The Role of Music Therapy in Developing Healthy Coping Skills for Adolescents Experiencing Eating Disorders: A Philosophical Inquiry

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ABSTRACT

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As music therapy services continue to become more accessible, music therapists are working with a wider range of clientele with specific needs. Adolescents experiencing eating disorders (AEED) are among those with whom music therapists work to provide support throughout the treatment process. The purpose of this philosophical inquiry was to synthesize existing knowledge and evidence to substantiate the argument that music therapy (as realized within three categories of experience) is an ideal way to support the development of healthy coping skills for adolescents experiencing eating disorders. The methodology involved clarifying the research terms, exposing and evaluating underlying assumptions, relating ideas as systematic theory, and using argument as a primary mode of inquiry. The findings discussed how adolescents engage with music, current approaches in music therapy for the targeted clientele, and considerations for music therapists working with AEED. The findings confirm that music therapy can be a valuable resource for AEED, providing a space to reflect on coping patterns through composition, improvisation, and receptive music therapy experiences.

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Table of Contents

List of Tables

Chapter 1: Introduction

Significance and Need

As music therapy services continue to become more accessible, music therapists are working with a wider range of clientele with specific needs (Heiderscheit et al., 2015). Adolescents experiencing eating disorders (AEED) are among those with whom music therapists work to provide support. Eating disorder diagnoses are determined by medical professionals based on the characteristics outlined in the fifth Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2022). There are several subtypes of eating disorders, each with its diagnostic criteria based on behavioral and physiological factors. These characteristics pertain to weight gain or loss, persistent eating patterns, and behaviors that substantially impact an individual's weight. Although each individual is diagnosed primarily based on physiological symptoms, the development of an eating disorder often begins with psychological factors (Wagener & Much, 2010).

The prevalence of eating disorders in adolescents is an ongoing challenge in Western society, with occurrences of diagnoses having increased over the past 50 years (Treasure, 2020). In fact, eating disorders are experienced by 5-10% of adolescents with more than 50% of those diagnosed experiencing the disorder for more than five years (Treasure, 2020). Statistics also indicate that adolescents are disproportionately affected by eating disorders, with the diagnostic stage typically appearing during the adolescent years (Treasure, 2005).

Psychological symptoms of eating disorders can include cognitive rigidity (Wang et al., 2021), perfectionism (Drieberg et al., 2019), negative self-image, and negative identity formation (Mantilla et al., 2014). The Canadian Psychological Association (2015) states that “eating disorder behaviors typically occur when an underlying struggle (e.g., emotional, interpersonal, or life challenge) exceeds an individual's capacity to cope.” (Canadian Psychological Association, 2015, What psychological approaches are used to treat the eating disorders section, para. 1). For this reason, eating disorders are considered coping mechanisms themselves (Wagener & Much, 2010). Disordered eating behaviours may form to cope with stressors, to gain a sense of control in an unpredictable environment, and to “avoid painful emotions” (Canadian Psychological Association, 2015, What psychological approaches are used to treat the eating disorders section, para 1.). The

literature suggests that participant focused treatment with an emphasis on healthy coping skills may be a helpful way to support AEED in mitigating maladaptive coping behaviours (Wagener & Much, 2010). Despite an increase in literature, there remains a gap between what is known about eating disorders and the support that is being offered to individuals living with eating disorders (Kazdin & Wilfrey, 2017).

It has been acknowledged throughout North American healthcare research that there is inconsistent knowledge about best practices when treating eating disorders (CPHC, 2014). This may manifest in a lack of treatment options and a scarcity of support in smaller regions. This was the focus of a Canadian study on eating disorder care in New Brunswick (Wilson & Weaver, 2019). Eight healthcare professionals were interviewed and voiced their concerns about the healthcare system and how many professionals do not receive adequate training to work with this clientele. Participants of the study explained that because of a lack of training and interprofessional work, patients are often left to help themselves and develop their own methods to manage their eating disorder (Wilson & Weaver, 2019).

Current mental health supports for AEED include a focus on empowerment, identity formation, self-esteem, and the development of healthy coping skills (Bibb & McFerran, 2019; Ceccato and Roveran, 2022; Heiderscheit et al., 2015; Wang et al., 2021). Medical treatment for AEED includes monitoring on an in-patient and/or outpatient basis and the stabilization of eating behaviors through cognitive and pharmacological therapies (Hay, 2020). The following section explores how music therapy has been used in conjunction with current approaches for AEED and indicates how music therapy may be considered as an important component of a comprehensive care plan.

Relevance to Music Therapy

The literature surrounding music therapy and adolescents experiencing eating disorders has been steadily increasing over the years with a focus on empowerment and identity related goals (Heiderscheit et al., 2015). Eating disorders have several psychological pre-diagnosis factors that often correlate with the later physiological signs needed for a formal eating disorder diagnosis. Some of these psychological factors include anxiety and negative self-perception which are further exacerbated by a low presence or lack of healthy coping skills (Wang et al., 2021).

Creative arts therapists have been building a reputation for providing support for those who do not feel comfortable in traditional therapies such as talk therapy (Heiderscheit et al., 2015) which is demonstrated by growing adolescent participation rates in creative arts-based therapies. Frisch (2006), for example, observed higher participation rates in eating disorder treatment programs that included creative arts-based therapies. Further exploration of the potential of music therapy with AEED could help to situate profession within standard care for the clientele.

The emotional and psychological efficacy of music makes it an ideal way for adolescents to explore their identity and creativity, however, it is also important to acknowledge the complex relationship one can have with music as it holds the potential to reinforce feelings of anxiety or facilitate rumination (i.e., dwelling on negative thoughts and emotion) (McFerran & Saarikallio, 2014). This highlights the importance of exploring the purposeful use of music within a music therapy context, particularly for AEED, where developing healthy means of coping plays an important role in the therapeutic process.

The literature examines how music therapy that utilises composition and songwriting, improvisation, and receptive music therapy experiences can support psychosocial goals for AEED (Pasiali et al., 2020). Pasiali et. al, (2020) found that music therapy can promote social engagement, facilitate emotional expression, and support healthy coping behaviours for eating disorders through active music making and listening. The study additionally highlighted the potential for group music therapy to support anxiety reduction. Bibb and McFerran (2019) similarly found that music therapy programming had significantly decreased post-meal anxiety in participants.

Clinical case studies make up most of the literature regarding music therapy for adolescents in eating disorder treatment (Heiderscheit et al., 2015). While these case studies provide important practical information, there is a need for further research that consolidates existing knowledge about music therapy for adolescents living with eating disorders. This could not only strengthen the case for its application within this population, but also identify gaps in knowledge that could be addressed by further research.

Personal Relationship to the Topic

Growing up in a small town, music played a significant role in emotional regulation and expression throughout my adolescence. I experienced my identity as being shaped by music, and coming from a Canadian province that has a vibrant musical culture, I had the opportunity to be

involved in many community-music based groups which positively impacted my sense of self. Disordered eating was something I struggled with throughout my adolescence. I believe this developed to help me cope with environmental stressors and was exacerbated by a lack of mental healthcare support in my community. Upon reflection, I have realized that I often used music to cope with environmental stressors as well. For me, songwriting was an important means of self-expression. I think this was a way for me to communicate with others and work through complex emotions. Because music played such a significant role in emotional expression, I think having access to music therapy services would have helped me better understand the positive impact songwriting had on my mental health. Because of my personal experiences as an adolescent with disordered eating, I decided to focus this philosophical inquiry on why music therapy is an important tool to support the development of healthy coping skills in adolescents experiencing eating disorders.

Statement of Purpose

The purpose of this philosophical inquiry was to synthesize existing knowledge and evidence to substantiate the argument that music therapy (as realized within three overarching types of music experiences) is an ideal way to support the development of healthy coping skills for adolescents experiencing eating disorders.

Research Questions

The primary research question was: Why is music therapy that focuses on the development of healthy coping skills an important component of a comprehensive care plan for adolescents who are being treated for eating disorders? The subsidiary research questions were: (1) What are the unique needs of adolescents experiencing eating disorders? (2) How can overarching categories of music therapy experiences (improvisation, song writing and composition, and receptive music therapy experiences[1]) support the development of healthy coping skills to address these needs in constructive ways?

Key Terms

Music Therapy

[1] See chapter 4 for definitions of improvisation, song writing and composition, and receptive music therapy experiences.

Music therapy is the safe and ethical use of music to address human needs within cognitive, communicative, emotional, musical, physical, social, and spiritual domains (CAMT, 2020). In Canada, music therapy sessions must be conducted by certified music therapists who hold a bachelor's degree or higher in the field of music therapy and are professional members in good standing with the Canadian Association of Music Therapists (CAMT). Music therapists work within a wide variety of clinical and educational contexts and situate their work in a variety of theoretical approaches. Music therapy sessions may be conducted on a group or individual basis depending on the context and/or individuals' needs (CAMT, 2020).

Adolescent

An adolescent is a person who is between the ages of 10-19 (WHO, 2022).

Healthy Coping Skills

Healthy coping skills are those that can be developed over time to help maintain emotional equilibrium through perceived positive experiences that may counter a perceived negative experience (Fitzsimmons & Bardone-Cone, 2010). The use of healthy coping skills for people living with an eating disorder may lead to healthier and more flexible methods of problem solving (Fitzsimmons & Bardone-Cone, 2010). The distinction of *healthy* coping skills refers to coping skills that work to improve the individual's situation/perception, vs. negative coping skills, which may pose potential harm to the individual.

Eating Disorders

Eating disorders are unhealthy and persistent eating habits that pose a threat to the well-being of the individual (American Psychiatric Association, 2022). Examples of eating disorders include anorexia nervosa, bulimia nervosa, and binge-eating disorder (APA, 2022).

Assumptions

The researcher assumed that music therapy that focuses on the development of healthy coping skills is an ideal approach to the treatment of adolescents with eating disorders. It was assumed that adolescents have intricate and unique relationships with music consumption and playing.

Summary of Chapters

Chapter 1 outlines the significance and need for this research, the research questions, and the purpose of this philosophical inquiry. Chapter 2 articulates the methodological approach used, which outlines the design, materials, data collection process/procedures, and ethical considerations. Chapter 3 identifies the literature relevant to the research question and subsidiary research questions. Chapter 4 explores how composition and songwriting, improvisation, and receptive music therapy can address these areas of need for AEED. Chapter 5 discusses the implications for future practice and research for AEED.

Chapter 2: Methodology

The current chapter outlines how a philosophical inquiry design was used to substantiate the argument that the use of composition, improvisation, and receptive music therapy experiences is an ideal way to support the development of healthy coping skills as part of the recovery process of adolescents with eating disorders. The chapter also presents materials, delimitations, data collection procedures, data analysis procedures, and ethical considerations.

Design

A philosophical inquiry utilises a philosophical approach to analyze and contextualize research, theory, and practice (Aigen, 2005). Aigen (2005) outlines the methods of the *Anglo-American Philosophy* approach as the process of clarifying the research terms, "exposing and evaluating underlying assumptions...relating ideas as systematic theory [and]...using argument as a primary mode of inquiry" (Aigen, 2005, p. 527). This philosophical inquiry's design is realized within an *Anglo-American Philosophy* approach to best address the research question (Stige & Strand, 2016).

Materials

To answer the research question, the researcher compiled relevant literature from music therapy and adjacent fields, as well as research that focused on adolescents, eating disorders, and diagnoses that are co-morbid with eating disorders. Further materials included hard copy textbooks and a computer for accessing and organizing online databases and publications.

Delimitations

Data sources were delimited to literature published in the English language between 1998-2023. Research on AEED and music therapy is limited, necessitating a large publication date span of data sources. The research timeline was delimited by the short duration of the student researcher's master's degree. No participants were involved in this study.

Data Collection

In accordance with the *Anglo-American Philosophy,* data collection included relevant scholarly books, peer reviewed journals, articles, and case studies. This included resources on eating disorders, music therapy, adolescents, and interdisciplinary research. Keyword search terms included: music therapy, coping skills, adolescents, eating disorder, eating disorder treatment,

adolescents and music, adolescents and eating disorders. These keywords were used in various combinations using various search engines: Concordia University's online library database Sofia, Google Scholar, ProQuest and PsychInfo. Music therapy journals were also searched, and these included: *Canadian Journal of Music Therapy, British Journal of Music Therapy, Nordic Journal of Music Therapy, The Journal of Creative Arts Therapies, Music Therapy Perspectives* and *Voices: A World Forum for Music Therapy.* Journals from related fields included: *Canadian Journal of Psychiatry, Journal of Eating Disorders* and *The Arts in Psychotherapy.* Relevant textbooks that served as sources of data included: *Creative arts therapies and clients with eating disorders* (Heiderscheit et al., 2015), *Music Therapy Handbook* (Wheeler et al., 2015) and *Statistical Manual of Mental Disorders* (APA, 2020). Zotero (reference management software) was initially used to organize the data, which was then placed in an excel spreadsheet and categorized by: title, author(s), year, discipline, methodology, notes, and central theme(s).

Data Analysis Procedures

To analyze the data in accordance with the *Anglo-American Philosophy* approach, the researcher first clarified the research terms within the research question. To expose and evaluate underlying assumptions, the researcher kept a personal journal to record her thoughts and reflections throughout the research process. To relate ideas as systematic theory, the researcher used an excel spreadsheet to review the literature and draw connections. To answer the primary and subsidiary research questions the researcher used argument as a primary mode of inquiry. The researcher organized the paper by common themes throughout the literature, including composition, improvisation and recreative music therapy experiences.

Ethical Considerations

It is important to consider that the literature reviewed, as well as the researcher's philosophical stance, are influenced by and grounded in Western culture. The scope of eating disorder symptoms and causes was defined from a Western point of view and did not consider how these diagnoses are conceptualized and supported within different cultural contexts. Due to the researcher's personal relationship to the research topic, the researcher kept a separate reflection journal to process her thoughts and feelings towards the research.

Chapter 3: Literature Review

This chapter provides foundational information on eating disorder diagnoses. The chapter includes common psychological co-morbidities, symptoms, and current psychosocial and behavioural treatments. Factors contributing to eating disorders from childhood to adulthood are examined as well as how eating disorders are a form of coping.

Understanding Eating Disorders

The term *eating disorder* is a broad label used to define several types of eating and feeding disorders. The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) characterizes eating disorders based on categories of differing criteria, each surrounding unhealthy and persistent eating behaviors that pose a threat to the well-being of the individual (American Psychiatric Association, 2022). Sub-categories of eating disorders include anorexia nervosa (AN), bulimia nervosa (BN), binge-eating disorder (BED), other specified feeding and eating disorder (OSFED), avoidant restrictive food intake disorder (ARFID), pica (the consumption of non-food items), and rumination disorder (American Psychiatric Association, 2022). Each eating disorder diagnosis has a unique set of characteristics and behavioural requirements that must be met for a diagnosis to be made (see table 1.).

Table 1. Overview of Eating Disorders

Eating Disorder Diagnosis	Diagnostic characteristics	Common psychological co-morbidities	Current Psychosocial and Behavioural Treatments	References
Anorexia Nervosa (AN)	Intense fear of gaining weight, to a point which impacts the individual's quality of life self-starvation, leading to significant weight-loss within the context of age, sex, development, and physical health self-worth influenced by weight Cognitive dissonance and rigidity: belief that low weight is not medically significant, and or altered perception of the body	Obsessive-compulsive disorder Attention deficit disorder Depression Substance use disorders Post-traumatic stress disorder Bipolar disorder Social anxiety disorder Panic disorder	Cognitive behavioral therapy Cognitive remediation therapy Family-based therapy Acceptance and commitment therapy Dialectical behavioral therapy	(American Psychiatric Association, 2022) (Lloyd et al., 2019) (Levinson et al., 2019) (Woodside& Staab, 2006) (Muratore & Attia, 2021)
Bulimia Nervosa (BN)	The act of consistently eating past fullness to the point of nausea, subsequently purging the food using various methods such as laxative misuse Secretive about binge-eating and purging due to feelings of embarrassment which many who experience the disorder report	Depression (most common) Anxiety disorders (generalized anxiety disorder, post-traumatic stress disorder, bipolar disorder, social anxiety disorder, panic disorder)	Cognitive behavioural therapy (leading psychological treatment) Brief-strategic therapy	(American Psychiatric Association, 2022) (Patel et al., 2018) (Murphy et al., 2010) (Pietrabissa et al., 2019)
Binge-eating Disorder (BED)	Persistent binge-eating to a point of nausea and discomfort	Mood and anxiety disorders Substance use disorders Depressive disorders Impulse-control disorders Personality disorders	Cognitive behavioural therapy (gold-standard) Brief-strategic therapy	(American Psychiatric Association, 2022) (Citrome, 2017) (Boutelle et al., 2023) (Pietrabissa et al., 2019)
Other Specified Feeding and Eating Disorder (OSFED)	The disturbance of eating patterns which affect the individual's quality of life, but do not meet the DSM-V criteria to be considered under a more specific diagnosis		Cognitive behavioural therapy	(American Psychiatric Association, 2022) (Riesco et al., 2018)
Avoidant/Restrictive Food Intake Disorder (ARFID)	Restrictive eating and food avoidance caused by one of more of the following: sensory aversion, lack of interest in food, and/or anxiety concerning health related issues that could arise from ingesting food	Neurodevelopmental, disruptive, and conduct disorders Anxiety disorders Depressive disorders	Cognitive behavioural therapy Family-based therapy	(American Psychiatric Association, 2022) (Kambanis et al., 2020) (Datta et al., 2023)
Rumination Disorder	The consistent regurgitation of food for at least one month. To be diagnosed with rumination disorder, food regurgitation must not be related to a pre-existing gastrointestinal disorder and appear separately to another type of eating disorder	Anxiety disorders Depressive disorders	Diaphragmatic breathing (gold-standard) Cognitive behavioural therapy Behavioural therapy	(American Psychiatric Association, 2022) (Raha et al., 2017) (Kusnik & Vaqar, 2024)

There are several psychological symptoms typically associated with eating disorders. The literature suggests that eating disorders such as AN, BN, and BED are often linked to cognitive rigidity (Wang et al., 2021), perfectionism (Drieberg et al., 2019), self-image, and identity formation in adolescents (Mantilla et al., 2014). Along with these psychological indicators, eating disorders have also been identified as a form of coping (Fitzsimmons & Bardone-Cone, 2010; Wagener, 2010). These areas of need further reinforce the importance of identifying gaps in treatment and exploring supports that prioritise the development of healthy coping skills.

The prevalence of eating disorders in adolescents appears to be an ongoing challenge in Western society. Eating disorders affect 5-10% of adolescents and more than 50% of those diagnosed have been living with an eating disorder for more than five years (Treasure, 2020). Of all psychiatric conditions, AN is reported as having the highest mortality rate throughout the lifespan (Treasure, 2005, p. 398). The prevalence of eating disorders has increased over the last 50 years (Treasure, 2020) with several new subtypes of eating disorders being identified in the DSM-V including PICA, rumination disorder, and ARFID (APA, 2022). While the literature emphasizes the persistent challenge of eating disorders in adolescents, a treatment gap persists resulting in most individuals receiving minimal support (Griffiths et al., 2015), with a specific notable gap in psychological treatment (Kazdin et al., 2017). Various factors across the lifespan contribute to the emergence and persistence of eating disorders including the multifaceted impact of psychosocial factors.

Factors Contributing to Eating Disorders from Childhood to Adulthood

Psychosocial factors have been identified as a precursor to the development of eating disorders (Cardi et al., 2018). Psychosocial factors have also been identified as maintaining factors, which prolong disordered eating behaviors (Cardi et al., 2018). Cardi et al. (2018) aimed to identify whether adolescent social factors played a role in the later diagnoses of AN. In a mixed-methods study, ninety participants over the age of eighteen diagnosed with AN were asked to answer a set of online questions that were used to assess memories of perceived lack of self-competence, involuntary submissiveness, perceived lack of social competence, feelings of social belonging, fear of negative evaluation from others, and eating disorder symptoms (Cardi et al., 2018). Participants were also asked three general questions about their perception of social relationships before and after receiving a diagnosis of AN. The results suggest that social factors play a role in the

development and maintenance of AN (Cardi et al., 2018). Two-thirds of participants described negative social relationships and self-perception, while more than two-thirds expressed that their experience living with AN has had a negative impact on their current social relationships (Cardi et al., 2018).

Similarly, a longitudinal study conducted by Kotler et al. (2001) examined the span of participants' relationships to eating disorders from childhood to adulthood. The study aimed to determine whether early childhood psychosocial factors contributed to the progression of an eating disorder diagnosis. The study followed approximately eight hundred children and their mothers over a 17-year span (Kotler et al., 2001). The researchers regularly administered eating disorder assessments based on the DSM IV criteria during childhood, adolescence, and adulthood (Kotler et al., 2001). It was determined that early childhood disordered eating symptoms correlated with the diagnosis of both AN and BN (Kotler et al., 2001). Findings indicated that the continuation of eating disorder behaviours, also referred to as eating disorder maintenance, increased exponentially throughout early adolescence to early adulthood. In both Cardi et al. (2018) and Kotler et al. (2001), it was determined that psychosocial factors and physiological symptoms of eating disorders indicate likelihood of the diagnosis and maintenance of eating disorders. Due to the appearance of these factors during adolescence, researchers suggest that support at an early age would be important (Kotler et al., 2001).

The relationship between quality of life and eating disorders is a valuable question to ask when discussing the importance of psychosocial supports for adolescents experiencing eating disorders (AEED). In a study by Bamford et al. (2015), 63 adults who identified as living with severe and enduring anorexia nervosa (SE-AN) were surveyed. Participants attended cognitive behavioural therapy (CBT) sessions and completed three questionnaires which evaluated quality of life (Bamford et al., 2015). The results suggest that there is a significant correlation between quality of life and eating disorders, as well as a positive correlation between weight gain and improvement of quality of life (Bamford et al., 2015). Bamford et al. (2015) suggest that the longevity of recovery was more consistent when participants received both behavioural and psychosocial based supports.

Eating Disorders and the Development of Coping Skills

Coping skills have been an area of focus for clinicians working with AEED due to their role in the maintenance and progression of eating disorders (Wang et al., 2021). Wang et al. (2010) analyzed three case studies following two adolescents and one young adult living with an eating disorder (i.e., AN, BED, and OSFED). Results of these case studies found that psychological symptoms as well as the causes of developing an eating disorder are highly unique to the individual (Wagner & Much, 2010). While such experiences are unique, Wagner and Much (2010) discuss the importance of identifying how the symptoms of eating disorders function as unhealthy coping mechanisms. They suggest that support centred on addressing unhealthy coping mechanisms and building new, healthy alternatives, may be an ideal way to support individuals in continued recovery while mitigating the risk of further harm. Costin (1999) suggested that the role of the therapist is to highlight ways in which an eating disorder may have developed as a coping mechanism, and how this may be replaced by a positive coping skill. Costin's (1999) case-based research suggested that the therapeutic process should be viewed as a process rather than a means to an end. Participants with eating disorder diagnoses do not typically implement healthy coping skills immediately following therapeutic support, meaning therefore, that the focus of treatment should be on developing healthy coping skills over time (Costin, 1999). This shift in focus from symptom reduction to the gradual incorporation of healthier coping skills could potentially make the therapeutic process more approachable.

The relationship between coping skills and eating disorders was examined by Fitzsimmons and Bardone-Cone (2010) to identify whether healthy coping skills were associated with eating disorder recovery. Participants were individuals who were either living with an eating disorder, were partially recovered, or were fully recovered. The researchers compared these participants to a control group of participants who had not had any prior eating disorder diagnosis. Coping was assessed using the Coping Inventory for Stressful Situations (CISS), which organized coping responses into three subtypes; emotion, task, and avoidance-oriented coping (Endler & Parker, 1990; Fitzsimmons & Bardone-Cone, 2010). The study found that recovered participants and the control group both displayed a high use of task- and avoidance-oriented coping, versus a minimal use of emotion-oriented coping (Fitzsimmons & Bardone-Cone, 2010). Participants who were in treatment for eating disorders displayed lower usage of all categories of coping compared to the recovered and control groups. This suggests the importance of process-oriented and psychosocial

supports, given that eating disorders are often chronic and may last a lifetime (Fitzsimmons & Bardone-Cone, 2010).

Current Mental Health Support for AEED

Current mental health supports for AEED include family-based therapy (FBT), cognitive behavioural therapy (CBT), and acceptance and commitment therapy (ACT). Each individual has unique needs; however, the literature suggests that participants may have varied experiences with different models of therapy depending on the subtype of eating disorder with which they have been diagnosed (see Table 1 on p.10).

FBT is seen as the first line of mental health support for AEED (Rienecke & Le Grange, 2022). FBT utilizes a pragmatic approach to treatment, takes a non-authoritarian stance, empowers parents to play an active role in the treatment process, and externalizes the eating disorder (Rienecke & Le Grange, 2022). Lock and Le Grange (2019) found that adolescents living with eating disorders thrive within FBT due to its reliance on the families' resources to elicit therapeutic change. FBT is situated within a psychotherapeutic model and its primary function is to facilitate collaborative care (Lock & Le Grange, 2019). FBT has been proven to lead to symptom relief for adolescent participants, and families reported a reduction in feelings of isolation, helplessness, and shame towards disordered eating behaviours (Lock & Le Grange, 2019). Identified that there are interventional barrios for FBT therapists, some of which include the need for weighing patients, the time commitment for therapists and family members, and the lack of dietitians present for this form of treatment (Couturier et al., 2013). FBT requires the therapist to weigh the participant at the beginning of each session, something which CBT therapists have said can be more harmful than informative (Couturier et al., 2013). This is because the interpretation of weight fluctuation is not in the scope of practice of FBT therapists, and, weighing the participant can be an anxiety inducing experience for the participant (Couturier et al., 2013).

CBT is a widely used approach for AEED (Rienecke & Le Grange, 2022). CBT has been shown to decrease the severity of symptoms for the clientele through its strengths-based approach (Atwood & Friedman, 2020). CBT aims to identify areas of need, address goal areas, and reframe perspective to elicit behavioural change (Hanser, 2016). Conversely, Turner et al. (2014) have suggested that although research shows that CBT can be successful for this clientele, it is often not delivered correctly due to clinicians concerns surrounding certain aspects of the treatment. The

primary concern found by --- is that therapists are worried about the process of ending treatment and exploring body image work. Similar to the hesitancies surrounding consistent weighting in FBT, CBT therapists (particularly younger therapists) worry about the harm that may come from placing emphasis on physical appearance during the treatment process. In. suggest that a hesitancy towards completing an aspect of the therapeutic model leads to a negative impact on the progress of the participant.

ACT is a third-wave therapy based in psychotherapy that focuses on the development of psychological flexibility (Hayes et al., 1999). The purpose of ACT is to work towards accepting the occurrence of unhealthy thoughts or behaviours rather than actively replacing them with new/healthy ones (Hayes et al., 1999). ACT is among the newer researched treatment options for AEED, particularly for AN diagnosis (Harris & Samuel, 2020). Onnink et. al's (2022) systematic review of ACT for individuals living with eating disorders suggests a rise in ACT because it has been shown to decrease symptoms of eating disorders in some individuals.

The identification and or implication of healthy coping skills is an underlying theme throughout FBT, CBT, and ACT. FBT supports healthy coping through providing a space to develop the relationship between the adolescent and their family and empowering the participant to play an active role in the recovery process. CBT similarly aims to replace unhealthy coping mechanisms e.g. disordered eating behaviours by reframing the participants' approach to coping with environmental stressors (Hanser, 2016). While ACT does not aim to replace unhealthy thoughts or behaviours, the act of accepting them may be a gateway to closing the loop of unhealthy behaviours. All subtypes of eating disorders have been identified as a form of coping which may manifest due to a need to cope with stressors in the individual's environment (Wang et al., 2021), highlighting the pivotal role of developing effective healthy coping skills.

The Treatment Gap

Factors contributing to the treatment gap include whether a therapist's educational background has provided sufficient treatment knowledge, and whether available services reflect current research. In a study that examined treatment gaps within mental, neurological and substance use disorders, findings indicate that there is a discrepancy between available treatments and what the literature suggests as best practice for this population (Shidhaye, Lund, & Chisholm, 2015). The literature discusses that overall, western healthcare systems are lacking in services which

reflect current research due to the care-models adopted by healthcare organizations. Additionally, Shidhaye et al., (2015) state that "the delivery of these interventions requires an approach that puts into practice key principles of public health, adopts systems thinking, promotes whole-of-government involvement and is focused on quality improvement." (Shidhaye, Lund, & Chisholm, 2015).

Kazdin (2015) echoed this assertion and further explored how the gap between knowledge and treatment affects those living with eating disorders, expressing a need for clinicians to adapt their clinical approach to reflect what the literature suggests. This could mean changes in practice and programming approaches, as well as referrals to external support to bring more effective support to the many individuals who are living with eating disorders.

Kazdin (2015) identified the dominant model of treatment that entails in-person treatment at a clinic administered by highly trained clinicians. The distinction between clinicians and a clinician who specializes in a diagnosis is highly important because services become more effective when clinicians adapt to current literature. The gap in treatment is further perpetuated because there are not enough mental health professionals to fulfill the needs of the dominant model of treatment. This arguably has a direct impact on adolescents, since they are disproportionately affected by eating disorders compared to other age groups (Treasure, 2005). Kazdin (2015) reported that many individuals claim that the process of obtaining psychosocial support for eating disorders is equally as bad as having no treatment at all. Given the considerable amount of time it takes for an individual to receive support, the process becomes untenable when many clinicians feel they lack the depth of clinical training necessary to work with this population (Kazdin, 2015). Along with the barriers surrounding clinical training as a contribution to the treatment gap, Kazdin (2015) acknowledges that limited resources in rural areas often result in a lack of support for individuals with eating disorders.

Robinson (2013) similarly explored issues related to a lack of clinical training in a survey of clinicians on their feelings towards clinical competencies for pediatric eating disorder treatment. Many clinicians within Canada did not feel adequately trained to support this population, stating that a "…large proportion of clinicians report an interest in learning more about all areas of the management of pediatric eating disorders, including prevention efforts." (Robinson, 2013, p. 160). Heiderscheit et al., (2015) acknowledged that creative arts therapists have similar feelings about

the availability of training surrounding this population. However, existing research demonstrates how music therapy may be a viable form of support to work towards filling the treatment gap (Heiderscheit, 2015).

Conclusion

Current literature suggests that adolescents are disproportionately affected by eating disorders. The development of eating disorders typically begins during adolescence and can develop due to various psychosocial and emotional factors. Psychosocial factors such as negative self-perception and a lack of social support have been identified as areas of need for AEED. These manifest as a need for social support systems and support which promotes feelings of social belonging. Additionally, these social factors have been identified as both a precursor and prolonging factor in eating disorder diagnoses (Cardi et al., 2018). The literature explores how AEED who do not receive psychosocial supports are more likely to develop negative self-perception and continue to engage in maladaptive coping (Wagener & Much, 2010). Emotional factors that lead to and/or are identified as prolonging facts are the presence healthy coping skills, positive self-perception, emotional expression, and positive identity formation. The literature also identifies that there is a treatment gap for AEED, particularly within the psychosocial domain, which leads to adolescents not receiving needed supports (Heiderscheit et al., 2015; Wang et al., 2021). Chapter 4 will explore how music can be integrated within a care plan to address these psychosocial needs through various music therapy experiences (composition and songwriting, improvisation, and receptive music therapy).

Chapter 4: Findings

This chapter aims to identify why composition and songwriting, improvisation, and receptive music therapy experiences are ideal ways to support healthy coping for AEED. To situate current uses of music for this clientele, the chapter begins with identifying perspectives on adolescents engagement with music. Three music therapy experiences are discussed (composition and songwriting, improvisation, and receptive music therapy experiences) with each section identifying how the experience can support AEED in developing healthy coping skills. Finally, considerations for music therapists working with this clientele are discussed.

Perspectives on Adolescents' Engagement with Music

The role of music in adolescents' lives is complex and can serve different purposes throughout their formative years (McFerran, 2012). The ways in which adolescents engage with music provide some context for why music therapy services could help mitigate unhealthy coping skills in AEED while developing healthy coping skills and strategies.

A step towards mitigating unhealthy uses of music is outlining what different uses of music may look like for adolescents. McFerran (2012) identified two main purposes for music in an adolescent's life: (1) the use of music as a *mirror* to develop the self and (2) music as *performance* to foster connection with others. Music may be used less effectively by adolescents who are at risk of mental health disorders due to the personal nature of music and the complex emotions it may elicit (McFerran, 2012). This suggests that attempts to use music to experience some sort of improvement may have no effect, or even adverse effects (McFerran, 2012). McFerran (2012) introduced the idea of labelling good and bad uses of music—in other words, how one uses music can have a positive or a negative impact on one's self. This concept was explored in an interview-based study with 40 teenage participants by McFerran and Saarikallio (2014). The researchers noted that the adolescent participants needed to be prompted to share their unpleasant experiences with music, as they typically defaulted to sharing only positive experiences. Furthermore, their findings suggested that adolescents, specifically those who may be feeling vulnerable, may benefit from receiving guidance on ways to use music that will have a helpful (versus an unhelpful) impact (McFerran & Saarikallio, 2014).

Music Therapy Services for AEED

Music therapy can be effective for adolescents experiencing eating disorders due to its ability to act as a reinforcer for healthy coping behaviors. Because music is an effective reinforcer, this also means that music must be used in therapy with knowledgeable intent (Saarikallio et al., 2015). Saarikallio et al. (2015) developed the healthy-unhealthy music scale (HUMS) with the aim of providing music therapists with an assessment tool to identify how participants are using music. The HUMS is a 13-item questionnaire where 5 questions address healthy uses of music and 8 address unhealthy uses of music (Saarikallio et al., 2015). Hense et al. (2018) used the HUMS assessment tool on an acute youth mental health inpatient unit for adolescents experiencing various mental health challenges. Participants who chose to answer the HUMS questionnaire noted that they had not previously considered how they used music. The insight gained from the HUMS assessment can be a way for music therapists to better support participants to develop healthy coping skills through the intentional use of music. Hense et al. (2018) also asked participants to complete a follow-up questionnaire regarding the participants' perceived benefits of music therapy. 12 out of 13 of the participants reported having a positive experience in the session and/or gained insight on how they could use music more effectively.

The integration of music therapy within care plans can be a way to mitigate the gap in treatment for this clientele. Research has recently begun to specify how positive coping skills could be fostered within music therapy by exploring adolescent uses of music and identifying resources for coping with environmental stressors. Composition and songwriting, improvisation, and receptive music therapy experiences can be used to address areas of need for AEED including self-esteem, identity formation/rediscovery, self-expression, coping, anxiety relief, and other psychosocial needs. Music therapy can provide valuable and effective support for adolescents experiencing eating disorders and could be even more valuable if interventions focused more specifically on developing positive coping skills.

Although the literature on viable services for this clientele continues to grow, the treatment gap persists (Kazdin. 2015). Services such as music therapy in both group and individual contexts should continue to be highlighted as a potential addition to clinical teams as the current use of music therapy has shown to address emotional and social needs of this population. The following sections discuss how different music therapy experiences can be used to support the development of healthy coping skills for AEED.

Composition and Songwriting

In compositional experiences, the therapist assists the participant in creating original music which can include (but is not limited to) writing lyrics, creating instrumentation, and choosing accompaniment (Bruscia, 2014). Bruscia defines composition as the construction of something new, more specifically, "the composer builds a musical composition using sounds as the basic materials." (Bruscia, 2014, p.147). The process of composing can also involve the notation and or recording of the music written (Bruscia, 2014). The literature explores the potential of compositional music therapy for promoting emotional and social goals. Some of these goal areas include emotional expression, providing tools for coping, facilitating identity formation, promoting feelings of empowerment and social belonging, and anxiety reduction (Heiderscheit, 2023; McFerran, 2003; McFerran et al., 2006; Pasiali et al., 2020).

Songwriting is a type of composition often used within music therapy sessions with AEED (Heiderscheit, 2023; McFerran, 2003; McFerran et al., 2006; Pasiali et al., 2020). Songwriting can be facilitated in a variety of ways including word replacement experiences or guided songwriting experiences. Word replacement songwriting experience typically involve the use of pre-written songs which are meaningful to the participant. Key words are replaced by "blanks" which can be filled to create new meaning. The music therapist and participant work together to change the words of a song and will often sing and or play the re-written song. Music therapists also use guided songwriting experiences to support participants in the creation of a new song. This might look like providing chord progression choices, identifying the parts of a song, providing accompaniment and or helping the participant to structure their lyrics.

Songwriting can be an excellent resource to support adolescents in coping with difficult emotions (McFerran et al., 2006). This is seen in a retrospective lyric analysis of songs written by adolescents living with anorexia nervosa (McFerran et al., 2006). The study aimed to identify how songwriting can facilitate identity formation and exploration, as well as what common themes arose from songwriting experiences with this clientele (McFerran et al., 2006). The study examined songs written by 15 adolescents who attended inpatient music therapy sessions over a span of 2 years (McFerran et al., 2006). Six primary themes were identified from the 17 songs including identity formation, aspirations, relationship dynamics, references to eating disorder diagnoses, emotional awareness, and accessing support (McFerran et al., 2006). The themes expressed through

songwriting are prevalent within the literature as areas of need for AEED and highlight how songwriting is an important means of coping (Heiderscheit, 2023; McFerran, 2003; McFerran et al., 2006; Pasiali et al., 2020). McFerran et al. (2006) discuss that songwriting facilitates emotional expression and expression of needs due to its ability to provide both structure and flexibility. This is supported by Pasiali et al. (2020) who suggest that songwriting and song autobiographies can help participants express their emotions and (re)discover their identity.

Songwriting utilises music as a positive reinforcer to facilitate the development of healthy coping skills through empowering messages within lyrics. Hillard (2001) noted that the use of empowering lyrics in songwriting and lyric analysis experiences with AEED participants provided them with positive experiences during a time that had potential to be anxiety-inducing (Hilliard, 2001). Engaging music making itself is the coping mechanism for many in these cases, replacing unhealthy patterns with new resources and a sense of social support in group settings. In addition to this, low participation is common for AEED (Wang et al., 2021). Low participation may be characterized by decreased attendance in individual or group therapies or lowered active participation during sessions. Hilliard (2001) suggests that because songwriting supports emotional expression, the use of songwriting in music therapy can have a positive impact on participants' treatment motivation. Increasing willingness to participate in other therapies is an important role that music therapy can play, as participation in the therapeutic process is a healthy form of coping itself. When facilitated within a group setting, songwriting can additionally provide a space for AEED to express their emotions with peers (Ward, 2023). This might lead to developing feelings of social belonging and serve as a healthy form of coping.

In a case study which presented music therapy sessions with a group of adolescents experiencing eating disorders, songwriting was used to facilitate Dialectical Behaviour Therapy (DBT) goals (Ward, 2023). Group participants included adolescents admitted to an inpatient treatment program for eating disorders who attended weekly music therapy group sessions for approximately four weeks (Ward, 2023). In this case study, the music therapy intern used the song The Hardest Part (Coldplay, 2006) to facilitate a group songwriting experience. After the music therapy intern played the song live for the group, participants were invited to fill in the blanks on a lyrics sheet created by the music therapy intern. The theme of the rewritten lyrics was centred around acceptance, recovery, and hopefulness in relation to their eating disorders (Ward, 2023).

The group members reported feelings of optimism and empowerment after listening to the music therapy intern sing their re-written song (Ward, 2023). Along with the DBT approach, songwriting has also been used within a cognitive-behavioural music therapy (CBMT) approach (Hilliard, 2001).

In a CBT-based program which aimed to support participants in reframing their beliefs regarding their eating disorder, group and individual music therapy was offered to female participants aged fourteen to fifty-five (Hilliard, 2001). The treatment plan additionally aimed to mitigate behaviours which reinforced the physical manifestation of eating disorders (Hilliard, 2001). Along with living with eating disorders. some participants were also coping with co-morbid diagnoses including substance abuse, depression, dissociative identity disorder, and bipolar disorder (Hilliard, 2001). Music therapy sessions were structured around three phases, each progressively addressing different goal areas (Hilliard, 2001). Stage one aimed to establish the therapeutic relationship, educate patients on the process of CBMT, explain the purpose of working towards cognitive and behavioural goals, reduce the frequency of disordered eating behaviours, and establish weekly weighing (Hilliard, 2001). Stage two focused on eliminating dieting behaviours, facilitating cognitive restructuring, increasing emotional expression, and promoting the development of healthy coping skills (Hilliard, 2001). Finally, stage three focused on increasing healthy coping skills and relapse prevention (Hilliard, 2001). Songwriting was a successful experience for facilitating emotional expression, developing healthy coping skills, and promoting social engagement (Hilliard, 2001). The theme of the songs chosen as well as the lyrics written were often centred around feelings of anger, empowerment, hope, and insight (Hilliard, 2001). These are common themes amongst songs written within both group and individual music therapy sessions (Heiderscheit, 2023; Hilliard, 2001; McFerran, 2003; McFerran et al., 2006; Pasiali et al., 2020; Ward, 2023), further emphasising the important role songwriting can play in supporting healthy coping. Another music therapy experience commonly used within music therapy with AEED is improvisation.

Improvisation

Improvisational music therapy encompasses the use of instruments and the voice within the context of spontaneous music making (Bruscia, 2014) This may be achieved through instrumental and/or sung music using rhythm and/or melody (Bruscia, 2014). The therapist may guide or support

a client's improvisations by providing structure (demonstrations or instructions) and/or by accompanying the client (Bruscia, 2014).

Improvisational experiences are structured based on the participants' needs and may be based upon a theme relevant to the participant(s) goal(s). McFerran (2023) used improvisation with a young woman living with AN to facilitate self-listening. In the study, the participant listened to recordings of her improvisations and engaged in verbal discussion as a means of, analysing the recordings (McFerran, 2003). The findings suggested that the act of improvisation and analysing recorded improvisations helped the participant feel more connected to her emotions (McFerran, 2003). This idea of grounding through improvisation can also help participants work through the complex feelings of experiencing an eating disorder without the added pressure of verbal processing (Robarts, 2000). Improvisation has the potential to provide a space for AEED to cope with the emotional stress of experiencing an eating disorder, the stressors of hospitalization, and the experience of receiving other therapies which may not be a pleasant experience (McFerran, 2003; Robarts, 2000). Improvisation can also be an important means of nonverbal communication for AEED when, as Dvorak (2023) explains, verbal processing may be challenging due to disaffection or low motivation.

Improvisation is at the forefront of music psychotherapy and music-based interventions for those who have difficulty with verbal communication (Robarts, 2000). Robarts (2000) suggests that improvisation may be an inherent facilitator of change for adolescents living with AN because of the emphasis that is placed on the process of active music making. Adolescents living with eating disorder diagnoses are more likely to experience disaffection which hinders the individuals' abilities to reflect on thoughts and feelings. The focus on active improvised music making offered by improvisational music therapy can provide the participant with a space to reconnect with their identity without the need for verbal processing (Robarts, 2000). Receptive music therapy experiences have similarly been used to encourage self-reflection, emotional processing, and anxiety reduction.

Receptive Music Therapy Experiences

Receptive music therapy experiences include those that involve active listening to live or pre-recorded music and responding via non-musical means (e.g., movement, discussion, imagery, etc) (Bruscia, 2014). Receptive music listening is the primary experience used in the Bonny Method

of Guided Imagery and Music (GIM). Pasiali et al. (2020) explained that receptive music listening experiences such as GIM can help participants to engage more socially, promote a sense of social belonging, and support coping through active music listening and sharing (Pasiali, 2020). GIM is receptive based psychotherapeutic model of music therapy which can only be conducted by trained individuals (Pasiali, 2020). GIM is used to guide the participant through an exploration of their subconscious emotions, past traumas, and to empower the participant to gain insights that aid them in finding solutions to their problems (Pasiali, 2020). The participant perspective on this receptive listening based treatment has also been explored by Heiderscheit (2023) who conducted a case study involving eight adult females living with an eating disorder. Each participant received a total of 116 GIM sessions over twelve months, after which each participant rated their experience based on a feasibility analysis questionnaire (Heiderscheit, 2023). Participants rated the experience a 6.5/7 on a scale of helpfulness, and 6/7 on a scale that measures the overall ease of the experience (Heiderscheit, 2023). Participants found that receptive music listening helped them to reduce disordered eating behaviours and it helped them to develop healthy coping skills, decrease negative thoughts, and address perfectionism (Heiderscheit, 2023).

Promoting coping through social engagement was the primary focus in sessions offered to outpatients (ranging from 20-40 years-old) who were experiencing post-meal anxiety and attending group meal outings to work on personal food goals (Bibb & McFerran, 2019). Bibb and McFerran (2019) examined how music therapy services could lessen post-meal anxiety using a self-report method (SUDS) to measure anxiety levels before and after a music therapy session. Group music therapy experiences entailed listening, choosing, and analyzing preferred music as a group. The SUDS measure revealed that music therapy programming had significantly decreased post-meal anxiety, suggesting that participation in these music therapy sessions may have served as a positive coping mechanism for participants (Bibb & McFerran, 2019). It was reported that the amount of choice given within the session contributed to participants' receptiveness to music therapy (Bibb & McFerran, 2019). This aligns with the experience of individuals with eating disorders who often feel a loss of control. Ceccato and Roveran (2022) similarly aimed to identify the potential of receptive music therapy for lessening pre-meal anxiety.

Ceccato and Roveran (2022) aimed to identify whether group music therapy at a day-hospital treatment program for adolescents living with eating disorders could be effective in

reducing pre-meal anxiety in patients diagnosed with AN. The study was conducted over a six-month period where group music therapy was offered two times per week (Ceccato and Roveran, 2022). Music therapy sessions contained both receptive and active music making experiences including music listening, improvisational experiences, and songwriting (Ceccato and Rovern, 2022). The music therapist facilitated instrumental improvisations and receptive music listening experiences to promote emotional expression and relaxation. Ceccato and Roveran (2022) noted that because participants were often in clinically fragile stages of treatment, they initially presented low motivation and deflected mood. The music therapist kept a journal throughout the process, which highlighted a gradual increase in participants' motivation and emotional expression over the six-month period (Ceccato and Roveran, 2022). After frequent participation in music therapy sessions, participants stated: "For the first time I feel that I have some friends… real friends…"; "I finally felt that someone really understood me…"; "I didn't think that by listening to a song you would be able to understand so much about me…" (Ceccato and Roveran, 2022, p. 7). These quotes reflect how music therapy can promote social engagement and act as a bridge to connect AEED who otherwise may be hesitant to express themselves. Results found that participant anxiety levels were consistently lower after music therapy sessions compared to days where there was no music therapy as measured by an anxiety thermometer (Ceccato and Roveran, 2022). The researchers suggest that these results could be attributed to the effects of music listening on the autonomic nervous system and its short-term ability to relieve acute stress (Ceccato and Roveran, 2022). It was also mentioned that participants were seen gradually participating more in sessions and required less verbal prompting (Ceccato and Roveran, 2022). The study concluded that music therapy was found to be beneficial in helping participants express and experience their emotions authentically and showed significant results in decreasing pre-meal anxiety.

Music therapy aims and considerations are additionally important for all music therapists to consider within their practice with varying clientele. As a part of the music therapists' scope of practice, it is essential for music therapists to seek continuing education surrounding the clientele they work with. The following section discusses important considerations for music therapists working with this clientele.

Music Therapist's Aims and Considerations

Through a survey study, Dvorak (2023) aimed to identify how music therapists adapt their practice to best support individuals living with an eating disorder. A sequential analysis of music therapists' clinical practice for this clientele highlighted six treatment areas that were commonly seen in both adult and adolescent sessions (Dvorak, 2023). Goal areas were self-expression, depression, coping skills, identifying feelings, expressing feelings, and self-esteem (Dvorak, 2023). Among these goal areas, interviewees noted a wide variety of music therapy techniques and experiences including composition, receptive music listening, re-creative music making, and improvisation (Dvorak, 2023). Music therapists who were interviewed (14 in total) noted the importance of considering participant safety when working with AEED. Some participants may be experiencing cognitive or physical limitations that should be considered when session planning (Dvorak, 2023). Participants experiencing ED may experience vertigo, osteoporosis, malnutrition, dizziness, heart arrhythmias, difficulty concentrating, or may be at high risk for fall-related accidents (Dvorak, 2023). Due to the cognitive and physical conditions that may arise due to an ED, interviewees stressed the importance of consulting with a doctor or other medical professional on staff when working with this population, particularly in an inpatient setting where participants may be in a more fragile stage of recovery (Dvorak, 2023).

Conclusion

The literature explores how music plays an important role in coping, identity formation, and socialization for adolescents. Music can be a means for adolescents to cope with environmental stressors and to relate to others, something that can be further addressed through music therapy services. Research suggests that adolescents often have positive experiences in music therapy and gain insight from music therapy sessions. Because music plays a significant role in the lives of adolescents, music therapy for AEED can work towards goals in an accessible and familiar way. For AEED, Music therapy has the potential to provide support within the emotional and social domains through various music therapy experiences. Specific goal areas within music therapy include the development of healthy coping skills, promoting feelings of social belonging and social support, facilitating emotional expression, identity formation, and anxiety reduction. These goal areas may be addressed through composition and songwriting, improvisation and receptive music therapy experiences which are adapted to the goals of an individual. Chapter five discusses the limitations of the research and implications for music therapy research and practice.

Chapter 5: Discussion

This philosophical inquiry aimed to argue why music therapy which focuses on the development of healthy coping skills is an ideal way to support AEED. The primary research question was: Why is music therapy that focuses on the development of healthy coping skills an important component of a comprehensive care plan for adolescents who are being treated for eating disorders? The subsidiary research questions were: (1) What are the unique needs of adolescents experiencing eating disorders? (2) How can overarching categories of music therapy experiences (improvisation, songwriting composition, and receptive music therapy experiences) support the development of healthy coping skills to address these needs in constructive ways? The literature supports that music therapy experiences are an important means of developing healthy coping through active music making and receptive music listening. The purpose of the present chapter is to outline limitations of the present study as well as discuss its implications for practice and research.

Implications for Music Therapy Practice

Coping is a theme throughout the literature surrounding AEED. Throughout the current research on music therapy for AEED, coping skills are often developed through several pathways, both directly and indirectly. Music therapists might adapt their practice with this clientele to consider how they can support participants in identifying the role coping plays in their therapeutic journey. Music therapists might support the development of coping skills including coping with the eating disorder itself, coping with one's environment, or coping with the process of eating disorder treatment. While the primary goal of this philosophical inquiry was to argue that music therapy is an ideal support for the development of coping skills, the findings also identified empowerment, collaboration, self-discovery, identity formation, and self-expression as important aspects of the therapeutic process.

Music therapy experiences including composition and songwriting, improvisation, and receptive music therapy experiences each have unique benefits for AEED and might be used in different ways depending on participant goal areas. Music therapists may use these experiences to address prevalent areas of need for this clientele, including facilitating emotional expression, supporting identity formation, anxiety reduction, and developing healthy coping skills.

It is integral to the music therapy process that the music therapist(s) seek out guidance from healthcare professionals who understand the participants' ED diagnoses on a deep level and can provide guidance when physical or cognitive restrictions should be taken into consideration (Dvorak, 2023). This can be particularly crucial during the beginning stages of ED, as the likelihood of the participant experiencing cognitive or physical limitations is higher. This includes speaking about the participants' progress, sharing pertinent information with the clinical team, and taking into consideration how the participant(s) is progressing in other modalities. For the same reason, interdisciplinary sessions can be highly beneficial for both the music therapist and the other clinician(s) as collaborative work offers new perspectives and extra support for the participant. Maintaining an understanding of the scope of practice and special care considerations is equally important for music therapists looking to work with AEED through private practice or other community-based centres.

Limitations

The literature is primarily centred around white females in a Western context. This lack of diversity means that cultural considerations were not adequately accounted for in this thesis.

Implications for Music Therapy Research

Currently, the research surrounding music therapy for AEED is case-based, qualitative, or theoretical (Heiderscheit et al., 2015). While it is important to consider qualitative perspectives on how music therapy can be realized to support AEED, there is little quantitative research which investigate the effectiveness of music therapy as a treatment for AEED. Additionally, there is a lack of research directly investigating how participation in music therapy might contribute to the development of healthy coping skills. While this philosophical inquiry has identified inherent potentials of music therapy as a means to effectively support the development of healthy coping skills, further exploration is warranted. Mixed-methods approaches could potentially provide a more comprehensive picture of relevant evidence.

Music therapy need to become more available for AEED in clinical and community settings to provide access to those who benefit from the service. The accessibility of music therapy services could be promoted through research that explores the parameters of current music therapy

programs for this clientele. Future research might investigate referral processes, targeted goals, and the music therapists role in relation to the multidisciplinary care team.

Concluding Remarks

The research process for this project has significantly deepened my perspective on the critical need for psychosocial supports for not only this clientele, but within the broader context western healthcare. The participant perspective on care highlights the importance of agency, accessibility, collaboration, and empowerment as important factors contributing to continued engagement in therapies. An key take away for me is recognising that participants are the true experts on their own experiences. This project has further emphasized my role as a clinician, that is to provide a therapeutic relationship wherein the participant is empowered to achieve their goal(s).

Exploring the role music plays in the lives of adolescents has prompted me to reflect on my own relationship with music and how it has shaped who I am. Through my education and training as a music therapist, as well as my experiences in both the classroom and workplace have come to understand the vulnerability involved in sharing musical aspects of oneself. This insight is something I will continue to keep in mind, particularly when working this clientele.

This project explored coping skills, specifically emphasizing its role as an ideal goal area for this clientele. Focusing on healthy coping skills in music therapy can be done through many means, one of which is simply attending a session. For participants who are experiencing complex medical diagnoses, attending therapy can be both mentally and physically demanding. In such cases, engaging in healthy coping may involve being present during a session, regardless of what occurs. This research has taught me that sometimes, my role as a music therapist is to provide a space where individuals can take small steps towards their goals by simply being present.

Overall, this research project has enhanced my understanding of eating disorders and their impact on individuals, as well as how various music therapy experiences can support coping through both active and receptive music experiences. There is a need for more supports like music therapy, and music therapists can help to provide these services by advocating for the profession through research and practice.

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