therapists in this study found their career paths through illness experiences. Jamie had a grandfather with Alzheimer's, and she would notice physiological changes within him when she would come home from school and play piano. His movement would calm and his breathing would become slower. Jennifer was able to witness the way music helped a close friend with cancer get through treatments. Andrea had a cousin in Texas with significant medical needs, and music therapy was one of the best parts about his day. Suffering from Ulcerative Colitis, an inflammatory bowel disease, Kally says music helped her with pain management. She feels her diagnosis influenced her desire to work with people with chronic or terminal illnesses. These illnesses experiences led the research participants into music therapy.

Though Sarah neither had a particularly early experience with music therapy nor an illness experience, she found herself drawn to the field. Sarah, a music therapist with Metro Music Therapy, is one of two therapists in the study who began college as a Music Education major. She was doing a student observation, and a little girl was attached to her hip and wanted her attention every time Sarah was in the classroom. One day she told Sarah she would not see her anymore because she and her mom were running away from her dad and uncle. Sarah learned from the teacher that the dad and uncle were drug dealers, and Sarah felt helpless that she could not do anything to help this little girl. Sarah remarked:

And so it was really upsetting to me that like I was going to be going into a field where I would be seeing a lot issues and not really able to do anything about it. Especially since the primary focus is obviously teaching music.

With music therapy, Sarah felt she could focus more on the person rather than the music. More generally, I learned that for many research participants the music is often secondary and acts as a medium facilitating the interaction rather than a cure in itself. This will be discussed later in this chapter. Though Sarah's story is unique amongst the therapists, all have a passion for music, both inside and outside of work.

Some of the therapists are active musicians outside of the office performing in choirs, musicals, and bands. Beth sings with the Atlanta Women's Chorus, Jordan does professional theatre and musicals in the Atlanta area, and Andrea performs as part of a duo called *Corks and Chords*, pointing out that "sometimes you just want to be in it for the music." The duo even has a self-titled YouTube channel. Many of the therapists occasionally perform in church choirs and bands, and Jamie used to act and sing with a theatre troupe in Lawrenceville, Georgia located just outside of the city. Since the therapists play music all day for their jobs, many "enjoy the silence," as Andrea stated. Beth prefers silence when she gets home, and Jamie exclaims that the last thing she wants to do is hear music when she gets off work. Hearing music all day would most likely get very tiring, and Kally confirms this by stating, "your brain gets so stimulated by music," and she often sits in silence when driving in her car. Though they enjoy the silence, music still plays an important role outside for work.

When the therapists do play or listen to music in their spare time, it is often to relax. While discussing the impact of music on mood, Kally states she plays guitar in her spare time because she can control it, which relaxes her.

Kally: I think a lot of my want to play music and do things associated with music is that I can control it. Especially like if I have been in a stressful situation that I can't control.

Stephen: Okay, yeah this is not something I've thought of before.

Kally: Oh yeah, and I think too, like it's funny, I look back on college. In college I had a lot of the problems associated with Ulcerative Colitis. And I fought my way through it. I was proud of the way I fought through it.

Stephen: Right.

Kally: And I think, that, as a student, I channeled my frustration and my lack of control into helping other people, because it's something I could control. Right, like there's so many aspects of life in general that you can't, you don't have control of.

Stephen: Right.

Kally: You don't have control of, you know, if someone in your family dies, or if I don't know, you know, there's lots of things you're not in control of and that was something I manipulated, I could control, and I knew that I was trying to make a difference.

Playing music is something Kally can control versus the many uncontrollable variables of life.

Andrea agrees with these sentiments. When particularly stressed and feeling like something is

outside of her control, she will play piano until she feels better. Working in hospice with dying patients or working in substance abuse clinics with suicidal patients could certainly be stressful, and the participants use music personally to decompress. They feel much of their patients suffering is out of their control, and music allows them to regain control. This may also be what patients gain from music therapy, a sense of control over much of which is out of their hands.

4.2 Skeptics & “Hippy” Medicine

Simply playing or listening to music can help relieve stress, but Music Therapy involves much more than that. It encompasses many methods and techniques used to treat a myriad of mental and physical illnesses, but some people are not convinced. Opinions about the effectiveness of music therapy in alleviating suffering from mental and physical illnesses are mixed, and most people probably believe that traditional therapies are more effective at treating mental and physical disease. Only becoming established as a professional field in the US in the late 20th century (Peters 2000), music therapists often find themselves explaining, justifying, and legitimating music therapy with respect to biomedical discourses. One reason for this is because music therapy emphasizes mind and body connectedness in healing (Koen 2008), and during the 18th century, clinical discourse was reorganized around biomedicine, treating only what was observable and visible in the body (Foucault 1973). Diseases of the mind are invisible and hard to understand, and from “Unreason was born psychology” (Foucault 1973:197). However, traditional psychology emphasizes the mind-body distinction, focusing on the former at the expense of the latter. Therefore, music therapy is on the fringe of biomedicine and what many people accept as legitimate treatment in our society because it focuses on mind-body healing. It is easy to understand why many of the music therapists I interviewed are such firm believers in

the power of music healing given their musical background, early exposure to music therapy, and experiences with illness and alternative healing methods.

The therapists I interviewed argue many people are skeptical of the health benefits of music therapy, as the profession seems to have taken on a “hokey” quality with some skeptics. Countering these perceptions, participants emphasized the importance of interaction and emotional connection. For instance, music therapists Beth and Kally believe that public discourses, as evident in movies such as *Alive Inside*, perpetuate misconceptions about Music Therapy. *Alive Inside* is a documentary by social worker and pseudoscientist Dan Cohen. The film shows the effects of music on memory with Alzheimer’s patients. Cohen places headphones on their head and gives them an iPod, and like magic, the patients are pulled from the depths of their minds and come alive, connecting with music and family in the process. Beth argues plainly that giving Alzheimer’s patients an iPod is definitely not music therapy, and emphasizes the interactive nature of music therapy in doing so. She uses music to connect emotionally, visually, and sometimes spiritually to her patients, stating, “I am emotionally invested in the session.” Jordan analyzes the engagement aspect of music therapy. “This is what makes us totally different than someone playing the harp in a nursing home or hospital—the difference is the physical, mental, emotional, and sometimes spiritual engagement.” However, the music therapists struggle between espousing the spiritual healing in music therapy and needing to gain legitimacy in Western biomedical cultures. Kally agrees that movies like *Alive Inside* are creating the wrong impression of music therapy, because it is the only thing some have ever been exposed to. She acknowledges that it is even seen as taboo and feels she has to educate, advocate, and justify the benefits and utility of music therapy all the time.

Both Jamie and Andrea of The George Center frequently find themselves educating people about music therapy as well. Some people assume music therapists prescribe music listening, but music therapy is all about interaction. Jamie says she would never prescribe a CD for patients to listen to so they feel better, and that it is a ridiculous notion to prescribe Bach, for example. Music therapy is interactive and involves music activities, so music therapy is not happening unless Jamie is present and providing the music. Jamie states:

Music is a universal language, music heals, music educates, music is used in every culture in the world, in medicine and education. Why [do] we even need to talk about it? I mean, I can show you the research, but why do I need to show you the research? Literally every culture from the beginning of time has used music in medicine and education.

Jamie seems exhausted having to explain to skeptics the merits of music therapy. However, though music is frequently used in healing around the world, it can also be irritating depending on mood, and it has even historically been used as a torture device.

Research participants indicate that in US culture, people have a hard time buying into alternative therapies that treat the mind as connected to the body, and this is due in part to biomedical views of the clinic. Andrea explains people have images in their heads of someone sitting in a field playing guitar and singing hippy songs. Jamie concurs with this statement regarding hippies:

We hate the fact that there are people that think music therapists are a bunch of hippies sitting around a campfire singing kumbaya and that's music therapy, which is not what we're doing. But I [also] hate the fact that we're losing a bunch of hippies sitting around a campfire singing kumbaya. Like that's what's so special about music is it brings people together.

This is an interesting observation by Jamie. On the one hand, the fact that people immediately get an image of hippies singing campfire songs when they think of music therapy means people are invalidating it. They do not believe it or see truth in it, since a hippy may represent a free spirit who is medically unqualified and is perhaps, through the aid of illicit substances, in touch with a deeper, spiritual, and false realm, a realm that exists outside of the realm of biomedical

discourse. On the other hand, Jamie is arguing that we have maybe lost something as a society. We have perhaps lost age-old traditions of people coming together around fire, food, and music to partake in communal sharing, camaraderie, and ultimately, healing. The therapists interviewed for this study were exposed to Music Therapy early in life, so they never developed the skepticism of some of their critics. Their music backgrounds and upbringings, combined with music healing experiences with close friends, family, or themselves, created firm believers and practitioners of music therapy.

4.3 Socially Constructed Mental Disorders

Before exploring the methods and techniques of Music Therapy, this section discusses the process of and rise in socially constructed mental disorders. A number of the music therapists interviewed spoke about the beginning of professional Music Therapy in the context of PTSD, or Post Traumatic Stress Disorder, a disorder commonly diagnosed to soldiers returning from war. According to Jamie, music therapy began after WWII when nurses discovered using music with soldiers diagnosed with PTSD had positive physiological and psychological effects. Kally states research on the impact of music therapy on PTSD is currently being done with active duty military. PTSD is a fairly recent mental disorder when compared to other mental conditions. PTSD and other mental disorders are often socially constructed, just as subjectivity and emotions are socially constructed, and they are not only the result of biological phenomenon. By altering socioeconomic, sociopolitical, and historical landscapes, intersubjectivity is transformed, emotions and memories are remade, and mental disorder is socially constructed (Kleinman & Fitz-Henry 2007). PTSD as a mental illness is partly a cultural phenomenon.

Anthropologists and social scientists have studied the idea of universal human nature based in neurobiology and unchanged throughout history. Western perspectives have historically

emphasized emotion as the essence of an individual, innate, inherent, instinctual, and universal across cultures (Lutz 1988:4). However, thoughts, feelings, beliefs, conscious experiences, i.e. subjectivity, are not characteristics of only individuals (Lutz 1988). This viewpoint neglects historical, cultural, political, and economic influences on subjectivity (Kleinman & Fitz-Henry 2007:53). Collective experiences shape subjectivity, and this idea helps explain modern mental diseases such as depression and PTSD as socially constructed. Mental disorders are not uniquely individual and need to be analyzed as a social experience in social contexts. Universal neurobiological processes do not cause PTSD and other mental illnesses. Historical and social processes influence the way people experience their emotions, memory, and subjectivity. The imaginary line between self and the social world does not exist. Psychologists and anthropologists are shifting their understanding of mental illnesses from a universal, individual experience toward contextual framings of subjective processes (Kleinman & Fitz-Henry 2007:64). This is important for music therapists in understanding the various conditions of patients seeking music therapy.

Psychologists and psychiatrists diagnose patients with new mental illness with such frequency that the list of mental disorders grows more and more every year. Many of these disorders are socially constructed. Jamie points to this as a major problem in mental health right now. By labeling it, it gives it legitimacy she says. As a child, she thinks she would have been diagnosed with a relatively new mental disorder called Sensory Processing Disorder, a type of OCD or Obsessive Compulsive Disorder. Jamie states:

I'm telling you right now, if I was born today, I would be diagnosed with Sensory Processing Disorder. Like I couldn't stand the wrinkles in my socks, and I'd pull them until they ripped, and then I'd throw them away in the trash, and my mom said, if you come home with no socks again, you're grounded for the rest of your life.

Eventually she grew out of it because it no longer served, but she argues kids today are receiving these new socially constructed diagnoses, and parents then believe their kids need therapies and medications. This behavior serves children since they get a lot of attention for it, and they cannot process the difference between negative and positive attention. As a music therapist, Jamie feels there are many developmental and cognitive disorders needing music treatment, but she feels as a society, we have gone too far in labeling every little nuance as diagnostic. Regarding her own past experiences with OCD, she gets better every year of her life. Perhaps Jamie's childhood OCD and sensory processing proclivities make her uniquely suited to empathize with children dealing with the same issues and help them realize that wrinkled socks are no big deal. PTSD, OCD, and Sensory Processing Disorder are just a few of the socially constructed mental disorders music therapy treats.

4.4 Methods & Techniques

There are six methods and techniques of music therapy, including assessment, goal setting, music interventions, determining music function, and selecting music material followed by implementing, documenting, and evaluating treatment (Peters 2000). Assessment occurs prior to treatment to learn client history, strengths, weaknesses, and needs. It involves reviewing medical records, interviewing the client and family members, discussing client needs with a treatment team, and engaging and observing client interaction with music (Peters 2000:65). Assessments at Therabeat usually last three sessions. If a child is still not responding to music by moving or dancing, Jennifer realizes the child cannot process the music and will be unable to follow directions. In the case of an unresponsive patient with Alzheimer's or dementia, Kally will interview family members to assess history and music preference.

Goal setting creates the therapeutic goals and objectives of what the client seeks to accomplish by giving direction, purpose, and focus to treatment (Peters 2000:66). Jennifer will obtain goals directly from Occupational, Physical, and Speech Therapy records. When asked what patients are looking to accomplish, Beth states:

Therapy is goal-focused. So every patient has goals and objectives, and that is what we're working on, right? First we figure out what are their goals and objectives. Either their doctor tells me, or me and the patient decide...So as I'm finishing up a session, no matter who, right, I'm thinking, okay, what is my big goal, and how are they doing with that goal today? And is there anything they could do at home this week to help us get to our ultimate destination.

If a client is able to articulate what he or she wants to accomplish, Andrea will choose goals with the patient, but sometimes goals are discussed with parents and she bases them on school and other therapeutic needs. Andrea comments:

Yeah, well [the client] sometimes is able to say this is what I want to accomplish over this time. Most of the time, it's going to be something that we discuss with the parents. What do you want to see your child accomplish over this period of time? What are their needs in school? What are their needs in their other therapies? How can we support that with music therapy?

Music interventions, such as songwriting and lyric analysis, are the music procedures that help clients reach therapeutic goals, and procedures include music function, music experience, and music material (Peters 2000:67). One technique that came up in nearly every interview is the ISO Principle, which is a technique used to facilitate an intervention. Kally explains it this way:

ISO principle, so that particular technique is about, it involves essentially meeting the person where they're at. So if a person is very agitated, and that is in turn causing them to have more pain, um, we with either our voice or guitar or whatever we're using match where they're at musically. So if they're breathing very shallow, we're not going to pick very slowly. We're going to start at a faster tempo and try to slow them down with breathing and helping them take deeper breath by slowing our instrument down.

The ISO Principle involves matching patient mood with the rhythm and tempo of the music, and then bringing them into a different state in order to perform an intervention.

Determining music function is another method. There are five determinants of music function: music as an information carrier, a reinforcer, background for learning, physical structure, or reflection of skills to be learned (Peters 2000:67). Finally, selecting music material

combines music function with client reaction to music stimuli to plan types of music experiences for therapy treatment interventions (Peters 2000:68). Jamie makes it clear that music selection is very important, and they always use music preferred by the patient.

Always patient-preferred music, so regardless of the therapists preferences or what the therapist thinks would be helpful in the situation, it really doesn't matter. What matters is the patient's preference. So, if the patient really loves death metal, then we need to be using death metal in the session. Now, if we feel like death metal may not be appropriate for the situation, or we may want to expand on different genres, we're still going to incorporate death metal, and we're going to try to venture out into different genres through using them. But we've got to use patient-preferred music, because that's the hook. That's how we get our patient to buy in. That's how we get them to participate. That's where they're going to have the most emotional connection with music, and that's where they're going to be able to open up and talk about what's going on, or being motivated to participate in the activity.

This statement implies patients may not have confidence in music therapy due to clinical discourses on biomedicine (Foucault 1973), and by selecting and connecting to their own music, they are more willing to believe in the power of music in healing.

Assigning "music homework" is another technique some music therapists employ. Most of the research participants assign music tasks to patients, but Jamie does not, emphasizing therapy is interactive and only occurs when a music therapist is present. Playing piano at home helps with motor skills, reading music, and sequencing, and by practicing you will work towards those goals, but that is not therapy. Beth has some patients agree to homework tasks as part of their goals and objectives, and it does not need to be music oriented. For example, an OCD patient may complete a reflection assignment by observing other people's behavior, and then comparing it to their own. Beth elaborates:

Um, like I don't know, like when I treated a lot of preadolescents with OCD, their self-awareness is a big issue, right? They're not really understanding that their OCD is different, right? You know like when you're twelve, you're like, I don't know how I'm different, how I'm the same. So I would have them do little like reflection homework. You know, observe some people, and then compare to themselves, or interview five people in their house, you know what I mean?

Self-awareness is the focus of the activity, and she wants them to understand their behavior is different and not necessarily healthy. Andrea assigns practicing, and Jennifer and Chelsea do home programs. The only music therapist who does not assign any type of homework is Sarah.

This chapter discussed the field research, which took place in Greater Atlanta, including music therapy clinics where the study occurred, the interview process, and introducing the music therapists and providing their background information. All of the therapists interviewed had musical backgrounds and knew early on they wanted a career in music, often finding out about music therapy through a personal illness experience. They are also all women, which may be related to the history of the disenfranchisement of women and the marginalized status of Music Therapy as a professional discipline in the US. As such, they must constantly legitimate and justify music therapy, which focuses on mind-body connectedness in healing in a medical climate that emphasizes the biomedical model. Again, embodiment theory rejects this dichotomy and aids in understanding music therapy as a healing method in cultural practices. Also, the music therapists were firm believers in the power of music in healing, likely due to their music backgrounds and personal illness experiences. In exploring the emergence of PTSD and other diagnoses in the US, the social construction of mental illness was examined. Finally, the chapter concluded with methods and techniques. The next chapter gives a general overview of illnesses and interventions and explores the deeper role and purpose of music in therapy.

5 ILLNESS AND INTERVENTION

When I began this study, one of the primary objectives was to examine the use of music therapy with stress and depression, given that 9.5% of the US population suffers from depression (NIMH 2010). I was under the incorrect assumption that music therapy treats mostly stress and depression. Only about 1% of Beth's private practice patients come in for stress-related

depression, while 60 to 70% of Sarah's substance abuse and hospice patients are treated for stress and depression. Through interviewing the research participants, I realized music therapy is used to treat a wide range of both mental and physical diseases, from Parkinson's to Autism to Alzheimer's and ADHD. My own misconception of music therapy's use in treating a variety of illnesses underscores the marginality of music therapy in modern medical discourse. The music therapists in this study primarily work at four private practices. Though these are private practices, they all have contracts with various entities in the Atlanta area, including nursing homes, substance abuse clinics, special education programs, Hospice, and nonprofit organizations, and the setting tends to impact the type of clients the music therapists serve and the particular mental or physical diseases they are treating.

Kally and Sarah work for Metro Music Therapy, and MMT contracts mostly with hospice and substance abuse patients who tend to be older. Hospice patients are in the dying process, and many of them have Alzheimer's and dementia. Sarah works with substance abuse patients, so she sees many more patients with stress and depression than a private practice inpatient care serves. While discussing Sarah's internship at a psyche hospital, she states private practices usually do not contract with hospitals or psyche units, places that have more stress and depression patients.

But as far as private practice goes and working with depression/anxiety, private practices aren't usually going to contract with hospitals, like a psyche unit. And there aren't a lot of freestanding psyche facilities like that, you know? I don't think I know of any place that's like an in-patient counseling kind of place, you know? Like that wouldn't be very realistic, you need more acute care for that.

She explains stress and depression patients would have to seek out private practice care, and that is usually not the case since these patients often end up in hospitals or psyche units only when the condition has become critical and debilitating.

The George Center, Therabeat, and MTSofGA all work heavily with pediatrics, so they tend to see children with Emotional and Behavior Disorders, or EBD, and developmental

disorders, all subcategories of mental disorder. The list of mental disorders the private practices treat are too innumerable to list here. As Jordan points out, “anything and everything is viable for music therapy treatment.” The most common mental disorders treated that were consistently mentioned across all the interviews are Autism, ADHD, OCD, Down syndrome, Alzheimer’s, and of course, stress, depression, and anxiety. Some of these will be discussed in the next sections in more detail. Regardless of the condition, Jennifer makes it clear she treats the symptoms of the disorder, not the diagnosis.

Like I’m going to treat the symptoms. I’m not treating the diagnosis. I’m going to treat the symptoms of autism. I’m not treating autism. I’m going to treat the symptoms of depression, but I’m not treating depression itself, sort of, if that kind of makes sense. I’m [not] going to treat Down syndrome...but I’m going to treat the symptoms of Down syndrome. I can’t change Down syndrome. Does that make sense?

She treats the symptoms of depression, autism, and Down syndrome, emphasizing the point that she cannot change the fact that a person has that particular disorder.

That being said, the focus of this thesis, and by extension the goal of this study in focusing on anthropological perspectives of music therapy, is not to explain every possible illness music therapy treats, nor is it to examine every possible intervention used to treat those conditions. If you wanted to find an exhaustive list of illnesses and interventions, one only need to read a book on Music Therapy or search the Internet to learn these facts. Besides, no two patients are treated in the same manner, even if they both suffer from the same condition.

Jennifer elaborates:

Say I have two patients with Down syndrome. You would see me facilitate completely different from one patient to the other, because you factor in their personality, you factor in their age, you factor in their family. I mean you really factor in the whole picture.

Specific interventions utilized by the research participants include songwriting, lyric analysis, music improvisation, therapeutic singing and instrument playing, music movement, sensory

integration, melodic intonation, gait training, sequencing, and dancing. Some of these will also be discussed in more detail in the next sections.

5.1 The Role of Music in Healing

As previously stated, this study is not interested in every illness treated by music therapy, nor is it focused on every possible intervention for treatment. This study is interested in deeper and not immediately evident processes taking place. It focuses on theoretical principles of use, such as its focus on mind-body healing rather than strictly biomedical healing. This chapter explores the role of therapeutic music in mind-body healing, creating community, in connecting to memories, and in acting as a medium and facilitator. It also examines music therapy in treating depression, anxiety, Alzheimer's, and physical disabilities (Peters 2000; Brummel-Smith 2008; Clair 2008). Finally this chapter concludes by discussing nontraditional uses of music therapy in birth and grief counseling. Music therapists frequently utilize and implement music therapy in coping with pain, pregnancy, and loss and mourning (Hanser 1999; Sekeles 1999).

Peters (2000) is a music therapist who offers her view of the role of music in healing. Music is made of real physical structures and vibrations in time and space that can be felt and heard with our senses (Peters 2000:50). Musical chords and overtones are connected to natural and physical structures, thus music connects people to the vibrations of physical nature and the universe in real time (Peters 2000:51). Music facilitates mind-body connectedness by acting both on mind and body, emphasizing holistic healing methods (Peters 2000:53). This overlaps with elements of musical healing traditions in other cultures. Rather than a dualism, many cultures view the physical and spiritual realms as a whole (Koen 2008:94). Music expresses this wholeness, and when combined with prayer, it creates heightened consciousness, spirituality, and transcendence, and facilitates communication with God, higher powers, or the spiritual (Koen

2008:97). For instance, through the Persian *madam*, or devotional music, prayer, and meditation, “participants can achieve a *certainty* that its energy will effect a healing change, which in turn aids in healing or can even cause it to occur” (Koen 2008:95). The HCP, or human certainty principle, can affect transformative healing by faith, certitude, and knowing (Koen 2008:95).

Music also unifies communities by facilitating interpersonal interactions through rhythm, organization, and emotional connection. These communities are created in social gatherings, religious settings, group performances, music concerts, and dancing (Peters 2000:54). They are also created in unconventional settings, such as substance abuse clinics and psychiatric hospitals. Sarah feels that through music, she gets to a different level of rapport very easily, and patients may not realize that therapy is taking place since they are simply enjoying the music. It gives patients a shared experience when they listen to a familiar song together. Sarah states:

We’ve all experienced it, we’ve all listened to it, so that gives us some kind of [common] ground. Then I feel like that is developing rapport as well, to say okay, you kind of understand where I’m coming from now that you have experienced this as well.

Patients develop rapport and understand each other through mutual experience. Many people have experienced having a conversation with someone and connecting through music, or hearing a song together and feeling a shared experience. Perhaps people feel understood through this connection, which is important for humans as social creatures, that others feel what they feel when they hear particular music.

The wordless and nonverbal aspect of music aids in conveying emotions, which has therapeutic implications by helping patients who have difficulty expressing emotions verbally, and thus music presents a nonthreatening outlet for sharing emotions (Peters 2000:56). Creating, performing, and listening to music gives people personal meaning and improves health and life satisfaction (Peters 2000:57). Music therapy helps individuals who feel alone connect to society

through shared emotions. Sarah gives an example of this connection and unity when describing a suicidal woman during a song rewriting exercise.

I don't remember what the woman ended up writing, but I remember, she was in for [being] suicidal, well I think she actually attempted suicide. She was sharing her lyrics that she wrote, and she just started crying. It was so genuine, and everyone in the group had this moment where we're all kind of sharing this understanding of like feeling what she was feeling.

Everyone in the group was supporting her, not trying to fix anything, but letting her share and experiencing with her. This was the moment Sarah felt she was making a real difference in people's lives as a music therapist.

A third role of music in therapy is connection to memories. The research participants discussed the powerful connection between music and memories. Jamie states:

Music defines moments in our lives. I mean, I think I said this in our last interview, but um, we attach big memories in our life to music. We all remember our summer jam our senior year of high school. We all remember the song we first made out to in the car with our boyfriend and girlfriend. We all remember our wedding song, or songs that we sang to our children when they were born. I mean, these are huge memories for us.

We attach significant memories of our lives to music. A song may come on eliciting a declaration of, "that's my jam!" Jamie continues discussing music and memories:

You hear a song you haven't heard in twenty years, and it comes on the radio, and you know every word. Well you couldn't memorize a monologue from twenty years ago, but you know every word to that music because you attach melody, you attach rhythm. All of those are different triggers for those memories, and how that affects you emotionally could be good, it could be bad, either way, it's real, you know?

Jamie argues we know every word to the music because we attach melody and rhythm, and those act as different triggers for those memories and how that affects us emotionally, good or bad. In my own experience, certain songs will take me to a very specific time and place. It reminds me of exactly what was going on in my life, who I was with and where, and what I was feeling at the time. Jordan agrees, stating:

Music for me holds memories. I always associate certain songs with certain times in my life, for better or for worse. And no matter how many years pass, whenever I hear that song, I'll be transported back to that memory I've associated it with.

It is as if music makes travel possible, in both time and space. This can be vital in healing when taken to positive memories. Even negative memories elicited by music may facilitate processing the past and healing the soul.

When working with substance abuse patients, Jamie uses patient-preferred music. If a patient has a favorite song, it is because they have attached memories and meaning to it. It reminds them of particular moments in their life, making those moments easier to talk about. Sarah's substance abuse patients listened to music when they were high, so the music reminds them of where they were and who they were with when they were high. She creates a safe space so they can listen to that music under different conditions, and they will be able to talk about emotions from those times more easily. Kally employs "Life Review," a technique in which she plays one of the patient's favorite songs eliciting strong emotions. The music promotes talking about their favorite memories and where they were at that time in their lives. "What one song means to one person is not going to mean the same thing for another." As a music therapist, Kally wants a response, and the music helps her patients draw their own conclusions. Music therapists are able to exploit this powerful connection between music and memories in therapy.

Finally, the role of music in therapy is it functions as a motivator, mediator, and facilitator. As previously noted, the music is secondary to the person being engaged. That is why Sarah switched her major from Music Education to Music Therapy, so she could focus on the individual rather than the music. Sarah and I had an interesting discussion on the role of music in therapy and healing:

Stephen: What do you think of the role of music in therapy and healing? I guess what we kind of already talked about is it's not so much about the music as it is about, well in your particular case, and I don't want to answer for you, but the role of music is more of the facilitator in terms of getting people to express things they wouldn't. I mean we kind of already talked about it, but just a general, what do you think is the role? It's going to be different for each type of condition that's treated most likely.

Sarah: When I was in school, we learned that music can be a motivator, and music can be a medium, you know? Kind of like what you were saying, it's a medium or facilitating something. This is in school. I'm trying dig back in the files.

Stephen: Give me the school answer, that's great.

Sarah: It's really true, because you know, as music therapists we use music to motivate. For a child who needs to work on some kind of physical, or playing an instrument can be the motivation to do something.

Stephen: Right.

Sarah: And it's also like, we can use music as motivation for ourselves in daily life. Like when you want to go workout, or when you want to clean the house, turn on some music.

Stephen: Right, a lot of times when I'm writing, I have like jazz or classical when I'm studying, something with no lyrics. Something that's just kind of like real repetitive, like movie score music I like to put on.

Sarah: Yeah, it sets up the mood. It can set up, like you could put it on as background music to set the mood of what you're trying to establish. Like, if I want people to come into the room and get excited, I'll put on I'm Walking On Sunshine or something, and they're going to be like, 'Oh my gosh!'

In this discussion, Sarah analyzes the many ways music acts as a medium and motivator in therapy and in our daily lives. Andrea and Lana also feel the role of music is to motivate. Andrea notes, music is the motivating factor driving the therapy, stating, "So music is to me, if I can do the activity without music and achieve the same outcome, then I'm doing it wrong. So, music is the thing that is driving the change." The music is essential to eliciting change. Lana comments that music is the tool that motivates clients to work towards improving their functional skills. Emphasizing the therapy always comes first, Jordan uses music to facilitate the therapy. She sometimes describes her profession as a "therapist who specializes in music."

Beth argues, "The human factor is really important." As an accompanist, for example, she will have a patient play black keys on the piano and accompany what they play, making it musical. She feels she has to be able to relate to them or she is not doing a good job. Sarah uses music to "meet nonmusical goals." She sees music as a medium in the healing process. Madison also notes that music aids individuals in reaching non-music related goals, stating, "While music is not a healing mechanism in and of itself, it is an excellent tool to promote health, wellbeing, and aid individuals in reaching their non-music related, therapeutically oriented goals."

According to Jamie, music serves as an excellent medium in bringing people together.

Like, that's what's so special about music is it brings people together...And it's what makes music an awesome medium, therapeutically, because I can get my guitar, my ukulele, and I can get right into you, and we can interact together in a musical way.

The music facilitates the interaction. Music as a medium, facilitator, and motivator appeared to be the primary role of music in therapy. By connecting to the music, patients are motivated to participate and open up to the therapeutic process and music healing in ways they may not in a traditional clinic focused on visual observations (Foucault 1973). The next section will analyze examples of mental and physical disorders treated by music therapy.

5.2 Stress, Depression, & Anxiety

The World Health Organization (2010) reports depression affects 121 million people, and in 2020, it is predicted to be the second most disabling illness in the world after heart disease. The largest cross-sectional study using retrospective data reports higher risks of mood disorders in each successive generation, and specifically higher rates of MDD or Major Depressive Disorder (Hidaka 2012:206). These statistics fueled my belief that music therapy largely treats stress and depression. While I learned it treats a myriad of conditions in addition to stress and depression, I still inquired about what techniques were useful in treating stress and depression. Songwriting and lyric analysis are frequently utilized.

Beth states songwriting and lyric analysis are some of the most common stress and depression interventions that increase self-awareness and self-expression. Expressing emotions through music is seen as “safe” for those who cannot verbalize, and writing songs with emotion-laden words provides an avenue for verbal communication (Peters 2000:253). Kally provides an example of music healing in songwriting. A teenage girl with a terminal illness suffered high levels of anxiety and depression. Every time she was anxious, she was told to write down her feelings, and they would turn them into a song. She immediately wrote down words and lyrics that talked about her family and her life. She was given two different chord progressions to

choose from, and they made a beautiful song from it. She now plays it and listens to it when she is anxious, and it helps her through some of those difficult moments. The following is a discussion between Jamie and I about the use of songwriting with a patient with Cerebral Palsy.

Jamie: She has Cerebral Palsy, she's a teenager, and she's just now cognitively realizing that she will probably never get married or have kids or have a normal life, you know, a regular life.

Stephen: Right.

Jamie: For a teenager to deal with that is a lot, and so, our focus on her therapy moved from fine motor and motor goals, because she has Cerebral Palsy, we were teaching her how to do three finger chords on the ukulele, so she could wash herself and feed herself, and that's how that transfers as a therapeutic goal, to really working on the depression, anxiety. She is not being able to process the fact that she's not going to get married, who's going to love me, and I'm in a wheelchair.

Stephen: Right, it's kind of like, my sister, similar thing. Like, having a terminal illness all her life affects her feeling like damaged goods. She might not be able to have kids, my sister, but she might. But, we're talking about suing for them not offering to freeze her eggs when we did the first treatments, chemo, things like that.

Jamie: Yeah.

Stephen: What methods, would you say with this girl, what methods are effective in treating [depression and anxiety]?

Jamie: Yeah, so she loves to sing, and so we do a lot of singing, lyric analysis, and songwriting with her, for her to process her thoughts and feelings that she's having.

The focus of her therapy moved from fine motor goals to working on depression and anxiety through singing, lyric analysis, and songwriting to help her process her thoughts and feelings. Music facilitates expressing emotions using words to help process illness.

Traumatic injury and serious illness changes ordinary experience into extraordinary experience. Previous research focuses on how people use narration to make sense of this disruption to normal life (Ochs 2004:271). One particularly relevant study focuses on occupational therapy. Like music therapists, occupational therapists (OTs) work with patients in various hospital divisions. And like music therapists, occupational therapists are somewhat marginal to mainstream biomedicine. They teach patients with disabilities to regain daily functions by playing games, teaching crafts, and motivating them (Mattingly 1998:51). OTs use narrative in the course of therapeutic interactions to help patients imagine the future while remembering the past through mundane tasks of the present, such as playing checkers (Mattingly 1998:65). A checkers game may symbolize not an ending, but a beginning in a larger narrative, a

new trajectory of becoming, as OT patients learn to complete this simple task (Mattingly 1998:69). Guided by prospective narratives, therapists and patients orient actions based on imagined endings. Like narrative stories, music songwriting helps patients renegotiate the social world with their new disabilities. Music therapists use present tasks such as writing songs and analyzing lyrics to help patients process the past while hoping for a better tomorrow.

Music therapy may increase the self-esteem of depressed patients in psychiatric hospitals and substance abuse clinics through improvising music and writing songs. Sarah and Kally work with substance abuse and hospice patients, and most of them suffer from stress, clinical depression, and high anxiety. Taking a slightly different approach, Sarah calls interventions “experiences,” and she breaks them into four categories: listening, improvisation, creation, and recreation. Listening is just listening to music, improvisation involves actually playing instruments, creation includes songwriting, and recreation is song rewriting or singing karaoke. It is helpful for depressed patients to express emotions using verbal and nonverbal means (Peters 2000:253). Sarah says one of the huge benefits of music therapy is that patients verbally process their emotions without realizing it versus daily psychotherapy, which can get repetitive.

I feel like one of the huge benefits of music therapy is that we're still doing verbal processing, but they don't realize that that's happening. And they are able to do a lot of emotional expression, which is one of the biggest goals for their other groups, but they don't realize that's happening until they take a step back, and they're like wow, I did a lot of this good processing and everything.

They just need a break sometimes, and to Sarah, “music therapy is the break without the real break.” Also, it is a chance for things to come out that might not otherwise.

In working with stress and depression patients at the drug and alcohol rehabilitation clinic, Sarah works on emotional expression and positive self-image by creating experiences that give patients the opportunity to be vulnerable. One example is karaoke. Karaoke is typically associated with a karaoke bar, so she creates a safe space for them to be vulnerable in the clinic.

Most of them have intense anxiety and fear about picking up a microphone and singing in front of their peers, but afterwards they feel amazing and alive. They realize they were able to be vulnerable in facing their fears, overcoming them, and ultimately succeeding. Through singing karaoke, they increased their self-esteem, self-confidence, and self-worth, alleviating symptoms of stress, depression, and anxiety. Songwriting, lyric analysis, and even karaoke are tools music therapists employ for patients suffering from stress, clinical depression, and anxiety.

5.2.1 The Family

Music therapists made the point that patients are not the only ones needing treatment for stress, depression, and anxiety. Family members are frequently and sometimes unavoidably impacted by the illness of a loved one, suffering stress, anxiety, and depression themselves. They care deeply, and it hurts to see a close family member struggling with a terminal illness or recent traumatic injury, learning to cope with a debilitating diagnosis. Sometimes a patient has a mental illness that causes him or her to be angry and violent, thereby causing the family to fear for his or her safety and the safety of others. Jamie gives the following example of an autistic patient.

This kid's nonverbal, playing in his own feces, self-injurious, violent, threatening to kill his family. I mean like, this is really really significant stuff going on. So the parents are depressed, and they have tons anxiety, and they're worried about their other kids and the siblings that aren't safe in the house with their child who they love but they hate at the time because their family is so bad, and they're nonverbal so they can't communicate. So there's all kinds of stress and anxiety going on within the family unit, and how that affects how they're learning and how they're behaving, seeking negative versus positive attention. So stress, anxiety, and depression is present in almost all of our families in some way, and almost all of our clients in some way, because they're dealing with some other issue, you know.

The parents are worried about their other children whose safety is now compromised. They love the child, but they are frustrated at the same time because he is unable to even communicate with them. This situation unsurprisingly causes depression and anxiety within the rest of the family.

Sarah describes working with the families of hospice patients who suffer from stress, depression, and anxiety, noting that though they are not patients themselves, she feels she is there

for them providing emotional support. Sometimes they are agitated or need comfort, and using the ISO Principle, she uses music to match their mood to calm them down and help them sleep.

Jennifer states some families go through a period of denial, grief, or anger.

But then you get [denial], and you also have the stage with the grief that our families deal with with a child that may be born with Down's syndrome, may be born with Cerebral Palsy. Those families, even though their child may not die, they have the stages of grief that they go through. So sometimes you get the angry parent, and you know they are just angry, and they've got to deal with knowing that their son is never going to run on a football field like they did. Their son is never going to do some of those things, and so then you've got to come at them and we just do it for love. I say girls, we got to bring them sunshine if they're grey, and show them what their child can do!

I can attest to the pain a family goes through when a loved one is suffering from a mental condition. My sister's mental illness has been emotionally very difficult for my mother and me. I feel a part of my sister has been lost, and in a sense, I mourn that loss.

5.2.2 *Mourning & Birth*

Pain and anxiety are described as largely psychological events, and music changes that perception (Hanser 1999:160). Music is used in loss and mourning, as death is another event that can create anxiety and depression. The fear and anxiety of death and finality causes people in Western societies to erect walls at a psychological cost (Sekeles 1999:186). Jamie's company works with Kate's Club in Atlanta, which helps children grieving the loss of a parent or sibling to gang violence, prostitution, or drug trafficking. The grief causes children to suffer from depression and anxiety, so Jamie works on emotion regulation and processing using music. Music therapists employ music as an alternative to verbal expression in creating personal rituals to alter perceptions, accept all life cycles, alleviate feelings of anxiety and helplessness, and work through death and loss (Sekeles 1999:186). This contrasts with other cultural uses of music to cope with death, as in cremation ceremonies in Bali, where death is celebrated to promote the memory of the dead and music is used to protect the soul (Bakan 2008:247).

Music therapy implemented for women in labor resulted in reduced anxiety and body tension, smoother childbirth, and less verbalization of pain and requests for pain medication through altering pain perception (Hanser 1999:160). The music therapist and patient listen to music and make note of responses and tempi, then create a “playlist” of personally significant music to play during birth (Hanser 1999:166). Calming music paired with deep relaxation and practice aided with anxiety and depression for women in labor as music cued the changed behavior. The pregnant women practiced breathing and relaxing exercises accompanied by selected music in preparation for delivery (Hanser 1999:163).

Both Jamie and Jennifer used music while giving birth with mixed results. Jamie made some “mellow playlists” that included Milk Carton Kids, Punch Brothers, and Nickel Creek. It was her first child, and she had to have a C-section. Her son was immediately taken away without her getting to hold him. Instead of a celebration, she remembers being very upset while the music played in the background, so it was not a good experience. Jennifer’s experience with music during birth also did not go as planned. Jennifer calls her second child her “very spirited child,” and there is a reason for that joke. Her playlist consisted of “chill music” like Nora Jones and Jack Johnson. She was pushing when the song dropped to the next track in the playlist ordered alphabetically, which was a song by Jamie Johnson, a hard country and rock metal mix that should not have been on the list. Jennifer stopped the birth demanding the track be fixed even though the baby was about to come out. Both her husband and the doctor thought she was kidding but she was serious. She was not going to have her child to Jamie Johnson. The joke is that “she must have heard Jamie Johnson because she came out ready to fight the world.”

5.3 Alzheimer's Disease

Music therapy is also used in treating Alzheimer's disease. Alzheimer's disease is the most common form of dementia impacting 4.5 million Americans, and this number will grow to 13.5 million by 2030 (Brummel-Smith 2008:185). Characteristics of the disease include wandering, forgetfulness, verbal attacks, hallucinations, and physical aggression. Medicaid covers most institutional care fees for long-term care. However, Medicaid and Medicare do not cover non-institutional fees, thereby shifting costs from the state to the individual (Brummel-Smith 2008:187). Medications are expensive and ineffective, and music therapy has proven effective in calming patients and memory recall. Music activates many areas of the brain improving function and allaying stress (Clair 2008:204). Cognitive function and music capabilities deteriorate as the disease progresses. Close relationships suffer as a result of Alzheimer's, and music therapy can restore meaningful interactions (Clair 2008:209). Again, music helps families that often suffer as result of the mental illness of a loved one.

In working with people with Alzheimer's disease, Kally utilizes reality orientation, while Jennifer helps her grandmother recall memories. Kally employs a technique with her Alzheimer's patients called reality orientation. Basically, if a patient thinks they live in a different time or place, she will orient to their reality.

So a lot of times with Alzheimer's and dementia, we work to help with reality orientation, so either helping to keep, like if they are oriented to a time and place, to help to sustain that, but if they're not, I mean our approach is that we don't try to correct them. Like if you were to sit here and tell me it's 1955 and your parents are getting ready to buy a house on a farm in South Carolina, I had a patient, like every time I saw her, well my parents are coming to get me soon, I'm getting out of here. She was never really getting [picked up]. Her parents were long gone. We go with that. It doesn't serve them any purpose to become agitated over us trying to tell them, well it's not 1955.

Kally says there are times when they orient to our time and reality through music. It pulls them from where they are and calms them if they are combative or irate. Jennifer cannot change her grandmother's Alzheimer's, but she can, for a moment, bring her back when she sings to her.

Her grandmother will stare at her eyes and begin singing, and in that moment, she perhaps recalls a more specific time and place. Music has the powerful effect of taking us to a specific memory in time. It seems clear that music's powerful connection to memories can bring someone back from the depths of their minds when they hear it, and they overcome the corrosive effects of Alzheimer's disease, even if only for a moment.

5.4 Physical Disabilities

The music therapists of this study commonly treat physical disabilities of patients in the Greater Atlanta area. Physical disorders treated include Cerebral Palsy, Parkinson's Disease, stroke, gross motor functioning, and muscular dystrophy. Kally has a patient who has difficulty crossing the midline, or reaching past the midline of her body. This is a condition I had never heard of, but it is something music therapy treats. During a session, Kally will intentionally place the instrument the patient wants to play on the left side of her body and probe her to use her right arm to reach past the midline of her body and grab the instrument. It is as though she is using the instrument and the music as the reward to reach goals without the patient realizing it. Jamie had a patient who suffered a traumatic brain injury in a car accident. She could no longer hold and draw her bow to play her violin because the right side of her body was weak from the injury. They made an adaptive cuff so she could hold the bow with her fist and play, and they continued adapting the cuff while strengthening her fingers so she could relearn to play. As music therapists, they knew the mechanics of how her hand needed to hold the cuff and were able to adapt the cuff to make it work for her.

Kally discusses the use of music in pain management as well. Kally suffers from ulcerative colitis and often has flares where her symptoms are heightened and it can be very painful. She listens to music to take her mind off the pain she is experiencing, but it needs to be

instrumental music because she finds music with voices distracting. She finds herself analyzing the words and ends up focusing once again on the pain. Instrumental music takes her mind off the pain. It seems to take her mind elsewhere, while words in the music bring her back to a place where she is experiencing pain. These are just a few of the uses of music therapy in treating physical illness.

This chapter began with a broad overview of illnesses and interventions before focusing on the not evident processing underlying music therapy. It did this by analyzing the role of music in healing as perceived by music therapists in the Metro Atlanta area. The role of music in therapy emphasizes holistic healing, community and interconnectedness, connection to memories, and mediation and facilitation of therapist-client interaction. Going beyond the mind-dichotomy and using music to facilitate the healing process are keys to the effectiveness of Music Therapy as practiced in Atlanta. This chapter explored music therapy interventions for stress, depression, and anxiety with patients, the family, and in the context of mourning and birth. This chapter then described the use of music therapy in treating Alzheimer's disease and various physical disabilities, sometimes due to traumatic injury or terminal illness.

6 MUSIC THERAPY ACCESS

This chapter discusses inequality in music therapy through an exploration of access to music therapy. It examines the socioeconomic and demographic makeup of patients in the Atlanta area, who has access to music therapy, and what factors impact this access, such as recent changes in the US healthcare system. The chapter then discusses deinstitutionalization of mental healthcare as a casualty of neoliberal and capitalist policies and agendas. Finally, this chapter will turn its attention to praxis solutions by discussing ways to make it more available to populations negatively affected by globalization that could benefit from integrative,

complementary, and alternative medicines. Potential solutions include gaining state regulation, general advocacy and education, restructuring insurance policies, and lobbying insurance companies to include using the University of Kentucky insurance model.

Atlanta has seen a recent expansion in the growth of Music Therapy, specifically in the area of pediatrics. As mentioned, Music Therapy is a relatively new field in therapeutic medicine. Music therapy in the US did not become prominent until after WWII and only gained legitimacy as a profession in the late 20th century with the development of the American Music Therapy Association in 1996 (Peters 2000). According to Jamie, Atlanta is a “hotbed” for music therapy, with the largest music therapy department school system in the state, twelve private practices, and departments in most hospitals. According to Kally, Music Therapy is growing every year with more people becoming board certified music therapists. Beth, who started the first music therapy clinic in Atlanta in 1998, agrees that private practices are growing, and she has “plenty of patients.” There are many ways people come to learn about music therapy and for information to get to populations that could benefit from music therapy.

Today, Music Therapy is becoming more common. CNN even did a report recently at Therabeat. According to the research participants, doctor or therapist referrals and word of mouth are very common ways of getting information out. Other venues for discovering music therapy include support groups, community groups, and social media, such as Facebook. Jamie states that within the disability community, the question is not what is music therapy, but “why don’t we have it?” It is not so much about educating as to what it is, but advocacy is still useful for disseminating knowledge. Kally comments that when they do wellness sessions for companies like Children’s Healthcare of Atlanta, part of the mission is spreading music therapy. Jamie does speaking engagements at community events, assisted living facilities, and other

companies. Through speaking events, Jamie gets referrals for individual clients. She gets additional referrals through contracts she has with private schools throughout Roswell, including Jacob's Ladder, Cottage School, Cumberland Academy, and the Academy at North Fulton. However, many of these new patients at The George Center are going to be of a higher socioeconomic status and pay out-of-pocket.

6.1 Demographic & Socioeconomic Makeup

This section seeks to explore the demographic and socioeconomic makeup of music therapy patients. Of the four clinics included in this study, I spoke with the owners of three. All clinics in this study are located north of Atlanta, and one clinic, Metro Music Therapy, is mostly mobile. This is the only clinic whose owner I did not interview. Sarah of Metro Music Therapy said her patients are majority White. Beth, owner of Music Therapy Services of Greater Atlanta in Roswell, noted that 75% of her patients are an even split between Black and White, with the other 25% being a mix of predominantly Indian, Hispanic, and Portuguese. She says her patients are largely representative of the Roswell area, and she feels she would see more Hispanic patients if she had a Spanish speaking therapist. Jennifer, owner of Therabeat in Canton, remarks most of her patients are White, some are Latino, and currently she only has three Black patients. Andrea at The George Center, also in Roswell, stated she sees predominantly White patients, and the rest are a mix of Black and Indian. It seems Therabeat in Canton has the least diverse population of patients according to the therapists. Jamie, the owner of The George Center, said her patient demographics depend on the environment or setting. If she is working with patients at a nonprofit organization, she sees more of a mix of races versus her private practice patients. No definitive conclusions can be made from this small sample of data, but it seems many different ethnicities receive music therapy in Atlanta.

Not only is music therapy marginal in terms of biomedicine (Foucault 1973) and gender (Hochschild 1983), but also it is marginal in terms of socioeconomic status. Music Therapy is not cheap. Jamie feels that unfortunately, the majority of music therapy patients at this time are private-pay and of a higher socioeconomic status. Many families simply cannot afford it. However, avenues for low-income patients to receive music therapy include nonprofit organizations, hospitals, and substance abuse clinics. For example, the hospice patients Kally and Sarah see are low-income patients, and music therapy is included in hospice care. The situation is complicated at the substance abuse clinic where Sarah works. The patients are broken into two groups: private-pay, which are majority White, and Medicaid, which are majority Black. Music therapy is included as part of the treatment program for private-pay patients only, and Sarah expresses her aggravation by stating:

And it's actually very frustrating, because like, it shouldn't be that way. If it's part of your program, it's part of your program. And why do private-pay people need music therapy and people who can't privately pay not need it? So it doesn't make any sense, but that is what's happening. It's extremely expensive, because rehab just is expensive.

Jennifer also expresses her sentiments regarding private-pay and reaching low-income populations, commenting:

So, then we have a lot of private-pay, and the thing that's frustrating for me as a business owner is the kids who I do want to reach, I can't reach, because I can't pay a therapist to go see them if they can't afford it. But that is one of those heart-wrenching things for me.

The majority of her patients are private-pay, and it is frustrating for her as a business owner that on the one hand, she wants to help people, but on the other hand, she has to run a business.

Beth suspects the large majority of music therapy clients have money. But, she believes the next major recipients are poorer, because the government pays for it through programs such as Babies Can't Wait or government waivers. Beth worked with Babies Can't Wait patients for twelve years and got to see "awesome families and awesome patients" that were appreciative of her services, but the program lost funding and is not what it used to be. Jennifer stays in Babies

Can't Wait only to reach families unreachable through other means. It seems that unless a client receives treatment in a hospital or through a government program, more often than not, they must pay out of pocket, making all but those at the high end of the socioeconomic ladder unable to pay for music therapy. However, this trend is not new. The deinstitutionalization of psychological care has shifted responsibility of costs from states to individuals for many years.

6.2 Neoliberalism & Deinstitutionalization

Not only do neoliberal agendas and policies shape poverty, inequality, and mental diseases, but they also shift psychological treatments from the state to individuals. During the 18th century reorganization of the clinic, governments became acutely aware that the health of the state depended on the health of individuals (Foucault 1973). Epidemics are collective, and a complex method for multiple observations and crosschecking was required to discover the root cause of epidemics, and this form of investigation was being institutionalized. Medical knowledge became politicized with the establishment of state health regulations providing information and supervision (Foucault 1973:25). States were not just concerned with healing the sick, but embraced the knowledge of the “healthy man,” and used this knowledge not only to advise citizens on health, but also to dictate policies, standards, and morals of health to society (Foucault 1973:34). Illness histories became necessary medical knowledge in education regarding potential disease threats. A mutually beneficial relationship developed between the wealthy and the poor. By helping the poor, the wealthy create a greater library of illnesses that may affect them (Foucault 1973:84). There is a “spontaneous and deeply rooted convergence between the requirements of *political ideology* and those of *medical technology*,” (Foucault 1973:38). The priorities of medicine became the priorities of states, and all obstacles preventing

the formation of centralized medical knowledge were removed. Medicine became free, but only for a short period.

In recent decades, state health care has become deinstitutionalized. Health services have transitioned from the state to profit-driven industries where individuals are responsible for footing the cost. Deinstitutionalization began in the 1960s when psychiatric hospitals and asylums released patients to community treatment centers resulting in numerous problems. Centers could not accommodate the number of patients, states refused to allocate funds to mental health centers or provide services for the chronically mentally ill, and patients could not navigate psychological, social, and financial difficulties of living alone or with groups, leaving former patients destitute and homeless (Desjarlais 1997:30). In the past, they would have been cared for in a mental and psychiatric hospitals, but now they are outpatients if lucky. Mentally ill people have more difficulty securing low-cost housing, finding employment, have poorer physical health, and little friends or family when compared to other homeless people (Desjarlais 1997:31). These centers were temporary and never able to implement adequate psychiatric services for patients (Desjarlais 1997:34). Through deinstitutionalization, the mentally ill have little access to adequate services such as psychological care, much less music therapy. Additionally, the marginalization of music therapy from biomedicine further limits access to music therapy.

6.3 Insurance, Waivers, & Grants

Insurance, waivers, and grants create avenues and obstacles to music therapy. According to Jamie, only the best insurance plans will pay for music therapy and benefits for many of her families have gotten worse under the Affordable Care Act. Families that formerly had a deductible of \$2,000 now have one for \$10,000. Jamie questions, “what’s the point of having insurance, because you can’t afford \$10,000 out of pocket?” Patients are forced to pay for a plan

they will never use, and Jamie notes 50 to 60% of her clients have seen deductibles skyrocket.

When asked if insurance companies cover music therapy, Jennifer explains:

Some insurance companies do, as long as there's not an exclusion. Some plans will say we won't cover, but thanks to Obamacare, now insurance deductibles are so high that even if the insurance will cover it, sometimes it's not an option for the family because they have a \$10,000 deductible, so it's unrealistic to ever meet that deductible to get your insurance to meet.

It seems for universal healthcare, society must shoulder additional costs, which can be viewed as a further example of deinstitutionalization in shifting these costs. Beth notes music therapy usually has to be covered under a separate policy, which provides further evidence of music therapy's marginalization from biomedicine. Kally and Sarah both remark that Medicaid and Medicare, insurance for low-income and older individuals, respectively, generally do not cover music therapy, highlighting the socioeconomic exclusivity of music therapy. Jennifer confirms, stating the only way Medicaid will cover music therapy is through a waiver. She treats between eight and ten patients who pay using a waiver.

During the 18th century, medical knowledge became free in the interest of the state, and neoliberal policies deinstitutionalized mental healthcare in the 1960s (Foucault 1973, Desjarlais 1997). Medical discourse changed focusing on treating visible disease in the body (Foucault 1973). Insurance does not cover music therapy in part because of deinstitutionalization, and in part because it is on the fringe of biomedicine. Treating the mind with music is not a "necessity," and therefore insurance companies do not reimburse costs. Psychotherapy and other mental health treatments such as music therapy are provided to low-income people only in certain contexts such as hospitals and substance abuse clinics. But even in Sarah's case, her substance abuse patients are split between those who are private-pay and can afford it, and those who have Medicaid and cannot.

Though insurance is limited, music therapy can be made more available to those who could use it. Various alternatives include waivers, grants, scholarships, and nonprofits. Nonprofit organizations such as Georgia Community Support and Solutions and Alchemy Sky provide funds for music therapy for low-income people. In discussing access for low-income populations, Jamie states, “we would all agree as a profession these are the groups in highest need.” Alchemy Sky pays for music therapists to provide treatment at VA hospitals and homeless shelters. Beth points out waivers are government money. She says many people think Georgia Community Support and Solutions awards grants, but it is usually government waivers. They dole money out to individuals and take a small cut. Kally and Andrea also have clients that pay for music therapy with funds from Georgia Community and Support Solutions.

Grants and scholarships are private companies or entities giving money. Grants are often given to nonprofit organizations, so Beth cannot utilize grants because she is for profit. Beth has a contract with a deaf and blind school, and she applies for grants through the school for music therapy. Hospitals also receive grant money for music therapy. Kally interned at a hospital where all the music therapy programs were funded by grants donated by families. Individuals that see the value of music in healing can give money obtained through fundraisers to hospitals. One of the main problems with grants and scholarships is that those who could benefit the most from the funds are usually the least likely to seek them out and apply for them.

Jennifer gives her Babies Can’t Wait patients, i.e. her low-income patients that receive government funds for music therapy, all the grant information they need. They have worksheets that instruct them on how to apply for the grants. However, her higher education and higher income patients are the ones she sees applying for grants, which are not the people grants are

“designed for.” When questioned about which patients Jamie sees applying for grants and scholarships, she explains:

So the upper class, they won't get approved for them, because typically to get a grant or scholarship for something like this, you have to prove financial necessity, and they aren't going to get approved for it because they're making enough money they can pay for it out-of-pocket or their insurance or whatever. We find that lower socioeconomic groups either don't have the resources or aren't educated enough on the resources to go out and find them. So these families are not getting online and Googling to find out what's available to me in getting funding sources, even though they're the ones that can use it the most. And there are many reasons. Sometimes it's education, sometimes it's just access.

Jamie states that this is why her middle class clients are the ones who receive grants and scholarships. Her upper class clients cannot prove financial necessity, and her lower class clients do not have the resources to go out and find grants and scholarships.

Despite little direct access to grants, low-income families still receive music therapy through donated services to nonprofits. Not only do nonprofits fund music therapy services, they are also the recipients of music therapists donated services. Jamie has interns that provide music therapy to Stark House, a nonprofit afterschool program for English as a Second Language and low-income households in Roswell. They also work with the nonprofit organization called Kate's Club, which helps children grieving the loss of a family member to gang violence, drug trafficking, or prostitution. Though grants and scholarships are usually awarded to middle class groups, waivers and nonprofits are available to lower class populations.

6.4 Lobbying for State Regulation

Though music therapy is a growing option for people seeking complementary or alternative treatment, and there are opportunities for funding for low-income populations such as waivers, grants, and scholarships, there are still roadblocks and hurdles requiring solutions to make music therapy more accessible. As Jamie states, every population “from birth to death” can benefit from music therapy. While many find out through doctor referrals, Kally notes, “I think other healthcare professionals is one of our biggest hurdles. Not that a lot of them are disagreeing

with it, but I just think it takes a lot of convincing.” Here is another example of the need to legitimate music therapy to skeptics. Even doctors require convincing in the face of studies that point to benefits of music therapy because it does not fit the mold of mainstream biomedical discourse (Foucault 1973). Doctors are not the only ones that require convincing. In order to affect real change and create access through private and state insurance, policymakers and state legislators must also be convinced.

Legitimation creates a double-edged sword for the research participants. On the one hand, music therapists emphasize mind-body connectedness and spiritual healing in music therapy. On the other hand, they must present hard data that documents improvements in health to participate in a culture that places a premium on biomedicine and visual healing in order to qualify for insurance and to receive accreditation. In Western capitalist societies, insurance companies and policymakers typically do not cover or advocate therapies that embrace mind-body or spiritual healing. Also, proving psychological improvements can be difficult. As such, the practice has had to adjust to a biomedical model of medicine driven by data. For example, when a patient performs correctly during sessions, music therapists must precisely count, record, and log the outcomes. Music therapists are even careful about the terminology used to describe music therapy. For example, Jennifer makes it clear that treatments are called “interventions” and not “activities” to make the terminology more clinical, and hence, more legitimate. Though music therapists feel the spiritual healing aspect of music therapy is essential, they need this hard data as evidence of its effectiveness in order to gain insurance coverage and accreditation for state licensure in a biomedical culture.

Beth wonders why patients and parents do not have more control over how to allocate insurance funds for therapy. For example, many insurance plans automatically cover physical

therapy (PT), occupational therapy (OT), and speech therapy, even if the patient does not need it or would be better suited to receive music therapy or horseback riding. Beth speculates these therapies are covered while other are not because they had good lobbyist or “played the game better.” If we pay for the insurance, we should get to decide what is best for us. Jennifer emphasizes an example in Kentucky other states should follow. The University of Kentucky program covers music therapy in addition to PT, OT, and speech therapy. UK recognized the benefits of music therapy, and they saw it was less expensive by decreasing the need for more expensive therapies or pharmaceuticals. By presenting this data to Blue Cross Blue Shield, the insurance company for UK, they wrote music therapy into their plan, while BCBS in Georgia and other state plans do not cover music therapy. In fact, when Georgia’s state plan switched from United Healthcare to BCBS, there was a large decrease in insurance reimbursement for music therapy. Under Western biomedical models, access to funds revolves around hard data. Since it is difficult to statistically show psychological improvement, following the UK model is a good option. By proving to policymakers that music therapy is effective *and* less expensive than more “traditional therapies” using hard data, BCBS was convinced and the UK program rewrote its plan. Sarah agrees that hard data would help with funding and coverage. They are currently using data showing the benefits of music therapy to setup programs in hospital NCUs.

Barring the UK example, it is nearly impossible to mobilize major changes within insurance companies since they are private and complicated. However, one of the most effective ways to create more access would be to lobby state governments for state regulation, which would create access to more funding and more quality services. Jamie states there is a joint effort between the American Music Therapy Association and the Certification Board for Music Therapists to pass legislature for state licensure in every state. Currently, there are five states that

have state regulation. Jamie is on the task force for the state of Georgia, which was the third state to pass legislation for state licensure two years ago, and there are grassroots task forces in every state. This means in order to practice music therapy, an individual must not only be certified by the National Board Certification, he or she must also be licensed by the state. This has two major implications for patients: access to quality services and access to state funds and reimbursement when it comes to insurance.

First, when the state regulates Music Therapy through state licenses, they are ensuring those practicing music therapy are board certified music therapists. Without regulation, anybody can claim to be a music therapist but not actually be certified with proper training, which is necessary for working with at risk populations, such as emotionally behavior disturbed children or those in the dying process. Foucault (1973) demonstrated how medicine became politicized, which may explain why today we feel licensure and certification with professional organizations means music therapy is more valid, legitimate, and acceptable in this country. Second, state funds and insurance reimbursements will become available meaning access for low-income individuals will increase. National insurance companies, such as United Healthcare and Aetna, do not require state licensure, so these plans can cover music therapy. However, BCBS is a state plan. In order to bill Medicaid, Medicare, or any other state specific insurance plane, music therapists must be licensed. Once licensed, music therapists can apply for Medicaid and Medicare coverage. If approved, low-income individuals with Medicaid and Medicare insurance will have more access to music therapy. If every state passes legislation for state regulation of state licensure, low-income populations will have access to integrative, complementary, and alternative medicines such as music therapy.

Exploring the recent growth of music therapy in Metro Atlanta, this chapter discussed the socioeconomic and demographic makeup of a limited sample. It examined the creation of “free medicine” through the politicization of medical knowledge and its institutionalization. This was followed by the deinstitutionalization of healthcare, i.e. the way neoliberal policies and agendas shifted responsibility of psychological care from the state to the individual creating problems in funding and access to music therapy. This chapter then discussed various avenues and obstacles to accessing music therapy, which includes insurance, waivers, grants, and nonprofits, and the ways Music Therapy has had to adjust to incorporate biomedical discourse and practices in order to qualify for insurance coverage and accreditation for state licensure. Finally, this chapter explored praxis solutions for creating more access to music therapy for low-income populations by either following the University of Kentucky model or through state regulation for access to quality services and more funding.

7 CONCLUSIONS

This thesis explores music therapy as a cultural practice in the United States. It relies on previously published research, synthesizes a number of topics in the anthropological literature, and combines this research with data from an ethnographic study of ten music therapists in Greater Atlanta to come to its conclusions. This thesis employs the theories of medical pluralism and embodiment in examining the ways music therapy is at the fringe of the Western biomedical model in rejecting the mind-body dichotomy. It is concerned with the ways medical discourse and neoliberal policies impact illness and access to ICAM such as music therapy. Medical discourse on biomedicine helps in understanding the marginalization of music therapy, efforts by music therapists to justify it as a legitimate form of healing, and who has access to this alternative healing method. Music therapists are in a difficult position in that they seek to

emphasize mind-body connectedness and spiritual healing in music therapy in a culture that places a premium on biomedicine in order to qualify for insurance and accreditation. Despite obstacles presented by biomedical discourse and the neoliberal conditions of structural violence and deinstitutionalization, music therapy is expanding in the US for those seeking alternatives to traditional psychotherapeutic treatments. This thesis analyzes theories that underlay the study, presents an ethnography of music therapists, and offers praxis solutions in seeking to further access for low-income populations.

The thesis begins with medical pluralism as a foundational theory that informs this study in recognizing multiple frameworks for illness and healing. Medical ethnomusicology is explored in the context of medical pluralism in examining the role of narrative and music used in cross-cultural healing rituals. It examines the development of the clinic and the history of Music Therapy as a professional discipline in the US. This is followed by a discussion of embodiment, a theory that dismisses the mind-body dichotomy and helps in understanding music therapy as a cultural system of healing beyond the realm of Western biomedicine. It then analyzes music, including the narrative within music, common in cultural healing practices around the world. In linking illness to inequality, this thesis examines the impact of neoliberalism and structural violence on poverty, disease, and access to music therapy. The ethnography of the thesis is then interested in music therapy in US contexts as a treatment option for mental and physical diseases, often due to structural violence, and the ways medical discourse and neoliberal policies impact this treatment option.

The next phase of the thesis provides research methods and background information. It analyzes the research questions, methods, and objectives. The study asks the following questions: What brought Atlanta music therapists into the profession? What mental and physical

disorders do music therapists treat, and what methods and techniques do they employ? What is the role of music in healing? Who has access to music therapy, and how do historical and cultural factors impact this access? How does discourse surrounding Western biomedicine impact access to music therapy? The thesis answers these questions utilizing interviews and participant observation with music therapists. The research objective is to understand the cultural practice of music therapy in the US and how the music therapists treat mental and physical diseases of Atlanta patients using music. The thesis places myself in the study by providing my background information. My early connection to the power of music, musicianship, and family illness experiences lay the foundation for my interest in the areas of ethnomusicology, medical anthropology, and psychological anthropology.

This thesis discusses the field research, which took place in Atlanta from June to October 2015. Semi-structured interviews and analysis of interview data were the anthropological methods utilized. A total of ten music therapists were interviewed representing four clinics, and patients were not included in the study. All of the therapists knew they wanted a career that incorporated music for two reasons: they had musical backgrounds and many were exposed to music therapy early in life through personal illness experiences, which created firm believers in the power of music in healing. However, the research participants feel they must constantly legitimate music therapy to skeptics who see it as “hippy” medicine. Music therapy emphasizes mind-body healing in a culture fixated on biomedicine, and the music therapists grapple with integrating these two perspectives to legitimate the practice. Embodiment further aids in explaining music therapy as a cultural system of healing. The thesis then reviews the social construction of mental illnesses and the methods and techniques used for intervention in mental

and physical illnesses. The focus of this thesis, and by extension the goal of this study, is to examine anthropological perspectives of music therapy.

The thesis discusses specific illnesses and interventions. From the outset of the research, I incorrectly assumed many of the patients would seek treatment for depression given that 9.5% of the US population suffers from depression. However, I learned music therapy is used to treat a wide range of both mental and physical diseases, from Autism to Alzheimer's to Cerebral Palsy. However, the purpose of this study is neither to explain every illness treated by music therapy, nor every possible intervention for treatment. This study is interested in the underlying and not immediately evident process taking place in music therapy in examining the role of music in healing. According to the music therapists, the role of music in healing focuses on mind-body connectedness, unifying communities, connecting to memories, and facilitating and mediating the interaction between therapist and patient. Music therapy uses music to go beyond the mind-body dichotomy in facilitating the healing process. The thesis then explores music therapy in treatment interventions for stress, depression, and anxiety with patients, the family, and within mourning and birth. Songwriting and lyric analysis are effective interventions that help make sense of traumatic illness that disrupts normal life, alleviating symptoms of stress, depression, and anxiety. It also discusses music used to treat Alzheimer's disease and various physical disabilities due to traumatic injury or terminal illness.

Finally, the study analyzes trends in music therapy in addition to the socioeconomic and demographic makeup of patients in the Metro Atlanta area. It discusses the politicization and institutionalization of medicine in the 18th century that liberated truth in medical discourse freeing medical knowledge. This was followed by the deinstitutionalization of mental healthcare in the 1960s that shifted psychological care from states to individuals. The deinstitutionalization

of mental healthcare, in addition to the marginalization of music therapy due to biomedical discourse, has impacted access to music therapy. Deinstitutionalization continues today with insurance deductibles so astronomical that patients have no incentive to seek alternative treatments, and marginalization exists by the fact that separate policies are required to access music therapy. Avenues for accessing music therapy exist, including waivers, grants, and scholarships. However, in order to qualify for insurance coverage and accreditation for state licensure, music therapist must reconcile mind-body connectedness and spiritual healing in music therapy with the biomedical model of modern medicine. This has altered the practice of music therapy in terms of meticulously documenting therapeutic outcomes and changing clinical terminology from words like “activities” to “interventions.” The thesis then explores praxis solutions for creating further access to low-income populations, including more patient agency in deciding how to allocate insurance funds, general education and advocacy, state regulation, and lobbying insurance companies to include Music Therapy using the University of Kentucky insurance policy as a model.

In conclusion, clinical discourse on biomedicine and deinstitutionalization both have implications for access to music therapy today. When discourse shifted to treating visible disease, little weight was given to mind-body healing methods. This partly explains why medicines such as music therapy are on the fringe of Western biomedicine today, creating barriers to access. Deinstitutionalization further limits access in shifting responsibility of healthcare options from the state to individuals. It is difficult to demonstrate mental healing or provide “hard data” as results are often not visible versus seeing physical healing of an injury. Therefore, music therapists must constantly legitimate and justify mind-body healing in music therapy to doctors, skeptics, and insurance companies that may view music therapy as “hippy

medicine.” At the same time, they have had to alter the practice to focusing on hard data that demonstrates improvements in health in order to participate in a culture that places high value in the biomedical model. Insurance companies do not see validity in mental healthcare in part due to the history of clinical discourse in Western biomedicine. However, by following the UK insurance model, insurance companies may see the value of music healing through hard data that shows music therapy is effective *and* less expensive than many traditional therapies.

Finally, this thesis analyzed the marginalization of Music Therapy in terms of Western discourses on biomedicine, occupational gender in the field, and socioeconomic status. Additionally, various ways neoliberal policies facilitate deinstitutionalization and structural violence are discussed throughout this thesis. One concern of the study is that those most impacted by neoliberalism would have the least access to music therapy, which often treats disease highly correlated with inequality and poverty due to structural violence. The study concludes that conversely, some opportunities do exist for low-income people to receive this treatment option. Modeling insurance policies after the UK plan, in addition to lobbying for state regulation, will create further access for low-income populations that could use this alternate and complementary form of mind-body healing.

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