ABLE-DIVERSE MUSIC THERAPY: TOWARD A NEW MODEL OF DISABILITY AND MUSIC THERAPY

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BY

ROBERT DALE GROSS, B.M., M.M., M.A., D.M.A.

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DEDICATION

This thesis is dedicated to the memory of Kenneth Wayne Downey (1973-2016).

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ABSTRACT

ROBERT DALE GROSS

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Because many if not most of the clients of the music therapy profession are disabled, it is incumbent on the music therapy profession to find best practices in the service of disabled people. Much of the music therapy profession, however, remains involved with the medical model of disability, which locates disability in the individual and pathologizes bodily differences and abilities. This is at odds with the field of disabilities studies and what it calls the social model of disability. This thesis proposes to square the music therapy profession more closely with a disability studies model in creating what it calls *able-diverse music therapy.* Able-diverse music therapy is the result of several alignments and sub-alignments of existing scholarship, synthesized to create a new model of music therapy. Able-diverse music therapy is defined by the present author as *music therapy that seeks musicking, community building (in a multicultural manner whenever possible), and social justice for people with socially constructed developmental differences in ability that should be recognized and respected as any other human variation.*

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PREFACE

Author Background

I begin by situating myself as a disabled scholar. I have experienced chronic clinical depression most of my adult life (and probably beginning in my adolescence). My background includes one hospitalization for severe depression, which I readily admit because I believe the stigma that surrounds depression and hospitalizations must be resisted. In fact, it is precisely because of this depressive episode that I came to study music therapy at Texas Woman's University.

I began my studies in Denton, Texas not in music therapy at Texas Woman's University, but rather in music theory at another school. However, the lack of faculty support for my rather freewheeling and adventurous brand of music theory scholarship led me to become deeply depressed. One very unfair and critical remark from one of my professors plunged me into a nearly suicidal depression, which necessitated the hospitalization.

I had undertaken time away from the school through its student health center as a medical leave of absence, which was renewable on a semester-by-semester basis. I elected to take one and a half semesters away in total so that I could fully recuperate emotionally and rebound from my depression. I had the full support of the staff of the student health center, which completely approved of my plan.

When I returned, however, I was told by the chair of the theory department that my graduate teaching fellowship had been given away to another student because I was deemed too unreliable to teach. I was now expected to pay full tuition for doctoral studies in music theory, which I was in no position to do. I left the school. In my view, the music theory department wanted me gone because of its own ableist intolerance of mental illnesses like depression. Despite the fact that I had the full approval and support of the student health services, I decided not to fight and instead began looking elsewhere.

Some of my scholarship in music theory had begun trending toward music therapy. I had been long interested in music and cognition, and had written several unpublished papers that variously proposed a musical template for analogical thinking, and a low-tech algorithm to perform Schenkerian analyses without the aid of a computer. But most importantly, I had been working with my now sadly late musical partner and best friend Kenneth Downey, who was congenitally blind and who also had been developing Meniere's disease, the latter of which is an audio disorder that also causes vertigo. Because of Meniere's disease, Ken had been unable to participate in music because all music sounded out of tune to him (which is a common effect of Meniere's disease).

I proposed to him one day that he compose an electronic piece of music that was atonal, therefore taking pitch considerations out of the picture for the time being, and that instead focused on other parameters such as rhythm, dynamic, color, texture, form, etc. I wanted him to focus on all the ways one makes music *besides* pitch. A few days later, he contacted me with a 30 minute electroacoustic piece that was very impressive. I

proposed that we edit it together down to about 18 minutes, and that is how Blind Labyrinth, our experimental electroacoustic music duo, was born.

We composed many experimental, mostly atonal electroacoustic pieces together in the years 2014-2016. We were very much committed to the experimentalism of our work together, and we managed to produce one commercially available album of music called *Blasted Light* on the Beauport Classical label. But that is not what was so interesting. What was really interesting was the more we worked together on any kind of music at all, the more Ken's pitch-location abilities came back to him.

After two years of working together, music sounded in tune again for Ken. He was able to compose tonal music again, which was very important to him, and he was able to harmonize vocally as he had been able to before. His pitch recovery was, one almost hesitates to say, nearly miraculous.

I wanted to know if anybody else had had an experience like this, and my research kept coming to one common basis: *music therapy.* We were using music to help someone heal and work through a disabling condition. This made a great deal of sense to me. Ken had been my musical partner and friend for 30 years and I had been quite familiar with issues having to do with blindness and visual impairment. I had always been friends with various disabled people throughout my life, and when I realized and embraced my own form of disability, I had already been well-versed in the orthodoxies of disability studies.

I came to learn about disability studies because of my wife, Rebecca Morris. She had been a voice major as an undergraduate, but lost her voice when she had to take

medications that affected the musculature of her throat. Singing became a struggle for her, and she began to study musicians who had lost the ability to perform music because of lost limbs and other various impairments. She became immersed in disability studies as a master's student in musicology at University of Southern California (which is also, incidentally, where I received my doctorate in music composition). Because I had always been interested in disability studies myself, I tended to read the same books and articles she was reading. I became versed in the social model of disability and the various controversies and amendments surrounding it.

This personal perfect storm, then, leads me to the present thesis. I believe that music therapy is still a relatively young profession, and because the majority of clients served by music therapists are disabled, it is therefore incumbent on members of the profession to be well-versed in disability studies and scholarship. Because of the relative youth of the profession, I think there is still room for evolution. My thesis proposes a reconciliation between the music therapy profession as it presently exists (which is rather immersed in something called the *medical model of disability*) and disability studies (which favors various incarnations of the *social model of disability*).

Music Therapy Definition

There are a myriad of unofficial definitions of music therapy that one can find, but the official United States definition resides with the American Music Therapy Association (AMTA). I reproduce the definition in its entirety here for those who are perhaps unfamiliar with the music therapy profession:

> Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music Therapy is an established health profession in which music is used within a therapeutic relationship to address physical, emotional, cognitive, and social needs of individuals. After assessing the strengths and needs of each client, the qualified music therapist provides the indicated treatment including creating, singing, moving to, and/or listening to music. Through musical involvement in the therapeutic context, clients' abilities are strengthened and transferred to other areas of their lives. Music therapy also provides avenues for communication that can be helpful to those who find it difficult to express themselves in words. Research in music therapy supports its effectiveness in many areas such as: overall physical rehabilitation and facilitating movement, increasing people's motivation to become engaged in their treatment, providing emotional support for clients and their families, and providing an outlet for expression of feelings. (American Music Therapy Association, 2018)

The definition is provided here not just for the sake of familiarity, but also because it will be critiqued later in the thesis. The purpose of this thesis is to update the profession of music therapy as to comport to a certain set of principles, and this updating cannot take place without some mention of the starting point. It is my hope that readers already familiar with music therapy will forgive the brief reprinting of the official AMTA definition here.

Organization of Thesis

What follows in this thesis is a set of alignments that arrives at, in the final chapter, a concept I call *able-diverse music therapy*. Chapter One will introduce the important concept of the social model of disability. The chapter will also discuss a number of critiques and updates to the social model of disability. Chapter Two will introduce the concept of neurodiversity, also the work of various scholars (but one particularly important one), and show how neurodiversity and the social model of music therapy synthesize to create my own concept of *able-diversity.* Chapter Three will introduce how the syntheses of culture-centered music therapy, music-centered music therapy, community music therapy, and anti-oppressive music therapy again align to create my own concept of *progressive music therapy.* Chapter Four then aligns *able-diveristy* and *progressive music therapy* to create and define *able-diverse music therapy.* I will then examine some existing models of able-diverse music therapy and will make some concluding remarks about the possible future of music therapy.

The following diagram (Figure 1) illustrates the various alignments and syntheses proposed by this thesis (following this diagram is a description of the diagram for visually impaired readers). First, the intersection of the social model of disability and neurodiversity combine to give rise to what I call, in general, able-diversity. Community music therapy, culture-centered music therapy, music-centered music therapy, and anti-oppressive music therapy then align to form progressive music therapy. Finally, progressive music therapy and able-diversity meet to create able-diverse music therapy.

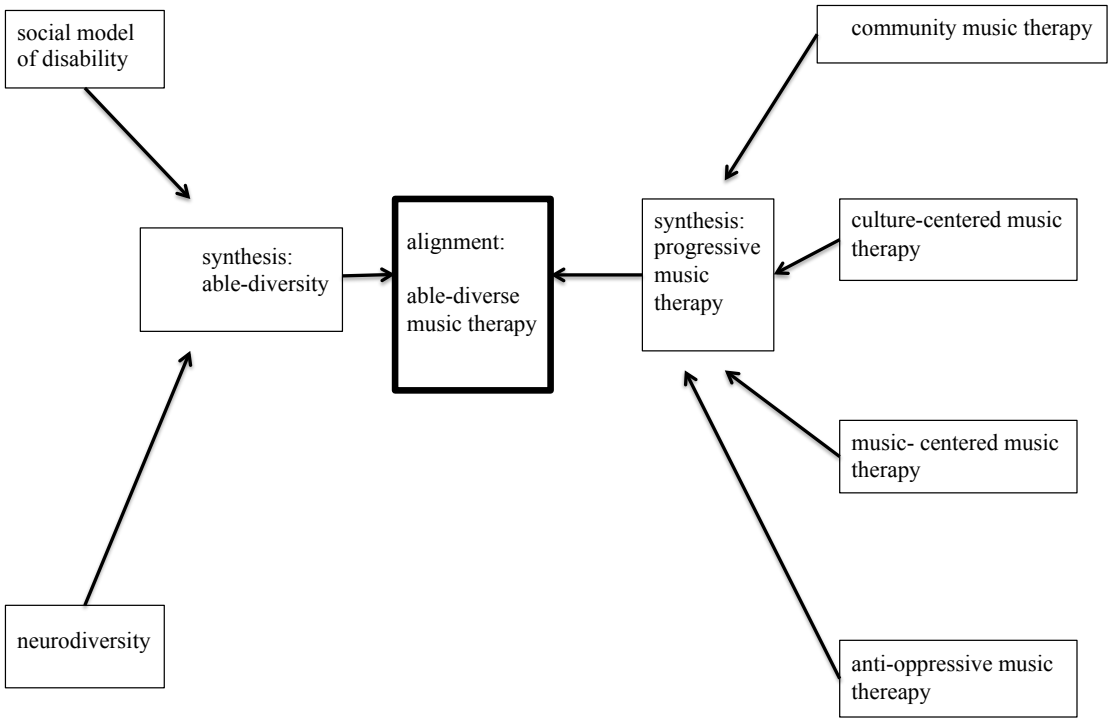

Figure 1. Able-Diverse Music Therapy

Image description: on the far left, "social model of disability" is in a box and "neurodiveristy" is in a box. On the far right, "community music therapy" is in a box, "culture-centered music therapy" is in a box, "music-centered music therapy" is in a box, and "anti-oppressive music therapy" is in a box. The "social model of disability" and "neurodiversity" boxes each have an arrow pointing to a box in the next level of hierarchy which says "synthesis: able-diversity." The "community music therapy" box, the "culture-centered community therapy" box, the "music-centered music therapy" box and the "anti-oppressive music therapy" box each have an arrow pointing to a box in the next level of hierarchy which says "synthesis: progressive music therapy." The "synthesis: able-diversity" box and the "synthesis: progressive music therapy" boxes each

have an arrow pointing to a box in the center that says “able-diverse music therapy,” which is the final level of hierarchy in the image.

CHAPTER I

THE SOCIAL MODEL OF DISABILITY AND MUSIC THERAPY

Portions of this chapter were originally published in Gross, R. (2018). The social model of disability and music therapy: Practical suggestions for the emerging clinical practitioner. *Voices: A World Forum for Music Therapy 18* (1). Retrieved from https://voices.no/index.php/voices/article/view/2541. https://doi.org/10.15845/voices.v18i1.958

The social model of disability represents a great change in the way of thinking about the subject of societal perception. Since its inception, this model has been discussed in countless journal articles, presentations, books, and book chapters. Their critiques examine reflexive assumptions having to do with normativity, hierarchy, and the nature and function of social institutions that create barriers to the full inclusion of disabled people[1] in society. Why does the music profession not engage the social model of disability, since many of the clients of music therapists are disabled people? In 2014, *Voices: A World Forum for Music Therapy* published an issue devoted to music therapy and disability studies. However, this single issue of *Voices* notwithstanding, examinations of the interface between disability studies and music therapy are few and far between, necessitating the present project.

The Social Model of Disability

Much work on disability today is the province of disability studies, an interdisciplinary field that places disabilities alongside other models of diversity including race, class, and gender (Kudlick, 2003). The founding principle of disability studies is the social model of disability, which holds that disabled people are socially oppressed by barriers created in society, both physical and attitudinal (Thomas, 2008). Most accounts of the history of the social model trace its initial articulation to the work of the late disabled scholar Michael Oliver at least as far back as the 1990 publication of *The Politics of Disablement.* In the second edition (2012), retitled *The New Politics of Disablement*, Oliver and new co-author Barnes stated,

> To illustrate the point: a disabled person's inability to find paid work is widely attributed to their lack of ability to carry out the required tasks or capacity to undertake the necessary roles. However, such arguments ignore the fact that despite environmental and attitudinal barriers many disabled people compete successfully in the labour market and acquire a wide range of jobs. The problem is that the unemployment rate amongst disabled people is much higher than that of non-disabled peers and this suggests that a structural rather than a personal explanation is needed. We know, for example, that the disabled population generally experience exclusion from the workplace *due to environmental and social barriers* [emphasis added]. (p. 13)

Consequently, the emphasis of the traditional medical model on the pathology of the individual with the disability was rejected by Oliver and Barnes.

The development of the social model of disability in 1990 may strike one as rather a late time of entry compared to the emergence of other liberation movements (e.g., race, gender, sexual orientation). One possible reason may be an observation by Kudlic (2003): practically no one consciously professed to be against disabled people. However, she was quick to point out the ways in which media representations and everyday language demean disabled people.[2] I would observe that if the oppression is usually not consciously made, it is nevertheless just as real as other forms of oppression brought about by animus. Perhaps it is exactly this insidious and invisible nature of the oppression of disabled people that held off the emergence of the social model's widespread acceptance. Making it worse, Kudlick further observed that academia tends to believe that disability is marginal, and addressed properly by entrance ramps rather than academic inquiry (2003).

Oliver and Barnes (2012) maintained that staunch individualism as an ideology is responsible for the lack of focus on state and society as the proper locus for the construction of disability. Barnes (cited in Oliver & Barnes, 2012) pointed out that during the 18th and 19th centuries, as society became industrialized, ideology shifted, and the role of disabled people was marginalized by "the ascendant egocentric philosophies of the period, which stressed the rights and privileges of the individual over and above those of the group and the state; in relation to property rights, politics and culture" (p. 80). The authors (2012) argued, then, that this ideology of individualization persists to this day, and is seen most readily in the medicalization of disability:

> [T]he main group to center their gaze on 'the body' were doctors… Consequently thereafter disability was connected to the medical profession and the 'biomedical model of health'. People with impairments, or 'chronic ill health', were subject to control and exclusion by this newly emerging group of professionals who readily seized the opportunity to increase their power and influence by classifying people in relation to the labour market and by facilitating their segregation. (p. 83)

To wit, they maintained that medicalization had escalated to intrude upon almost every aspect of everyday life: they continued that "Medicine as an institutional complex has acquired the right to define and treat a whole range of conditions and problems that previously would have been regarded as moral or social in origin" (Oliver & Barnes, 2012, p. 84). This had led to the inevitable takeover of perceptions of disabled people by the medical model. This argument has opened up Oliver and Barnes to charges of being anti-medicine, which they deny, saying that instead they are merely "anti-medical imperialism" (2012, p. 84).

In my view, Oliver and Barnes (2012) were not so much anti-medicine as they were anti-capitalism. They make clear in no uncertain terms throughout *The New Politics of Disablement* that capitalism is largely to blame for the individualized locus of disability (see for example, p. 119). Yet there is a subtle tension in their argument. Throughout *The New Politics* they maintained that the social model of disability has proved its usefulness in facilitating pragmatic policy adjustments, and that social policy, and not abstract theorizing, was their end goal (indeed, the final three chapters of the book were collected as a unit entitled "Agendas and Actions"). This is at odds with their

continual railing against capitalism, because if pragmatic social policy is the end goal, the overthrowing of capitalism writ large seems hardly likely. Their critique of capitalism was valid enough—capitalism certainly has its profound faults—but the degree to which *The New Politics* emphasized the blistering critique of capitalism seems unwarranted if the end goal truly is the realistic and pragmatic adjustment of contemporary social policy.

More successful was their argument following Derrida (Oliver & Barnes, 2012) that critiqued Cartesian dualism: unchallenged Enlightenment thought, they maintain, is responsible for dualist distinctions such as "mind/body, individual/society, normal/abnormal" (p. 89). Before Enlightenment thought, disabled people were not specially marked as defective (2012). The authors maintained, "Consequently the dominant discourses around notions of the 'grotesque' and the ideal body in the Middle Ages were completely overturned by the 'normalizing gaze' of modern science" (p. 89).

The problem, then, is that these dichotomies have become so ingrained in our culture, that they become common sense (2012). Everybody knows, in other words, that disability is a personal tragedy. Everybody knows that the goal of every disabled person is to become as normal as possible. Everybody knows that disabled people must learn to be independent. (It is worth noting that dependent/independent is one more false duality, like normal/abnormal.)

On the subject of false dualities, Rolvsjord (2014) elaborated by pointing out that other binaries co-exist with the "disabled/normal" construction (she names binary constructs such as "victim-survivor," "weak-strong," "ill-healthy" and "active-passive," citing Goodley, 2014). She added to the list of binaries that of "client-

therapist," which she says contributes to discourses that some might experience as oppressive (Rolvsjord, 2014).

Oliver and Barnes (2012) critiqued the "dependent/independent" duality. All human beings are dependent on other humans for survival, they claimed. Therefore, the dependence of disabled people only varies by degree and so the construct of "dependence" is not binary (2012). Oliver and Barnes (2012) also questioned the ideological rhetoric that maintains that dependence is bad in the first place, noting that "the culture of dependency" has become a bugaboo for (particularly right-wing) politicians to rail against (Oliver & Barnes, 2012). They point out that people with impairments are socialized into a negative self-outlook and therefore often see themselves as completely dependent on the charity of others for survival (2012).

The social model of disability had its critics. Perhaps the most forceful among them was Tom Shakespeare (2010), who acknowledged the simplicity of the social model, but maintained that its simplicity was also its "fatal flaw" (2010). Shakespeare, who is disabled, argued the social model neglects impairment itself as an important aspect of disabled people's lives (2010); the social model tautologically assumes the conclusion that disabled people are oppressed (2010); the distinction between the medical perspective of impairment and the social perspective of disability is a crude one (2010); and a "barrier-free utopia" is difficult to realize (2010).

Shakespeare made one other very important point: his observation that other authors emphasized the degree to which representations of disabled people in the media foster prejudice even more so than physical barriers, the latter of which tended to be

overemphasized by the social model of disability. It is a good reminder that attitudinal barriers are also barriers and must be taken into account by the calculus of the social model (CDLPNUIG, 2013).

Shildrick (2007) agreed with Shakespeare and maintained that the concept of disability is "slippery, fluid, heterogeneous and deeply intersectional"[3] (p. 223). The criticism of the social model of disability that this quotation suggests is that the distinction between the social model and the medical model is perhaps too simplistically binary. Frazee, Gilmour, and Mykitiuk (2006) thought of the social model, however, as an important "starting point;" it was an expression of first principles from which more complex and nuanced critical disability theory, like that of Shildrick, follows. It is important to remember that before the social model of disability, the medical model was the prevailing normative thought regarding disability, and, for many invested in concepts of remediation, still is. The authors of the social model of disability and most other critical disability theorists who have developed more evolved theories since the social model essentially reject the medical model as the prevailing, standalone approach to disability. As DeVolder (2017) pointed out, approaches as broad as the social model, the minority group model, the cultural model, the economic model, the affirmation model, the biopsychosocial model, the relational model, and the axial model each reject the medical model as their point of consensus.

One further criticism of the social model of disability remains here. The social model of disability, as it originally appeared in the United Kingdom, tended to focus primarily on inclusion of disabled people in the British work force. This is important, of

course, but does not create a comprehensive theory of disability. In light of criticisms by Shakespeare, Shildrick and others, the social model of disability is due for an upgrade. In my view, there is much to be learned from the successful framing of neurological disability as *neurodiversity*, which will be discussed in Chapter Two.

Defining Music Therapy per the Social Model

Music therapy can be defined in a way that comports to the spirit of the social model of disability. Following is my own definition of music therapy that builds on the language of the official AMTA definition (see Preface), but with some adjustments made to emphasize particular aspects of the social model of disability, such as the emphasis on community (as apposed to individualized locus of disability), collaboration (as opposed to hierarchical superior-client-inferior-therapist relationships), and a great deal of client choice. Here, then, is my definition:

> Music Therapy is an established collaborative health profession in which music is used within a therapeutic relationship to address physical, emotional, cognitive, and social needs of individuals or larger groups. After collaboratively working with each client to assess her or his strengths and needs, the qualified music therapist provides the indicated treatment including creating, singing, moving to, and/or listening to music. Through musical involvement in the therapeutic context, clients' abilities are strengthened per the wishes of the client and transferred to other areas of their lives if desired by the client. Music therapy also provides avenues for communication that can be helpful to those who find it difficult to express themselves in words. Quantitative and qualitative research in

music therapy supports its effectiveness in many areas such as: overall physical rehabilitation and facilitating movement, increasing people's motivation to become engaged in their treatment per the client's wishes, providing emotional support for clients and for others designated by the clients, and providing an outlet for expression of feelings.

Music Therapy is practiced in multi-modal environments (including but not limited to clinics, offices, hospitals, schools, homes, etc.) on the basis of quantitative and qualitative evidence in equal measure. It is the use of music interventions to accomplish individualized, collaborative or communitarian goals within a therapeutic but collaborative relationship by a professional partner who has completed an approved music therapy program.

Honisch (2014) pondered what would occur if music therapists were to ally themselves with disability studies scholars as to perceive disabled people differently. "Such a move requires engaging a different set of critical concerns," he wrote, including a re-orientation away from medical diagnosis, "but rather with reflexivity, digging at the methodological foundations of both scholarly research, and the philosophical assumptions of therapeutic practice" (Honisch, 2014, para. 7). In other words, he asked, what if music therapy was not there to remediate anything at all, but rather to reveal what he calls "an 'equality of condition'" that must be "accept[ed] on its own terms"? Honisch proposed to replace traditional music therapy as currently practiced with a "spirit of collaborative learning" (2014, para. 7).

Other therapeutically oriented professional organizations similar to music therapy

exist that engage in language that conspicuously resists ableism. Music therapy as a profession ought to consider modeling upon these. One such organization is SLP Neurodiversity Collective International, whose mission statement, authored by Julie A. Roberts, MS, CCC-SLP, reads as follows:

> We are a growing group of like-minded Speech-Language Pathologists who believe that the emotional well-being of the child supersedes mandating "compliant" behavior. We are autistic allies who assert that all behavior is communication, and that sometimes behavior is the only communication a child may have the ability to produce at that particular moment. We are anti-ABA [Applied Behavior Analysis]. We advocate neurodiversity, self-determination, inclusivity, dignity, respect of individual rights, sensory preferences, and the power to say "no". Above all, we seek to understand the reason behind our clients' behaviors. While supporting the child's emotional well-being, we provide them with therapy to expand their communication in meaningful and functional ways, and in the manners which best work and are most natural for them. (Roberts, 2018b, para. 1)

Compare and contrast this to the original AMTA definition of music therapy. Where the dominant model of music therapy is the medical model that finds pathology in the individual and emphasizes the powers of music therapy to remediate, these speech and language pathologists are taking a contrary stand proclaiming the inherent rights of clients and embracing difference as not only non-pathological, but sometimes as necessary. What if music therapists embraced language as bold as “We advocate

neurodiversity, self-determination, inclusivity, dignity, respect of individual rights, sensory preferences, and the power to say 'no'?" (Roberts, 2018b, para. 1). Instead, some music therapists embrace language like this, a statement regarding autistic clients:

> Music captures and helps maintain attention. It is highly motivating and may be used as a natural 'reinforcer' for desired responses. Music therapy can stimulate I ndividuals to reduce negative and/or self-stimulatory responses and increase participation in more appropriate and socially acceptable ways. (AMTA, 2012, p. 2)

This is wonderful news for families that are uncomfortable with their autistic members and for a society that is also uncomfortable with the socially *un*acceptable ways autistic people act. However, the social model of disability shows that this language fails to see that *society is constructing the problem because of* its *discomfort.* This language emphasizes normalization and the masking of autism, which is ableist.

The SLP Collective advocated for neurodiversity (Roberts, 2018a). Neurodiversity is the idea that modalities of mind orientation such as autism, ADHD, etc., are not pathologies *per se* but rather reflections of human diversity. (Neurodiversity will be explored in Chapter 2.) What if this neurodiversity model was extrapolated to all disabilities in such a way? Music therapy as a profession worries about getting paid by insurance companies, and insurance companies are deeply invested in the medical model and are also, by the way, deeply ableist. However, these speech and language pathologists are presumably being paid by the same insurance companies. If the SLPs can find the courage of conviction to proclaim their client-centered principles, can music

therapists do the same? In the next chapter I will examine the synthesis of neurodiversity and the social model of disability to define the concept of *able-diversity.*

CHAPTER II

ABLE-DIVERSITY: THE SYNTHESIS OF THE SOCIAL MODEL OF DISABILITY AND NEURODIVERSITY

Introducing Neurodiversity

The social model of disability was described in the previous chapter as a starting point for discussion; now the concept of neurodiversity will be discussed. The social model of disability interfaces with the concept of neurodiversity in a number of important ways. In this chapter, I will integrate salient aspects of the social model of disability, as described in Chapter One, with neurodiversity from this chapter to develop a theory of able-diversity (see Figure 2).

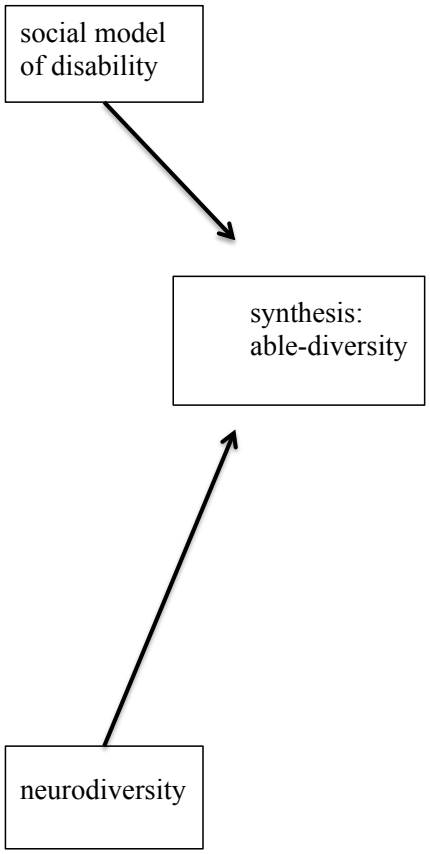

Figure 2. Social Model of Disability and Neurodiversity Synthesize to Create Able-Diversity

Thomas Armstrong suggested in *Neurodiversity: Discovering the Extraordinary Gifts of Autism, ADHD, Dyslexia, and Other Brain Differences* (2010) that rather than being glad to observe the natural diversity of human brains, we tend to pathologize the differences. One person has *autism*; another has a *learning disability*; still another "suffers" from *attention deficit hyperactivity disorder.* Armstrong challenged this by imagining if we did this with national differences (e.g., "People from Holland suffer from *altitude deprivation syndrome*" [2010, p.2]) or racial differences (e.g., "Eduardo has a

pigmentation disorder because his skin isn't white" [2010, p. 2-3]). Armstrong (2010) rightly pointed out that we would be regarded as racists. Yet, objective science maintains these lines of thinking vis-à-vis the human brain constantly (Armstrong, 2010). Furthermore, our disability politics often ignores the positive contributions that disabled people are able to make, as Whitworth pointed out, such as the bi-cultural social structures of deaf people, or the musical proclivities of people with Williams Syndrome (J. Whitworth, personal communication, October 3, 2018).

Armstrong (2010) argued that society has seen an enormous growth in the number of psychological disorders and notes reputable sources that estimate that half of all Americans may suffer some sort of mental illness in their lives. He found this implausible, and instead believes that *difference* accounts for the proliferation of these neurological ways of being that many classify currently as disorders. *Neurodiversity* was the word that described the alternative mode of thinking about these so-called disorders (Armstrong, 2010).

In an article for the American Institute for Learning and Human Development, Armstrong (2017) outlined eight principles of neurodiversity. Here, I will quote each principle directly, and following each I will comment as to how each principle interfaces with the social model of disability as well as a newly aligned principle for able-diversity.

Armstrong's First Principle: The Human Brain Works More Like an Ecosystem than a Machine (Armstrong, 2017, par. 5, emphasis in original)

Armstrong wrote:

> Up until now, the most often used metaphor to refer to the brain has been a computer (or some other type of machine). However, the human brain isn't hardware or software, it's wetware. The characterization of the brain as an unbelievably intricate network of ecosystems is much closer to the truth than that of a complex machine. We should devise a discourse that better reflects this new conception of the brain. (2017, para. 5)

This principle interfaces with the social model of diversity in its observation of the systemic nature of disability. Neurodiversity recognizes the mind as an ecosystem; the social model of disability recognizes a collection of human minds as a *political* ecosystem (one that often serves to oppress disabled people). In both cases, however, an overlooked *system* is in play; each system is one of which we should be aware as we address disability critically.

Aligned principle for able-diversity no. 1. Disability, whether physical, intellectual or emotional, is a systemic construct that is complex, fluid, and dynamic. An able-diverse perspective recognizes the fluid systemic nature of the locus of individualized disability; meanwhile, the locus of disability in the collective sense is ecosystemic, societal, and political in nature.

Armstrong's Second Principle: Human Brains Exist Along Continuums of Competence (2017, para. 6, emphasis in original)

Armstrong wrote:

> Rather than regarding disability categories as discrete entities, it's more appropriate to speak of spectrums or continuums of competence. Recent research, for example, indicates that dyslexia is part of a spectrum that includes normal reading ability. Similarly, we use terms such as autistic spectrum disorders to suggest that there are different gradations of social ability that merge ultimately with normal behavior. This suggests that we are all somewhere along continuums related to literacy, sociability, attention, learning, and other cognitive abilities, and thus all of us are connected to each other, rather than being separated into "normal" and "those having disabilities." (2017, para. 6)

The social model of disability would demand consideration of the possibility that concepts of competence are socially constructed. Armstrong was right: there is no discrete division between the "normal" and the "disabled." However, I would state explicitly that competence itself is a concept that is socially constructed. Wendell wrote in her examination of the social construct of disability: "…the assumption that permanent, global incompetence results from any major disability is still prevalent; there is a strong presumption that competent people either have no major physical or mental limitations or are able to hide them in public and *social* life [emphasis added]" (Wendell, 1996, p. 67).

Aligned principle for able-diversity no. 2. Competence, like ability, is a social construct. Competence in the individual is fluid and dynamic vis-à-vis broader society. There is no discrete division between "competent" and "disabled" in the individual;

likewise, there is no discrete division between the individual and the rest of society in the construction of the general concept of competence.

Armstrong's Third Principle: Human Competence is Defined by the Values of the Culture to Which You Belong (2017, para. 7, emphasis in original)

Armstrong wrote:

> Categories of disability often deeply reflect the values of a culture. Dyslexia, for example, is based upon the social value that everyone be able to read. One hundred and fifty years ago, this wasn't the case, and dyslexia was unknown. Similarly, autism may reflect the cultural value that suggests that it's better to be in relationship than to be alone. We should recognize that diagnostic categories are not purely scientifically-based but reflect these deeper social biases. (2017, para. 7)

This argument is subtly different from the argument that competence is socially constructed. The argument posits that competence is *culturally* constructed. Culture has to do with the beliefs and value systems of a collective world-view of a given population. For example, Wendell (1996) discusses the case of a disabled author (whose leg was damaged by childhood polio) whose close friend commented at her wedding to her new husband what a burden he expected the author to be. There are many cultural values to unpack: (1) a woman with a disability is a burden; (2) married partners should not be burdens to one another; (3) a social burden has a duty to isolate; and (4) as Wendell points out (1996, p. 61), physical imperfections particularly "spoil" women, who experience undue pressure culturally to come as close to physical perfection as possible.

"The power of *culture* alone [emphasis added]," wrote Wendell, "to construct a disability is revealed when we consider bodily differences—deviations from a society's conception of a 'normal' or acceptable body—that, although they cause little or no functional or physical difficulty for the person who has them, constitute major *social* disabilities [emphasis added]" (Wendell, 1996, p. 62). The distinction between the cultural and the social is subtle, but important. Cultural values inform what then becomes social policy. A cultural value that states women should attain physical perfection results in a (usually unspoken) social policy of stigmatization, isolation, and exclusion.

Aligned principle for able-diversity no. 3. Disability is both a social and cultural construct. Any culture's values, beliefs, and mores inform its concept of disability. Often a cultural value of (unspoken and usually unattainable) perfection leads to stigmatization, isolation and exclusion. An able-diverse perspective proactively resists this and seeks to substitute oppressive cultural messages with those that instead embrace disability. This is done by emphasizing and promoting the benefits to society and culture of diversity.

Armstrong's Fourth Principle: Whether You are Regarded As Disabled or Gifted Depends Largely on When and Where You Were Born (2017, para. 8, emphasis in original)

Armstrong wrote:

> In other times and other places, there have been different disability/ability diagnoses depending upon cultural values. In pre-Civil War America, for example, there was a disorder called "drapetomania" said to afflict blacks. Its

> meaning was "an obsession with the urge to flee one's slave masters" and reflected its racist roots. In India, today, there are people who would be labeled in the West as schizophrenic, but who are regarded as holy beings by the local population. We should not regard diagnostic labels as absolute and set in stone, but think, instead, of their existence relative to a particular social setting. (2017, para. 8)

Does the social model maintain that *giftedness* is also a social construct? At least two scholars think so: Harvey Molloy and Latika Vasil (2002) maintained that the condition previously known as Asperger Syndrome is realized through a social construction of *both* gifts and deficits. They also accurately predicted in 2002:

> It is likely that the labeling of children as having [Asperger Syndrome] will be increasingly contested as scholarship in the field is challenged into addressing the issues of the power dynamics involved in and the social repercussions of such labeling with its implications of deficit and pathology. (Molloy & Vasil, 2002, p. 669)

Indeed, Asperger Syndrome as a diagnosis was removed from *The Diagnostic and Statistical Manual of Mental Disorders* (5th Edition), and conceptualized instead as a location on the Autism spectrum. Furthermore, the idea that people can simultaneously maintain both gifts and deficits is sometimes called *twice-exceptionality*, and at least one scholar (Ronksley-Pavia, 2015) acknowledged that if twice-exceptionality is not altogether socially constructed, it is at least profoundly informed by its socio-cultural milieu.

Aligned principle for able-diversity no. 4. Disability and giftedness are both social constructs. The relationship between disability and giftedness is also fluid and dynamic. The same trait in some social contexts may be viewed as a deficit and in other social contexts as a gift. Therefore, it is important to remember that so-called deficits can manifest themselves as gifts in different contexts, which is cause to embrace diversity in general as a positive attribute of the human condition. It is also worthwhile to examine the lens that differentiates "gifts" and "deficits" as itself inevitably packed with cultural biases. One critical cultural bias to unpack is the association of *giftedness* with the positive and *disability* with the negative.

Armstrong's Fifth Principle: Success in Life is Based on Adapting One's Brain to the Needs of the Surrounding Environment (2019, para. 9, emphasis in original)

Armstrong wrote:

> Despite Principles 3 and 4, however, it's true that we don't live in other places or times, consequently [sic] the immediate need is to adapt to our current contemporary culture. This means that a dyslexic person needs to learn how to read, an autistic individual needs to learn how to relate to others socially, a schizophrenic individual needs to think more rationally and so forth. Tools such as psychoactive medication or intensive remediation programs can help achieve these aims. (2017, para. 9)

The social model of disability would question what "success" means. If anything is a social construct, the concept of "success" (particularly that rather dubious phrase "success in life") certainly is one.

Aligned principle for able-diversity no. 5. All people have intrinsic value, whether they are "contributing to society" and "successful in life" or not. While disabled people face discrimination in the workforce, able-diversity rejects the idea that human value is determined by a marketplace. Armstrong followed up on his "success in life" salvo with the following clarification.

Armstrong's Sixth Principle: Success in Life Also Depends on Modifying Your Surrounding Environment to Fit the Needs of Your Unique Brain (Niche Construction) (2017, para. 10, emphasis in original)

Armstrong wrote:

> We shouldn't focus all of our attention on making a neurodiverse person adapt to the environment in which they find themselves, which is a little like making a round peg fit in a square hole. We should also devise ways of helping an individual change their surrounding environment to fit the needs of their unique brain. (2017, para. 10)

This is closer to the aims and goals of the social model of disability: we have to change the milieu in order to fully include disabled people. The social model would still likely question the word *niche* ("niche construction"): I imagine that proponents of the orthodox social model of disability would rather seek universality of design rather than relegate disability-friendly design to the realm of the niche. Relegation to niche still has the risk of isolation and stigmatization of the disabled person. It is perhaps better then to emphasize the degree to which Armstrong argued that milieus and contexts must also be changed to include neurodivergent people.

Aligned principle for able-diversity no. 6. For disabled people to be fully included, social contexts and milieus must change. This goes beyond the building of ramps; disabled people must be included in representation in the media, in politics, and in the everyday frame of social consciousness. Disabled people must be permitted to emerge from the shadows and penumbra of "the other."

Armstrong's Seventh Principle: Niche Construction Includes Career and Lifestyle Choices, Assistive Technologies, Human Resources, and Other Life-Enhancing Strategies Tailored to the Specific Needs of a Neurodiverse Individual (2017, para. 11, emphasis in original)

Armstrong wrote:

> There are many tools, resources, and strategies for altering the environment so that it meshes with the needs of a neurodiverse brain. For example, a person with ADHD, [sic] can find a career that involves novelty and movement, use an iPhone to help with organizing his [sic] day, and hire a coach to assist him [sic] with developing better social skills. (2017, para. 11)

Armstrong's essential point was that the environment can be altered through emerging technologies with greater ease than ever before. The emphasis on careerism in Armstrong's seventh principle remains slightly troubling; people have value whether they have thriving careers or not. Also, the term "social skills" is eminently a social construct, so I posit that it may be as fruitful to campaign for understanding of the neurodivergent individual as it is for the neurodivergent individual to invest in social skills coaching. It is perhaps not *either-or* but rather *both-and.*

Aligned principle for able-diversity no. 7. As Thomas Armstrong said, "There are many tools, resources, and strategies for altering the environment…." (2017, para. 11). While efforts to entrain to the needs and expectations of society at large are understandable, such efforts are often unfairly one-sided, and therefore oppressive to disabled people. It is incumbent on society to make the resources available that facilitate full inclusion of disabled people, both legally (in comportment with the Americans with Disabilities Act) and morally. Finally, Armstrong gave his eighth principle:

Armstrong's Eighth Principle: Positive Niche Construction Directly Modifies the Brain, Which in Turn Enhances its Ability to Adapt to the Environment (2017, para. 12, emphasis in original)

Armstrong wrote:

> In experiments with mice, neuroscientists have shown that a more enriching environment results in a more complex network of neuronal connections in the brain. This more complex brain, in turn, has an easier time adapting to the needs of the surrounding environment. (2017, para. 12)

It is ambitious to extrapolate from the neurology of mice a broad principle applicable to humans. However, my suspicion is that human neurology will eventually bear this out too. Armstrong was describing virtuous circle (i.e., a positive vicious circle): a more complex environment creates a more complex neural network; a more complex neural network is better able to apprehend still more complex environments; these create still more complex neural networks, and so on.

The social model of disability admits a similarly virtuous circle: as more disabled people are included in society, the more disabled people have input into universalizing the environment; the more universal the environment, the more disabled people that can be included, and so on.

Aligned principle for able-diversity no. 8. Disabled people must be included and give input on the environment in which they find themselves. Disabled people are the experts in the disabled experience, and should be at the helm of efforts to universalize the environment and to pioneer greater representation in the media, politics, and social affairs.

Able-Diversity Defined

Where the social model of disability and neurodiversity (the latter of which at least as Armstrong discussed it) seem to agree broadly is on the insistence that social forces conspire to bar disabled people from full inclusion, particularly in the work force. Where they do not align is subtle: the social model of disability insists that society constructs disability, where the neurodiversity model locates neurodivergence in the individual, postulating that it is a diverse trait like race, gender, sexual orientation, etc., that ought to be treated as some sort of similarly protected class. The two approaches are reconciled here as able-diversity: able-diversity asserts that disability is socially constructed *and* that able-diversity is an inherently individual trait that should be afforded the same regard as other protected-class traits of marginalized people. Able-diversity recognizes the conundrum as not *either-or* but rather as *both-and*.

Armstrong (2017) cited the following definition of neurodiversity from Wikipedia, a definition he presumably endorsed: "...an idea which asserts that atypical (neurodivergent) neurological development is a normal human difference that is to be recognized and respected as any other human variation" (para. 3). In the spirit of *both-and*, able-diversity is here defined as any socially constructed developmental difference in ability that is to be recognized and respected as any other human variation.

The inclusion of "socially constructed" reflects the alignment between the social model of disability and the model of neurodiveristy as they both inform able-diversity. Developmental differences in ability are socially constructed in as much as abilities are subjectively evaluated by society and deemed as either important or unimportant by society. The latter point is particularly germane. The importance of various abilities exists on a spectrum. The importance of being able to feed oneself or to clothe oneself or bathe oneself is high. The ability to read, compute mathematically, and to socialize is perhaps the next in line. The ability to play sports well or perform on a musical instrument is not seen as crucial, but each is an ability that is often rewarded by society if present.

The inability to walk, see, or hear is a disability only inasmuch as we have constructed human society to assume that walking, seeing, and hearing are default experiences, with social—and literal—infrastructure constructed accordingly. However, if the minority status of a particular disability is indeed a social construct, then it should be afforded the same consideration as other human variances that are social constructs. The minority status of a race is a social construct, and because of the experience of

oppression on the part of minority races vis-a-vis the social construct race is seen as a protected class, particularly in the eyes of the law. Able-diversity demands that disability be treated with the same affordances, socially and legally, as other protected classes.

Summary

In this chapter, I synthesized the social model of disability with the concept of neurodiversity by outlining eight principles that emanate from the coalescence of the two concepts. These principles are as follows: (1) disability, whether physical, intellectual or emotional, is a systemic construct that is complex, fluid, and dynamic; (2) competence, like ability, is a social construct; (3) disability is both a social and cultural construct; (4) disability and giftedness are both social constructs; (5) all people have intrinsic value, regardless of whether they are "contributing to society" and "successful in life"; (6) for disabled people to be fully included, social contexts and milieus must change; (7) it is incumbent on society to make the resources available that facilitate full inclusion of disabled people, both legally (in comportment with the Americans with Disabilities Act) and morally; and (8) disabled people must be included and allowed to give input on the environment in which they find themselves.

CHAPTER III

PROGRESSIVE MUSIC THERAPY: THE SYNTHESIS OF CULTURE-CENTERED MUSIC THERAPY, COMMUNITY MUSIC THERAPY, MUSIC-CENTERED MUSIC THERAPY, AND ANTI-OPPRESSIVE MUSIC THERAPY

Progressive Music Therapy Introduced

In this chapter, I will synthesize four modes of music therapy that lend themselves to the deconstruction of the traditional medical model (see Figure 3). The first of these is outlined in Brynjulf Stige's *Culture-Centered Music Therapy* (2002). Stige argued that music is really musics, plural, and culturally situated (Stige, 2002). Stige discussed the concept of *musicking*, coined by Christopher Small but developed at length by Stige (Small, 1998). Where traditional concert music is unidirectional, musicking is two-way in nature (Stige, 2002). This begins to deconstruct hierarchy (superior performer, inferior audience). While Stige was skeptical of the proposition that "changing nouns into verbs will solve too many of our problems" (2002, p. 101), he nevertheless discussed the "power of musicking" (p. 103). Stige presented a tripartite model in which musicking, protomusicality and musics (plural) all inform one another. When "musics" is achieved, then "diversity of cultural artifacts with a variety of affordances" emerges (Stige, 2002, p. 107). Consequently, I would argue that the equality of cultures interfaced through musicking leads to an egalitarian sensibility of music therapy when it engages in musicking. This egalitarianism is important because this frame for therapy

leads to other deconstructed hierarchies, particularly that of superior (able-bodied/minded) therapist and inferior (disabled) client.

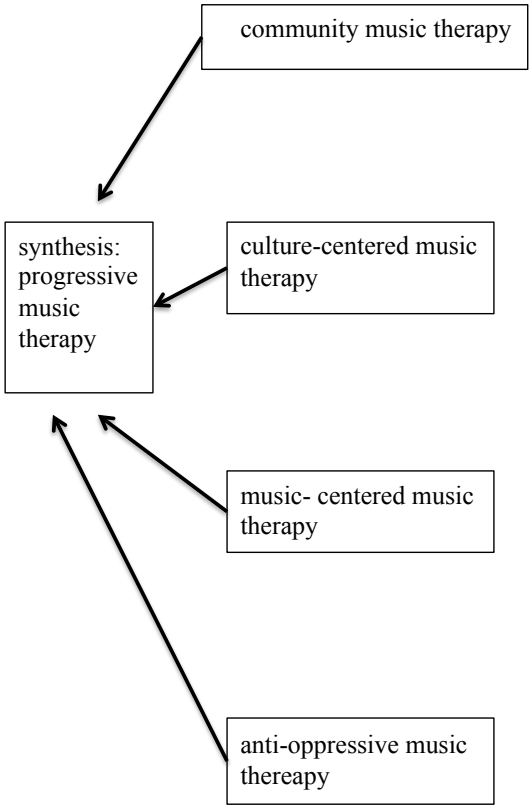

Figure 3. Synthesis of Community Music Therapy, Culture-Centered Music Therapy, Music-Centered Music Therapy, and Anti-Oppressive Music Therapy to form Progressive Music Therapy

Next, Mercédès Pavlicevic and Gary Ansdell edited a volume titled *Community Music Therapy* (Pavlicevic & Ansdell, 2004). Community music therapy is any coming-together of therapists and clients for musical-therapeutic purposes (2004). Community music therapy by definition is communitarian, and therefore, also deconstructs the hierarchy between superior therapist and inferior client. Ansdell refers to it as an "anti-

model" (cited in Pavlicevic & Ansdell, 2004, p. 21). It resists what he called "one-size-fits-all-anywhere" models (cited in Pavlicevic & Ansdell, 2004, p. 21). Because of its communitarianism, and because of the plurality and flexibility of definitions of community music therapy, I would argue then that the authoritarian model of superior therapist and inferior client is intrinsically rejected.

The third of these is *Music-Centered Music Therapy* (Aigen, 2005). Music-centered music therapy was created by Kenneth Aigen.[4] As music-centered music therapy is discussed below, it should be remembered that its chief architect, Kenneth Aigen, is not anti-science *per se*, as he is sometimes accused of being. Science vs. anti-science is a neat, but false, dichotomy. Aigen (2005) argues that music-centered music therapy is as academically rigorous as scientific research.

It has its origins in the thinking that underpins Nordoff-Robbins music therapy (Aigen, 2005). It is an expansion of the *music as therapy* concept initially put forward by Bruscia (Aigen, 2005). Aigen added that the term *music-centered* is possibly applicable to clinical practice, theory, education, training, and research. Aigen (2005) said "The music-centered perspective cannot be represented simply, as there is no official doctrine or set of beliefs and practices that define the approach" (p. 51). Be that as it may, here is a brief summary of music-centered music therapy. The essential idea is that music-making is the primary purpose and point to therapy, *not* the non-musical goal that is usually sought by the traditional music-therapeutic paradigm. If the non-musical goal is achieved as a by-product of music-making, all to the good. But the music is still the central purpose. There are good reasons for this. First, it can be argued that if one does not

engage music completely and fully and for its own sake, one cannot fully benefit from music, an argument put forth by Garred (2004). Second, music-making (or *musicking*) promotes self-growth according to Elliot (1995). Third, and most germane to the present argument, musicking breaks down the structural hierarchy of superior therapist and inferior client.

Because music-making is its own end, music-centered music therapy rejects the normalization process of medicalized music therapy. Because musicking can occur between any people within the music-centered music therapy model, disabled people are inherently included without the accompanying imperatives toward normalization, rehabilitation, cure, etc. Aigen wrote (2005):

> The starting point for this way of thinking is that music enriches human lives in a unique and necessary way. Music therapy consists of providing opportunities for muiscing to people for whom special adaptations are necessary. *The functions of music for disabled individuals or for those in need of therapy are the same as for other people* [emphasis added]. (p. 93)

Aigen (2005) also pointed out that music-centered music therapy promotes communal dimensions. Aigen described this relationship as *communitas*, which is a sense of community in which all participants are equal. In other words, music-centered music therapy seeks egalitarianism in its organizational structure, contrary to the hierarchies (e.g., superior therapist and inferior client) and dualities (e.g., sick or well) of the medical model. Aigen identified several ways in which *communitas* powerfully operates spontaneously through music: altruistic sacrifice for the sake of the group's

community music making, coordination of individuals, group creation of an aesthetic product, and experience of group enjoyment through the application of skill. All of these are experienced by therapists and clients alike whether the therapists or clients are deemed disabled or not.

Deconstructing the distinction between therapist and client is important, according to Rolvsjord (2014) because the therapist is often motivated to "fix" the client. In other words, the impulse to "help" can be oppressive. In the music-centered music therapy model, thankfully, music-making, rather than "fixing" the client, is the prime mover of the therapeutic enterprise. I propose then that subsequent formulations and editions defining music-centered music therapy formally and explicitly embrace the social model of disability. Chapter Five of Aigen's (2005) *Music-Centered Music Therapy* is titled "Rationales, Practices, and Implications of Music-Centered Music Therapy" and entails the following subheadings, which read like a constitution of sorts:

- The Client's Experience in Music Is Primary;
- Musical Goals Are Clinical Goals;
- The Primary Focus Is Enhancing the Client's Involvement In Music
- The Convergence of Personal Process and Musical Development;
- The Intrinsic Rewards of Musical Participation;
- The Experience of the Musical Process Is the Therapy;
- and so forth.

I propose here, then, that Aigen's constitution be amended to include one more important subheading: "Music-Centered Thinking Embraces the Social Model of Disability" and that an accompanying explanation would read something like this:

> The social model of disability rejects the locus of problematized impairment as inhering within the individual as is the case with the traditional medical model. Rather, it maintains the problem is with society in its construction of disability itself as socially inferior and the institution of barriers, both social and literal, placed in the way of disabled people. Furthermore, the social model of disability rejects the hierarchization of superior therapist and inferior client, and rejects the false dualities of sick/well, dependent/independent and disabled/able-bodied.[5] Instead, disability exists on a spectrum that includes everyone, as everyone eventually experiences some form of impairment at some point in each life if one lives long enough. Music-centered music therapy, then, joins the social model of disability in critiquing the traditional medical model similarly. By focusing on egalitarian music-making for its own sake, the hierarchy between superior therapist and inferior client is deconstructed.

My proposed amendment is only meant to reinforce explicitly what I already believe to be implicit in the emanations and penumbra of Aigen's document. It is not in any way to suggest any sort of error-by-omission on Aigen's part.

The fourth and final model discussed here that lends itself to the deconstruction of the traditional medical model of music therapy is anti-oppressive music therapy, the main exponent of which is Sue Baines (2012).[6] Where the other three were very specific in

their aims and goals for music therapy, Baines's model was quite broad: it explored ways in which music therapy must resist oppression in dimensions that include not only ability, but also race, gender identity, sexual orientation, etc.

Anti-oppressive music therapy assumed that power imbalances exist "based on age, class, ethnicity, gender identity, geographic location, health, ability, race, sexual identity, and income" (Baines, 2012, p. 2). Much of the constructive form of anti-oppressive music therapy was based on the work of Freire (Baines, 2012), whose commentary on the education field deconstructs the nature of power between teachers, students, and society. Baines also based much of her model's construction on the work of Carolyn Kenny (Baines, 2012). Kenny's work in music therapy is critical of the centrality of the white male and "instead she propose[s] a more inclusive ecological paradigm" (Baines, 2012, p. 2). Baines, as I do, drew upon models such as music-centered music therapy, culture-centered music therapy, and community music therapy (Baines, 2012). However, she criticized these as "struggl[ing] with a semantic lack of clarity" which she felt was remedied by the umbrella term "anti-oppressive music therapy" (p. 3). (For example, Baines, 2012, on page 4 pointed out the problematic nature of the term "community" because of its "multiple meanings and contexts.") She perceived music-centered music therapy, culture-centered music therapy, and community music therapy all as resisting the medical model, an analysis with which I agree. She furthermore rooted her model in sociology (Baines, 2012), particularly in the work of Victoria Kannen (2008, p. 160) who stated anti-oppressive work must proactively "combat/disrupt/subvert/undo oppressive barriers."

Baines's model was the most ambitious of the four models presented here. It sought remedies in music therapy practice for oppression in the dimensions of race, gender identity, ability, sexual orientation, class, and so on. Collaborating with Edwards, they defined oppression as "the brokering of power in all aspects of service delivery and in the privileging or silencing of certain theoretical perspectives" (2015, p. 32). It is no trivial thing to attempt to define oppression. Recall Shakespeare (2010), who pointed out that it is not enough merely to assume that disabled people are oppressed; Shakespeare maintained this must be proven first. I tend to prefer a model that expresses what it is embracing rather than what it is rejecting. This is why I am developing in this work a model that can be embraced: able-diversity. It is all well and good to be anti-oppression, but if branding a model is of a premium (as Baines seemed to insist), then it is perhaps better to highlight what we can proactively embrace. The opposite of oppression is the embrace of diversity.

This is a minor criticism, of course. Baines's model was overall a very important model with which any serious critic of the medical model of music therapy must contend. If we can assume for the sake of argument that the medical model is in some way oppressive, then it falls to us as music therapists to "combat/disrupt/subvert/undo" those aspects of the medical model that oppress. As Edwards and Hadley (2007) pointed out, therapists are not benign and neutral helpers; their acts are both political and social. Furthermore, Baines and Edwards (2015) argued that music therapy conducted without an anti-oppressive political lens may be unethical.

Progressive Music Therapy: Developed

The intersection of culture-centered music therapy, community music therapy, music-centered music therapy, and anti-oppressive music therapy is what I call *progressive music therapy*. Progressive music therapy is political, overtly concerned with social justice, and seeks not just change in both client and therapist (if indeed either want change), but also in communities and society at large.

Why should music therapy take such a seemingly activist stance? Many music therapists may object on the basis that she or he never sought to be an activist, particularly through music therapy. I would argue, though, that the personal is political (not an original thought, of course) and that one's professional choice is a personal choice that is also, inevitably, framed by political overtones, whether one likes it or not. When one chooses to be a therapist, one is taking the lives of clients into her or his hands, so to speak. That in and of itself is a political act: one inherently becomes a confidant of, an ally of, and most importantly, an advocate for the client. This is particularly true if the client is situated at the behest of larger, and therefore more impersonal, institutions, where power dynamics are imperious, portentous, and ubiquitous.

How are each of the four models—culture-centered music therapy, community music therapy, music-centered music therapy, and anti-oppressive music therapy—progressive? First, progressive music therapy is culture-centered music therapy in its acceptance of the equality of cultures and its emphasis on sensitivity to cross-cultural differences. Progressive music therapy eschews ethnocentrism in favor of a worldview that follows from Stige's observation, "That persons and groups to a large degree identify

with the values and worldviews of their own upbringing and cultural context is of course inevitable and in itself not problematic. Problems arise when such taken-for-granted views are integrated in oppressive practices" (2002, p. 132). In other words, music therapy ought not be in the business of perpetuating practices and attitudes toward multiculturalism that reinforce oppression.

Progressive music therapy is community music therapy in its emphasis on the consequences to the larger community of the music therapy enterprise. Community music therapy maintains that music therapy by and large can and should take place in groups that are egalitarian rather than hierarchical, in which exchanges are two-way rather than one-way. Progressive music therapy adopts this posture, and extrapolates from this posture a worldview which is also more inclusive, democratic, and equal.

Progressive music therapy is music-centered music therapy in that its focus on *musicking* removes the locus of pathology from the client altogether, and instead replaces the pathologically marked client with collaborative musician. A pathologically marked client is inherently lesser. A collaborative musician is equal.

Additionally, progressive music therapy is anti-oppressive music therapy in its emphasis on social justice and its recognition of the political act that is therapy. Furthermore, each of the four models interfaces with each other in a synthesis, as the next section describes.

Six Syntheses and Accordant Principles

From each synthesis we can glean a principle of progressive music therapy. Below, each synthesis entailed by the chart above will be discussed, beginning with the synthesis of culture-centered music therapy and music-centered music therapy.

Synthesis No. 1: Culture-Centered Music Therapy and Music-Centered Music Therapy

The common element to both is a concept of *musicking*. This verb-form of the common noun *music* has a specific definition owing to the similar work of two separate scholars: David Elliot (*musicing*) and Christopher Small (*musicking*). (Note: for the sake of simplicity, I will refer hereafter to the form *musicking*.) First, Small's effort will be discussed in conjunction with Stige's culture-centered music therapy; next, Elliot's work will be discussed in conjunction with Aigen's music-centered music therapy.

Small's volume interrogated questions about the fundamental nature of music and its meaning in human life (1998). Small maintained that music is not a *thing*, it is an activity, something that people *do*. Small challenged the idea that musical performance is a "one-way system of communication" (1998, p. 6) that proceeds from composer to performer to listener. Small instead suggested that feedback from listener to performer to composer proceeds in the opposite direction. He critiqued the idea that musical works are autonomous and devoid of the contexts of religion, politics, and society (Small, 1998). For these reasons, musical performance is a rich and complex affair that cannot be neatly summarized by the unidirectional model most people assume.

Musicking, or "to music" (to take the infinitive voice) is "*to take part, in any capacity, in a musical performance, whether by performing, by listening, by rehearsing or practicing, by providing material for performance (what is called composing), or by dancing* [Italics original]" (Small, 1998, p. 9). Because music is an activity per Small's construction, *musicking* is a two-way participatory activity. It is a communal activity. Investigations of meaning for Small have more to do with the meaning of the *events* of music-making rather than specific individual pieces of music or corpora of music. Communal music-making that includes bawdy sing-alongs among drunken compatriots has as much interest to Small as does the meaning of a performance of Bach's *Saint Matthew Passion* (Small, 1998). The investigation of *musicking* is hence sociological.

In the paradigm of *musicking*, all human beings are inherently and natively musical, so "everyone's musical experience is valid" (Small, 1998, p. 13). This also lends itself to a communitarian argument for the fundamental nature of music, which underpins both culture-centered music therapy and music-centered music therapy. In communitarian music-making, hierarchical, unidirectional relationships (e.g., primary composer, secondary performer, tertiary listener) are called into question, if not deconstructed altogether.

For Stige (2002), definitions of music must necessarily be culturally contingent, and are therefore fluid and malleable as cultures themselves vary across the globe. So for Stige, as with Small, investigations into "the nature of music" are problematic. Stige concurred with Small that music is both an event and an activity: "Music may be considered a situated event and activity. As event music is sound-in-time, organized as

culturally informed expressions of human protomusicality. As activity music is the act of creating and relating to emerging sounds and expressive gestures" (Stige, 2002, p. 318). According to Stige (2002, p. 359), because music is an activity ("to music"), it is imperative that music therapists meet music-making where it actually resides: both in the karaoke event *and* the concert hall.

Aigen made the distinction between motoric perseveration by an autistic child who plays only the white notes on a keyboard and *musicking,* which the child is not yet doing. However, when the therapist joins in and suggests specific tempos, meters, and a harmonic landscape that complements the child's diatonicism, and the child engages with the therapist, then the child is truly collaborating and *musicking*, not merely perseverating on the white keys (Aigen, 2005).

Musicking is an opportunity for self-growth, self-knowledge and enjoyment (Aigen, 2005). Thus, when music is engaged for its own sake, but with musical intentionality, then the opportunity for self-growth and self-knowledge are fully realized. This is one of the core principles of music-centered music therapy: the non-musical goal is a happy byproduct of *musicking.* We can therefore glean a first principle about progressive music therapy from the synthesis of music-centered music therapy and culture-centered music therapy.

Synthesized principle for progressive music therapy no. 1. Progressive music therapy requires *musicking*. This is a thoughtful and egalitarian exchange of music between client(s) and therapist(s) where music-making breaks down the hiearchy

between superior therapist(s) and inferior client(s). *Musicking* is inherently collaborative, multi-directional, and a valuable exchange for *both* the client(s) and therapist(s).

Synthesis No. 2: Community Music Therapy and Music-Centered Music Therapy

As previously described, one of the central tenets of music-centered music therapy is the idea that music itself is a sufficient goal of therapy and that if non-musical goals are met, this is a happy byproduct of *musicking* However, the secondary nature of the non-musical goal is also an aspect of community music therapy that requires discussion. This next section will deal with Pavlicevic and Ansdell (2004) who describe community music therapy as having a "ripple effect": an isolated person makes a connection to a sub-community of musicians; the sub-community of musicians makes a connection to a community, and the community carry the effects of the music to broader society. However, a bi-directionality is also involved; so the ripple effect can ripple inward too. I observe that broader society can make resources available to a community in a building to *music*; the community can encourage and support a sub-community of musicians; and a sub-community of musicians can support the musical individual in need. Community music therapy, because of its fluid and multi-directional nature, is not a "one size fits all anywhere" model according to Pavlicevic and Ansdell (p. 17). It also resists definition; wherever *musicking* in a group happens with therapist(s) and client(s), community music therapy is taking place. Community music therapy is as multivalent as the communities served themselves, and moreover, there can be more than one community involved.

Community music therapy does however define itself *against* something else: something Pavlicevic and Ansdell referred to as the "consensus model" (2004), which is the generally accepted and conventionally understood model of ordinary music therapy. It comports to the medical model, understands non-musical goals to be primary, and understands music as a vehicle for therapeutic delivery in addressing the non-musical goal. In community music therapy, a non-musical goal of remediation is secondary to other considerations. First and foremost is the construction of *community* through music. Community inevitably entails an awareness of social policy, a sense of place that contextualizes the community, and connections between people through music. I would observe that the creation and observation of community is in and of itself inherently therapeutic for the client(s) involved in community music therapy. Community is the antithesis of isolation. Isolation can lead to anxiety, depression, and other maladjustments. Community music therapy also recognizes that music is "an active, transformative social force" (Pavlicevic & Ansdell, 2004, p. 27). So social transformation through music is also another more immediate goal of community music therapy, making the non-musical goals of remediation secondary.

Pavlicevic and Ansdell recognize that any music therapy enterprise that sees the remediation goal as secondary could be described by some as not music therapy at all (2004). Pavlicevic and Ansdell (2004) respond by pointing out that authoritative stances of "right" and "wrong" in a discipline like music therapy are "dubious" (p. 28). Too many music therapists have had positive experiences creating musical communities for their own sake to be dismissed. The authors observe that many music therapists have had

to adjust music therapy praxis based on the needs of their clients to be more communitarian in nature; community music therapy did not arise in an intellectual vacuum. They suggest that rather than being *pathogenic* (treatment for a problem), an approach to music therapy should be *salutogenic* (working for health and fun; Pavlicevic & Ansdell, 2004). So community music therapy joins music-centered music therapy in making secondary the remediation goals typically sought by music therapy in the consensus model. This brings about the second principle.

Synthesized principle for progressive music therapy No. 2. Progressive music therapy allows for the focus on primary goals of music-making and community-building, making the traditional goal of remediation secondary. To do so is to create musical communities that are egalitarian, non-hierarchical in nature, and collaborative. This is in recognition of the fact that music-making and community-building are in and of themselves inherently therapeutic for clients, whatever else the non-musical goals for therapy may be.

Synthesis No. 3: Anti-Oppressive Music Therapy and Music-Centered Music Therapy

Both anti-oppressive music therapy and music-centered music therapy share a commitment to client-therapist equality as a necessary dimension in a truly therapeutic relationship. Baines (2012, p. 2) believed that anti-oppressive music therapy can be a basis for "patient empowerment." She believed that it is necessary to counteract oppressive medical practices; for example, she discusses using an anti-oppressive model to empower older clients with dementia in long-term residential care facilities. Baines

(2012) also noted the intersectionality of the therapist-client hierarchy with dimensions of race and age. I would observe that further dimensions of intersectionality such as gender, sexual orientation, class, ethnic background and culture, and other markers of identity would be fruitful for exploration in conjunction with the therapist-client hierarchical dyad.

Meanwhile, Aigen argued that the equality of the therapist and client inevitably allows the clinician to think "first and foremost as [a musician]" (Aigen, 2005, p. 128). The relationship between the two is based on a shared love of music and occurs "musician to musician" (Aigen, 2005, p. 128). Aigen (2005) maintained that barriers between clients and therapists are transcended in his model, replacing the unidirectional hierarchy of superior therapist and inferior client with that of "mutality and equality between therapist and client" (p. 128). "In a musical relationship," Aigen (2005) wrote, "the primary message from the therapist to the client is *I am here to help you make music*, rather than *I am here to change you, fix you, control you, or heal you* [emphasis original]" (p. 128).

The delicate irony here is that precisely *because* the relationship is more equal, egalitarian and non-hierarchical, it is all the more likely to facilitate therapeutic benefits for the client. It is counter-intuitive. Rather than exerting control, the therapist invests in the mutuality of the relationship, which I would argue is far more likely to see non-musical dividends. This is because the client is more likely to be engaged with the *music.* Remember, it is the *music* that facilitates the benefit for the client first and foremost. A client that is one-down in the relationship with the therapist is going to be more guarded,

suspicious, defensive, and dubious than a client who feels like a fully affirmed, equal musical partner. The music-making (*musicking*) will be unabashed and unencumbered by doubt if the relationship between client and therapist is intrinsically collaborative.

Synthesized principle for progressive music therapy no. 3. Relationships between client(s) and therapist(s) in progressive music therapy are equal, equitable, egalitarian, and collaborative in nature. They are furthermore bi-directional and non-hierarchical. Clients and therapists mutually benefit each other through the action of *musicking.*

Synthesis No. 4: Community Music Therapy and Culture-Centered Music Therapy

Stige (2002) discussed in his essay "May We Too Play in the Brass Band?" whether it was possible to integrate intellectually disabled students into a community music school concert band in Norway. The question that prompts the essay's title was a literal question coming from a student with whom Stige worked. The question is aspirational in nature, and according to Stige, touched upon important issues in music therapy. Challenges to the possibility of inclusion included the attitude of the prevailing concert band, which had been unknown to Stige, and the also then-unknown musical aptitudes of the intellectually disabled clients Stige was charged with serving. Stige relied heavily upon improvisation as a way into musicality for his clients. Stige (2002) as director developed a set of hand signals that meant "slow," "fast," "hard," and "soft," as well as other musical parameters, and eventually became "more coordinated and collaborative" (p. 454). After eight months of intensive practice, integration took place in a concert event, with Stige strategically deploying the local newspaper for publicity as to

be "geared to change of attitudes and *breaking down of barriers in the community* [emphasis added]" (2002, p. 456).

Stige's efforts go to show that local culture can accommodate change and come down on the side of greater inclusion. Even though the brass band had its own longstanding subsets of traditions, Stige was able to find a way to include his intellectually disabled clients by emphasizing improvisation, close listening, and collaboration. What is also important to note is the degree to which Stige's efforts successfully broke down barriers in the community. This is what Stige's model has in common with community music therapy: large, egalitarian groups of people with varying degrees of ability are able to *music* together.

In supporting his view of community music therapy, Ansdell (2004) proposed that music therapy itself has focused on the discourses of music and therapy, but needs to focus on a third discourse, that of community. He questioned at first whether community actually exists anywhere but in the minds of idealistic people. He comes down on the side that community exists, but is distinct and not interchangeable with the concept of society. Kirkpatrick defines community as "the locus of ultimate personal fulfillment: communion, fellowship, mutuality and intimacy" (Kirkpatrick, 2001, p. xii). Society is, by contrast, about the locus of power distribution among peoples (Kirkpatrick, 2001). Ansdell whittled down many concepts of community to three main models: communities of place (geographically based communities), communities of hope (communities based around common ideals), and communities of interest (identity, e.g., black/gay/woman). Ansdell (2004, p. 77) proposed a fourth possible model, that of "circumstantial

communities" where people live together by force through the circumstances of illness or social sanction.

Indeed, Ansdell cited Stige's concepts of communal musicking as a foundational example upon which community music therapy can build (see, for example, Ansdell, 2004, p. 83). Community is often something that is achieved among clients through the course of *musicking.* Ansdell described this as a three-step process: first the music is a "collage of monologues"; next, "concerted action" leading to some sort of music congruence; finally, *musical communitas* is achieved in which there is a shared musical experience that achieves both diversity and unity.

Communitas for Ansdell was "the graceful but prepared happening of musical experience within a social and cultural context. Communitas can be both a nourishment and a critique of host communities (whether these be circumstantial or natural)" (Ansdell, 2004, p. 86). He also maintained that *musical communitas* was the focal concept of community music therapy. Though Ansdell did not explicitly state as much, I would argue that *musical communitas* to be achieved must be egalitarian and hierarchy-free. This is because clients who are perceived as existing on the inferior side of a two-way relationship can be guarded, untrusting, and possibly resentful of the inferiority. While it is possible to conceive of a client who finds comfort in being one-down in a two-way relationship, it is in my view safer to err on the side of non-hierarchy. Clients and therapists who exist in a truly equal community are far more predisposed to share, to invest in the mutuality of the relationships, and to come together for common musical goals.

Synthesized principle for progressive music therapy no. 4. Communities of progressive music therapy should be egalitarian, equal, non-hierarchical, and multi-directional in nature among therapists and clients. Community building is one of the important non-musical goals of progressive music therapy, as community building is therapeutic.

Synthesis No. 5: Anti-Oppressive Music Therapy and Culture-Centered Music Therapy

Baines (2012) discussed culture in the context of anti-oppressive music therapy. She observed, quoting Parrott (2009), that cultures are contingent on the groups that construct them, and that these groups are constantly in a state of negotiation regarding the content and meaning of the culture in which they are immersed. Baines emphasized that anti-oppressive music therapy must embrace an anticolonial paradigm: marginalized people have their own cultures and the equality of the culture of marginalized people must be respected.

It is not for nothing that Baines based her construction of anti-oppressive music therapy on the work of Kenny (1982, 1985, 1989). Kenny's own work heavily critiqued cultures in which white males predominated, and promoted cultures that were more ecological (i.e., egalitarian). Baines also based her work in developing anti-oppressive music therapy on Feminist theories such as Chesler (1971), Burstow and Weitz (1988), Dutton-Douglas and Walker (1988), Lerner (1988), and Curtis (1990) who all critiqued patriarchy in broader western culture in a myriad ways.

Meanwhile, Stige (2002) denied that he was a cultural relativist (i.e., a proponent of the proposition that all cultures are equally valid). However, he argued that universalizing components underpinning most if not all cultures is fruitless. Religion, one such component of most, if not all cultures, is too abstract to universalize. Instead, Stige argued in favor of a search for systematic relationships rather than common identities among cultures. So for example, I would observe that most cultures have a concept of reverence for the larger universe, a philosophical basis for moral and ethical behavior, and a means for marking group identities and communities as bound together (bearing in mind that the term *religion* itself comes from the Latin for "to bind"). Most cultures entail something that *functions* as what we would commonly understand to be religion. However, at the same time, not all cultures are oriented around monotheism, for instance. Polytheistic religions have many names for many worship objects. But the *function* of polytheistic religion to its cultures is essentially the same as the function of monotheistic religion to its cultures. Because similar functionalities (e.g., religion, law, politics, etc.) exist across cultures, it can be argued on *that* basis—rather than on the basis of relativism—that cultures are more or less equal to one another.

So culture-centered music therapy and anti-oppressive music therapy have a common commitment to the view that cultures are equally valid, more or less. This is not to say that aspects of those cultures are beyond critique. Baines (2012) critiqued the patriarchy of dominant cultures, for instance. However, cultures entail similar social functions across the globe, and this should be recognized and respected.

Synthesized principle for progressive music therapy no. 5. Progressive music therapy recognizes that a myriad of cultures exist across the globe, entail functionalities that are broadly similar across the globe, and that cultures including marginalized people should be recognized as valid.

Synthesis No. 6: Anti-Oppressive Music Therapy and Community Music Therapy

It will be argued here that anti-oppressive music therapy and community music therapy are united by an interest in *social justice.* However, that term is often deployed by many people in many different contexts, and can have different definitions for different people. I am going to define social justice in music therapy as a concern with the use of music therapy as a springboard for advocacy of just and equitable relationships between the individual and society (loathe though one is to cite *Wikipedia*, compare this to the *Wikipedia* definition of "social justice," 2019). Social justice in music therapy is also a concern with the use of music therapy to advocate for and to advance fair and equitable distributions of power throughout society.

Anti-oppressive music therapy is first and foremost about incorporating principles of social justice into music therapy. Baines's article "Music therapy as an Anti-Oppressive Practice" entailed keywords "Anti-Oppressive Practice, Music Therapy, Feminist, Critical Analysis, Ethical, *Social Justice* [emphasis added]" and "Community Music Therapy" (2012). In the same foundational article, Baines discussed her background developing anti-oppressive music therapy: she focused extensively on social justice theoretical perspectives in related fields, particularly social work. She was

influenced by paradigms that included anti-imperialism, anti-racism, critical post-modernism, post-structuralism, post-colonialism, and disability studies, to name a few.

Baines wrote, "Anti-Oppressive Practice asserts that power imbalances are based on age, class, ethnicity, gender identity, geographic location, health, ability, race, sexual identity, and income and that personal troubles are seen as inextricably linked to these oppressive structures," (2012, p. 2). Baines offered six principles for an activist practioner, which were written by her sister, Donna Baines :

1. Be likeable! Be charming! Be human!

2. Be good at your job[.]

3. Use your privilege[.]

4. Remember that you are an instrument[.]

5. Build your allies: link with unions and social movements[.]

6. Remember, the system wasn't made for us or by us and we do not have to prop it up[.] (2011, p. 92)

Baines discussed (2012) being involved in a six-week group music therapy program in a mental health space as an example of anti-oppressive music therapy in the promotion of social justice. She used her privilege to integrate the ideas of the clients into the program; she advocated for the group participants to be able to communicate directly with staff and management about concerns; advocated "user-led mental health services, teaching and supporting how to navigate the system in terms of housing, nutrition, and clothing allowances, increasing peer support, and supporting creativity on

many levels" (Baines, 2012, p. 4). Social justice for Baines then was a matter of client *advocacy*.

Similarly, Pavlicevic and Ansdell said, regarding community music therapy, "The sense that music therapy *can* [emphasis original] have an agenda of social politics and social justice seems characteristic of a vein of [community music therapy]" (2004, p. 25). Stige (2004) stated that community work includes by necessity a broad range of approaches, but most all these approaches are steeped in social justice values.

I would observe that community music therapy engenders social justice by virtue of its emphasis on inclusion. When Stige (2002) included his intellectually disabled clients in a community brass band, that was an example of social justice in action. When Baines advocated for her mental health clients to be included in policy decisions at their institution, that was another example of social justice in action. Social justice is often about granting access to the marginalized, who traditionally and typically lack access at the table of policy decision-making.

Synthesized principle for progressive music therapy no. 6. Progressive music therapy concerns itself with the advancement of social justice. Social justice in music therapy is a concern with the use of music therapy as springboard for advocacy of just and equitable relationships between the individual and society. Social justice in music therapy is also a concern with the use of music therapy to advocate for and to advance fair and equitable distributions of power throughout society.

Summary

Outlined here are six synthesized principles for progressive music therapy. They are summarized briefly: Progressive music therapy requires *musicking*. This is a thoughtful and egalitarian exchange of music between client(s) and therapist(s) where music-making breaks down the hierarchy between superior therapist(s) and inferior client(s). Progressive music therapy allows for the focus on primary goals of music-making and community-building, making the traditional goal of remediation secondary. Relationships between client(s) and therapist(s) in progressive music therapy are equal, equitable, egalitarian, and collaborative in nature. Communities of progressive music therapy should be egalitarian, equal, non-hierarchical, and multi-directional in nature among therapists and clients. Progressive music therapy recognizes that a myriad of cultures exist across the globe. These cultures entail functionalities that are broadly similar across the globe, and that cultures including marginalized people should be recognized as valid. Finally, progressive music therapy concerns itself with the advancement of social justice.

CHAPTER IV

ABLE-DIVERSE MUSIC THERAPY: THE ALIGNMENT OF ABLE-DIVERSITY AND PROGRESSIVE MUSIC THERAPY

Able-diversity was defined in Chapter Two by me as any *socially constructed* developmental difference in ability that is to be recognized and respected as any other human variation. Progressive music therapy was defined in Chapter Three as something that requires: (1) *musicking*, which is a thoughtful and egalitarian exchange of music between client(s) and therapist(s) where music-making breaks down the hiearchy between superior therapist(s) and inferior client(s); (2) a focus on primary goals of music-making and community-building, making the traditional goal of remediation secondary; (3) relationships between client(s) and therapist(s) in progressive music therapy are equal, equitable, egalitarian and collaborative in nature; (4) communities of progressive music therapy should be egalitarian, equal, non-hierarchical and multi-directional in nature among therapists and clients; (5) the recognition that a myriad of cultures exist across the globe, entail functionalities that are broadly similar across the globe, and that cultures including (or especially including) marginalized people should be recognized as valid; and (6) progressive music therapy concerns itself with the advancement of social justice. Figure 4 shows this chapter's goal: the alignment of able-diversity and progressive music therapy to create able-diverse music therapy.

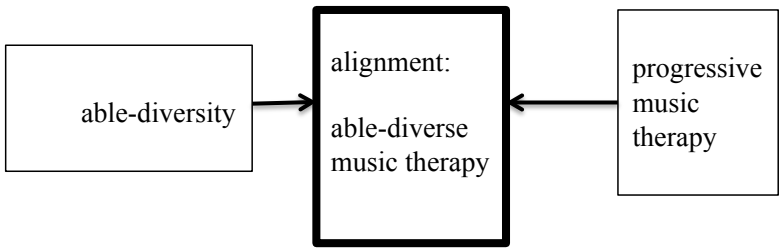

Figure 4. Alignment of Able-Diversity and Progressive Music Therapy to Form Able-Diverse Music Therapy

Able-Diverse Music Therapy Defined

I now introduce my definition of able-diverse music therapy: *music therapy that seeks musicking, community building (in a multicultural manner whenever possible), and social justice for people with socially constructed developmental differences in ability that should be recognized and respected as any other human variation.* What should able-diverse music therapy look like in practice? Consider the definition again. First, it seeks musicking, which is non-hierarchical, multi-directional in nature, and egalitarian. The music therapist is more like a facilitator, someone who creates situations and spaces through which *musicking* can occur. Second, able-diverse music therapy seeks community building (in a multicultural manner whenever possible). It is not always possible for music therapy to be multicultural, but when multiple cultures are present, the equality of cultures represented is of paramount importance. Community building respects the contributions of the cultural elements that build the community. Otherwise, we do not have a community, but a space in which a dominant group exerts superiority over an inferior group. This is of course to be avoided. Third, able-diverse music

therapy seeks social justice for people with socially constructed developmental differences in ability that should be recognized and respected as any other human variation.

There are those who may object to the inclusion of disability alongside race, gender, sexual orientation, etc. as so much identity politics. In my opinion, "identity politics" is a pejorative epithet that is thrown out by opponents of social justice in order to minimize and marginalize progressive advances for people lacking access to the social capital of power. Members of dominant groups tend to share power reluctantly, and it has become a strategy to object to identity politics as the *real* racism, sexism, homophobia in order to discredit attempts to seize greater access to power for marginalized people (for an example of the identification of identity politics as a form of prejudice, see Mackintosh, 2019). Slightly more sophisticated variations are offered by "classic liberals" who say that proponents of identity politics are self-interested (Malamet, 2017, para. 8): blacks are only interested in the advancement of blacks, etc., and this falls short of classic liberal orthodoxy that would see discrimination end across the board for all. So objectors to identity politics can be found both on the political right and the political left.

First, the argument that identity politics is itself inherently racist, sexist and homophobic hangs on the idea that the *blame* for these social ills is usually laid at the feet of straight white males, and that is in and of itself racist, sexist and homophobic because it adversely affects a class of people along dimensions of race, sex and sexual orientation (i.e., straight white males). The problem with this argument is that the terms *racist*, *sexist*

and *homophobic* are poorly defined. The classic academic definition of racism is that it is the nexus of prejudice against members of a race *and the power to adversely affect someone of that race* (Barndt, 1991). In this construction, United States whites can be racist against blacks, but United States blacks *cannot be racist against whites.* United States blacks can be *prejudiced* against whites, but they lack the power to achieve true *racism* against whites. (Similarly, women lack the power to be truly *sexist* against men.) Therefore, it is disingenuous to claim that opponents of racism are the real racists, opponents of sexism are the real sexists, etc. So, too, it would be disingenuous to claim that opponents of ableism are the real ableists.

Second, the "classic liberal" argument that identity politics is a politics of selfishness is a straw-man argument. Very few organizations operate in a vacuum devoid of intersectional awareness and coalition building. Organizations devoted to fighting racism routinely team up with organizations devoted to fighting gender discrimination. Academic studies programs that focus on specific identities (e.g., African-American studies, Latinx studies, women's studies, queer studies) all routinely focus on *intersectionality* (the ways in which each identity shares common ground with other identities, and explores common issues).

Third, the "classic liberal" argument is unfair and unrealistic. Oppressed people should not be expected to care about principled and cherished ideals in a vacuum when they are *experiencing actual oppression in practice.* When one is actively experiencing oppression because of a particular identity factor, it is imperative that the direct cause of the oppression is addressed. As it is said on airplanes, one has to place one's own oxygen

mask first before tending to the oxygen mask of someone else. This is not selfishness; it is survival. So, the argument that able-diversity amounts to identity politics and should not be incorporated into music therapy is fallacious. The question remains, though, what does able-diverse music therapy look like in practice? To answer this question, a set of examples is needed.

Examples of Able-Diverse Music Therapy in Practice

Profiled here are four organizations practicing able-diverse music therapy, even if they do not call it that: Able ARTS Work of Long Beach, CA; North Texas Performing Arts Starcatchers; Roman Music Therapy of Wakefield, MA; and Whole Notes of Lancaster, PA. Each one is working in comportment with the principles of able-diverse music therapy outlined heretofore.

Able ARTS Work of Long Beach, CA Summary

According to their website (www.ableartswork.org):

> The primary vision of Able ARTS Work (formerly known as Arts & Services for Disabled, Inc.) is to provide lifelong learning, community service and vocational opportunities through the creative arts for people of all abilities and all ages in an environment of warmth, encouragement and inclusion. Able ARTS Work offers valid continuing education to further the education of board-certified music therapists and other creative art therapists. (2019a, para. 2).

Able ARTS Works provides services to disabled people wanting to express themselves through various artistic modalities. According to the "Staff" section of their web site, "Able ARTS Work's (formerly known as Arts & Services for Disabled, Inc.)

team of instructors and therapists are visual artists, music therapists, performers and expressive arts therapists who are professionals in their discipline" (Able ARTS works, 2019b, para. 1). Their website also provides a section called "Beliefs," which is a credo of sorts. It can be found in the Appendix.

How this is able-diverse music therapy. Several themes commensurate with able-diverse music therapy are emphasized. First, the organization devotes itself to *community* service (emphasis added). This resonates with the principle of *communitas* that comes from music-centered music therapy, and which also has implications for community music therapy and culture-centered music therapy. Community-building through service is a value that is also recognized considerably by community music therapy.

Next, the services avail themselves to people *of all abilities* and *all ages* (Able ARTS Works, 2019a). The implicit rejection of ableism that is entailed by the inclusion of people of all abilities squares with able-diverse music therapy. The rejection of ageism also resonates with the social justice components of anti-oppressive music therapy. The services provided are made "in an environment of *warmth*, *encouragement* and *inclusion* [emphasis added]" (Able ARTS Works, 2019a, para. 2). Notice here the subtle rejection of the medical-model insistence on *fixing* or *remediation*. These values are absent, and instead, we have a more inviting and inclusive model.

Regarding their belief system, many phrases stand out as supportive of the aims of able-diverse music therapy. First, regarding "We believe all people regardless of functional capability, [sic] have a right and responsibility, [sic] to contribute to the well

being of their community and have a vocation of their choosing," (Able ARTS Works, 2019a, para. 5). Notice here that both the *rights* of disabled people and the *responsibilities* of disabled people are emphasized in equal measure. This is not just a manifesto demanding rights for disabled people; the idea that disabled people have responsibilities too is an acknowledgement that disabled people have something to contribute.

Second, consider "We believe all people should have access to an informed and supportive community, which must play a vital role in removing the barriers to full involvement and inclusion" (Able ARTS Works, 2019a, para. 6). Not only is there an emphasis on community building, but the community is charged with the responsibility for resisting ableism. This reflects the element of anti-oppressive music therapy and its focus on social justice.

Third, "We believe all people should have access to the expressive arts in vocation, education, leisure, health and wellness" (Able ARTS Works, 2019a, para. 7). The emphasis here is on access for disabled people. Whether disabled individuals want to pursue the arts professionally *or not*, they ought to have access and be able to decide for themselves.

Fourth, "We believe all people have the right to express and practice their cultural and artistic heritage" (Able ARTS Works, 2019a, para. 8). This is, of course, directly a reflection of the element of culture-centered music therapy. This statement respects the value of all cultures brought to the table by disabled people.

Lastly, consider the "Cultural Equity Statement": "Able ARTS Work supports a full creative life for all and upholds standards and practices that value the contributions of a diverse community" (Able ARTS Works, 2019a, para. 9). The interest in a diverse community in particular and diversity in general reflects the values of community music therapy. Anti-oppressive music therapy and culture-centered music therapy also specifically value diversity in their respective models.

All in all, Able ARTS Works is an organization that resists ableism, emphasizes community, rejects models of remediation, and respects the equality of clients in the therapist-client relationship. Therefore, Able ARTS Works serves as one excellent model of able-diverse music therapy in action.

North Texas Performing Arts Starcatchers Summary

By way of full disclosure, I should acknowledge that this is an organization with which I have had some involvement. I completed a practicum there, a partial internship there for three months, and then worked for them as an independent contractor. However, the Starcatchers program is really the brainchild of Gabrielle Banzon, a music therapist who was my supervisor at every step of my involvement with Starcatchers.

The Starcatchers program is an offshoot of the North Texas Performing Arts (NTPA) program, the latter of which sees children collaborating to put on musical theater shows. There are also some productions that are produced by and for adults, but by and large, the program is geared toward child participation. "Starcatchers" is the name of the therapeutic arts program of NTPA. Consult the Appendix for their mission statement and a critique.

How this is able-diverse music therapy. The program acknowledges that while "everybody loves the performing arts" (Banzon, 2019, para. 1), not everybody always has the opportunity to participate. Disabled people are often denied opportunities to participate due to ableism. The Starcatchers program resists ableism by creating space for disabled persons to express themselves artistically through the medium of musical theater. Again, while there are therapeutic goals to be had, the therapeutic goals are all happy byproducts of the *inevitable processes* that are entailed by putting on a show. Notice that learning to read and speak and developing cognitive, speech and communication skills are part and parcel of *learning lines and songs*; developing emotional expression and empathy is part of the process of *portraying a character*; learning coordination and enhancing spatial awareness and gross and fine motor skills are part of *choreography*. That these are all fortunate byproducts of the primary mission—putting on a show—is reflective of the ethos of music-centered music therapy; that it is done in a community that includes cast, director, staff, and audience also reflects the primary values of community music therapy. Incidentally, learning lines aids cognition for nondisabled children as well, and choreography helps develop spatial awareness for nondisabled children as well. The Starcatchers are doing nothing differently from their nondisabled counterparts. Therefore, the therapeutic values intrinsic to producing musical theater are not particularly oppressive because they are the results of the inevitable and natural processes of show production.

The final statement "We break down the boundaries of disabilities, promote inclusivity, and give everyone a place to belong" (Banzon, 2019, para. 8) reflects the

element of anti-oppressive music therapy because in promoting inclusivity and making space for everyone regardless of ability, ableism is radically resisted. I say "radically" because this theater program in its communitarian values is such a departure from much of the hypercompetitive nature of many theater programs (including theater programs for youth).

In summary, this is a program that resists ableism by making a fully inclusive space for disabled young actors. While there are therapeutic and remediating benefits to be had, these result from the essential tasks of learning and producing a piece of musical theater. I can attest that usually the actors are too busy having fun in the show production process to notice the therapy (which is wholly documented and traced) that is going on.

Roman Music Therapy of Wakefield, MA Summary

The approach described by Roman Music Therapy of Wakefield, MA is extensive, and is reproduced in the Appendix. Their initial bullet-points are reproduced here:

> Our Approach
>
> As a team, we stand united behind our values about music, music therapy and human-centered care.
>
> We Believe
>
> • Making music transforms lives.
>
> • Music connects people.
>
> • Everyone can make music.
>
> • Making music builds bridges and creates community.

• Music therapy celebrates abilities and allows us to see beyond limitations.

• Music therapy provides a safe space to be who you are.

• As music therapists, it's our job and responsibility to make music accessible to people of all ages and abilities.

• Inclusive opportunities allow people to be music makers, to belong, to contribute, and to connect with others.

• Music making is a form of communication that fosters expression and understanding.

• Music can be used as a tool, empowering people in their daily lives. (Roman Music Therapy, 2019a, para. 1-13)

Further information about their mission statement can be found in the Appendix.

How this is able-diverse music therapy. First of all, consider Roman Music Therapy's credo statements, paraphrased here: *Music transforms lives and connects people* (Roman Music Therapy, 2019a). The emphasis on connection between people entails a nuance of egalitarian community building that resonates with the element of community music therapy. The idea that "everyone can make music" (Roman Music Therapy, 2019a, para. 6) also breaks down significant hierarchies and barriers to *musicking* that we see in the elements of music-centered music therapy and culture-centered music therapy. Community building is named as an explicit value when they say they believe "making music builds bridges and creates community" (Roman Music Therapy, 2019a, para. 7). The statement that music therapy "celebrates abilities and

allows us to see beyond limitations" (Roman Music Therapy, 2019a, para. 8) is a statement of inclusion of people of all abilities, including disabled people. The statement (paraphrased here) that it is incumbent on music therapists to make music accessible to people of all ages and abilities (Roman Music Therapy, 2019a) shows that the onus of responsibility lies with the therapists to make the accessibility occur; this is diametrically the opposite of the model that posits that the individual client is responsible for his or her own "being fixed." The idea that opportunities should be inclusive as to allow people "to be music makers, to belong, to contribute and to connect with others" (Roman Music Therapy, 2019a, para. 11) again suggests strongly that the interest here is in creating non-hierarchical, egalitarian *musicking* with clients. Music-making "fosters expression and understanding" (Roman Music Therapy, 2019a, para. 12), and this also creates *communitas*. Finally, music can be used as a tool to "[empower] people in their daily lives" (Roman Music Therapy, 2019a, para. 13); this message of empowerment resonates with the element of anti-oppressive music therapy.

The idea that music therapists should remain flexible in their approaches is not new. In their essay, Roman Music Therapy cites Bruscia (2014) as a model for "integral" music therapy. Integral music therapy refers to an integration of multiple approaches and models that allow the therapist better to meet the client where she or he actually is, and address his or her needs accordingly. This is important to able-diverse music therapy because disabled clients will be disabled in any number of individualistic ways, with combinations of disabilities or singular disabilities that require a program that is tailored specifically to them. Remember, the social model of disability posits that we, the

institutions of society, create the barriers when we fail to meet the needs of the disabled person. An ethos of tailoring therapy to the individual needs of clients resonates strongly with the social model.

Roman Music Therapy describes itself as being comprised of community music therapists (Roman Music Therapy, 2019a). They distinguish between what they call a "little 'c' community" and a "big 'C' Community" (Roman Music Therapy, 2019a). Little-c communities are smallish and loosely connected; big-C Communities could conceivably encapsulate entire towns. They believe that music therapy can reach entire big-C communities; such an ambition resonates again with the social model of disability because the latter posits that the big-C communities must change in order to avoid creating barriers for disabled people. "Whether we are providing services, family-based afterschool groups, or group music therapy services in a school, nursing home, adult day health program, our team is always considering the needs of the individual in relationships to the world and environment around them," they maintain (Roman Music Therapy, 2019b, para. 2). This is commensurate with previous statements that assert a consideration for the individual needs of the disabled client. They furthermore stated that they believe in a "ripple effect" for music therapy across various communities, including home, schools and communities at large (Roman Music Thearpy, 2019b). The idea of the ripple effect positions the client and the community as relatively equal in standing; one can influence the other, and the relationship is mutually reinforcing. The equality of client and community is a feature of the element of community music therapy.

In sum, Roman Music Therapy is a model of able-diverse music therapy because it focuses on meeting disabled clients where they are, accommodating disabled clients as per their needs, and believes in community-building and attempting to influence the entire community at large, rather than simply trying to "fix" a pathologized client. Its model is flexible, malleable, egalitarian, and espouses a value of inclusion that fully embraces the disabled client as she or he actually is.

Whole Notes of Lancaster, PA Summary

Whole Notes of Lancaster, PA provides both a vision statement and a mission statement. The vision statement is short and succinct: "To use music therapy to create a more equitable and socially just community" (Whole Notes, 2019a, para. 1). Their mission statement is slightly longer, but still succinct: "To provide affordable, quality music therapy services to the community of Lancaster Pennsylvania and surrounding areas, or order to support individuals' pursuit of wellness, empowerment, and community and individual healing" (Whole Notes, 2019a, para. 2). They maintain an additional "About Us" section of their web site which can be found in the Appendix.

How this is able-diverse music therapy. First, the succinct vision statement "To use music therapy to create a more equitable and socially just community" resonates squarely with the element of anti-oppressive music therapy and its direct concern with social justice. Second, the mission statement emphasizes *empowerment* as a theme, which again reflects the element of anti-oppressive music therapy. It also discusses *community and individual healing*, which recognizes the equality of community music therapy and its more traditional individualized counterpart.

Whole Notes founder Christine Fry critiques corporate healthcare by stating that "People should not be able to profit from the wellbeing of others" (Whole Notes, 2019b, para. 1). Whole Notes is a not-for-profit 501(C)(3) corporation. This is a direct challenge to a medical model that seeks profit from the illnesses of others. This demonstrates an interest in social justice that is commensurate with the element of anti-oppressive music therapy. Furthermore, Whole Notes explicitly states that they are interested in promoting social justice as integral to their identity (Whole Notes, 2019b, para. 1).

In their model, the therapist is explicitly described as a "facilitator" (Whole Notes, 2019b, para. 1) rather than an "expert," which is again quite a direct challenge to the medical model. Instead, participants "determine the direction and focus of sessions" which leads to "a more equitable environment" (Whole Notes, 2019b, para. 1). These ideals comport tidily to the ideals of able-diverse music therapy. The hierarchy of superior-therapist/inferior-client is completely overturned in their model.

Finally, Whole Notes is deeply invested in community music therapy, and they quote Stige's PREPARE acronym. Several of these words spring out as commensurate with the ideals of able-diverse music therapy, including *participatory*, *ecological*, and *activist.* "Participatory" engenders a nuance of true and equal collaboration; "ecological" entails a nuance of social justice; and "activist" suggests that the client can be a self-determining advocate of her or his own cause.

In total, Whole Notes is a communitarian-based music therapy enterprise that emphasizes positive client-centered values. They emphasize social justice and activism,

and they resist the traditional model of hierarchically superior therapist and hierarchically inferior client. They not only incorporate these principles in therapy, but also in their not-for-profit business model, which is commendable.

Conclusion

Able-diverse music therapy represents a way forward for music therapy as society becomes itself less ableist and more aware of the needs of disabled people. Because many if not most of the clients of the music-therapeutic enterprise are disabled, it is incumbent on music therapy as a profession to squarely deal with these needs in a manner that is constructive, socially just, and which respects the dignity and equality of disabled people.

Where do I see the music therapy profession in the future if my ideas were to come to pass? Where would I see the music therapy profession after, say, twenty years of evolution? Certainly I would like to see more comportment with the principles of able-diverse music therapy. This would begin with the official AMTA definition of music therapy. I would like to see it amended so that the definitions emphasize more communitarian and collaborative goals for the profession of music therapy, with less protesteth-too-much emphasis on its evidentiary basis and rootedness in science. These goals are not mutually exclusive. We can retain the language about the "evidence-based practice" of music therapy, but we should supplement it with more broadly inclusive language that recognizes the importance of able-diversity and the contributions disabled people have to make in music and the arts.

Next, I would like to see amendments to the present music therapy curriculum

that would include a mandatory course for music therapists in disability studies in addition to the present requirement of training in special education. Music therapists should be uniformly aware of the orthodoxies, controversies, and issues surrounding disability studies as well as the issues involved in working with children in the special education setting.

Finally, I would want to live in a world where able-diverse music therapy was affordable, whether through insurance or some other mechanism. The music therapy profession constantly asserts its medical bona fides because it is collectively worried about getting paid. Insurance companies tend only to foot the bill for evidence-based practices, which is understandable. However, I am confident that able-diverse music-therapeutic practices would pass muster under an evidence-based testing paradigm. In 20 years, I would want to see randomized control trials showing that able-diverse music-therapeutic practices are as good as or better than music-therapeutic practices steeped in the current and traditional models. At this writing, there are major candidates for high public offices in the United States proposing dramatic overhauls to the way medicine is practiced and paid for in the United States. My hope is that broadly, affordable health care can be universalized in the United States, and that specifically, able-diverse music-therapeutic practices will be long recognized as legitimate for subsidizing. I therefore foresee a bright future for the profession of music therapy, particularly if it is able to become a welcoming, collaborative, non-hierarchical and egalitarian resource for clients of all abilities.

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FOOTNOTES

[1]I employ the form "disabled people" rather than "people with disabilities" following Oliver's argument for the former (2012, pp. 5-6).

[2]For example, she cites the following everyday phrases as demeaning and ableist: "a crippled/paralyzed economy," "blind obedience/rage/ambition," "that's so lame/idiotic/dumb," "her suggestion fell on deaf ears" and "stand up for yourself." She further recommends Zola (1993) and Wendell (1996) on the topic.

[3]I should like to thank Melissa Murphy for suggesting this quotation to me.

[4]A book by Brandalise (2001) entitled *Musicoterapia Músico-centrada* (Music-Centered Music Therapy) exists, predating Aigen's book, but the conceptualizations are quite different. In this book music-centered music therapy refers to Aigen's construction.

[5]LaCom and Reed (2014) note: "We use the terms 'able-bodied' and 'disabled' with reservations, recognizing that they shore up a binary way of understanding embodiement as either/or and potentially shoring up the hierarchy that accompanies that binary. The terms are limited and problematic but are currently the most accessible 'short-hand' available to us." I completely concur.

[6]I am indebted to Alejandra Lindan's Masters thesis for making me aware of the work of Sue Baines.

APPENDIX A

Additional Organization Statements: Able ARTS Work

> We believe all people…
>
> …,regardless of functional capability, have a right and responsibility, to contribute to the well being of their community and have a vocation of their choosing.
>
> …should have access to an informed and supportive community, which must play a vital role in removing the barriers to full involvement and inclusion.
>
> …should have access to the expressive arts in vocation, education, leisure, health and wellness.
>
> …have the right to express and practice their cultural and artistic heritage.
>
> We believe all people regardless of functional capability should be treated with dignity and respect, thus our philosophy and mission...
>
> *Love Before Learning. Learn for Life* [emphasis original]. (Able ARTS Works, 2019a, para. 2-8).

Finally, the "About" section of their web site contains a "Cultural Equity Statement" as follows: "Able Arts Work supports a full creative life for all and upholds standards and practices that value the contributions of a diverse community" (Able ARTS Works, 2019a, para. 9).

APPENDIX B

Additional Organization Statements: North Texas Performing Arts Starcatchers

This is their mission statement:

> The Starcatchers program is designed specifically for children and adults with special needs. In this program, students are given opportunities to shine through drama, music, dance, and visual art. These opportunities range from large theatre productions to intimate art classes and further the development of social, communication, motor, and cognitive skills. Not only can a student's involvement in the arts strongly impact these areas of his or her life, but it can also have an impact on the community. What makes the Starcatchers program unique is not just the work with children and adults with special needs, but its relational approach to the work. Each student is paired with a trained intern, who assists their development through rehearsals and shadows them during performances. In addition to fostering personal confidence and creativity, the Starcatchers work to foster collective compassion and empathy. There are no disabilities in making art. (NTPA, 2019, para. 1-2).

First, this statement is *not* a perfect example of able-diverse music therapy. There are some points that must be critiqued. It is true that there are non-musical goals of remediation that are in play (e.g., social, communication, motor and cognitive skills). The other issue that must be addressed is the statement "There are no disabilities in making art," which is an unfortunate erasure of disability, however well-meaning the statement may be. It is tantamount to saying "I don't see disability," which is in and of itself ableist (compare such a statement to the oft-heard declaration "I don't see race" to see why such a statement is ableist).

I am going to argue, though, that Starcatchers is *essentially* an able-diverse music therapy program despite these critical points. Regarding the remediation, in my experience of the program, the clients are barely aware that remediation is going on. They are simply having fun performing to the best of their abilities. It is *not* the case that music therapy is forcibly being imposed on a reluctant clientele as though it were some sort of bitter medicine or injection. As for the phrase "there are no disabilities in making art," while the phrase is unfortunate, its *intent* is easily corrected: "all abilities are valid in making art." This is what I believe the author of this phrase actually *meant*, and this meaning is commensurate with the ideals of able-diverse music therapy.

Banzon's own essay on the subject is better:

> Everybody loves the performing arts; participating in it, listening to it, watching it. It brings the audience feelings of joy, sorrow, and awe. It brings the performers senses of belonging, accomplishment, and autonomy. North Texas Performing Arts (NTPA) creates a space for this to happen every single day for families across the [Dallas-Fort Worth] metroplex. Youth and adults have the opportunity to learn about theatre and perform in plays and music productions.
>
> NTPA also extends its space for those who don't always get those same opportunities; through a therapeutic arts program called the Starcatchers. The Starcatchers is NTPA's branch for youth and adults with special needs. While the therapeutic arts are typically divided into music, dance, drama, and visual art, this program combines all of these mediums together to put on a variety of productions.

So, if the Starcatchers still put on shows, what makes it so different from the rest of the theatre? What makes it therapeutic?

Simple… It's the process and the goals.

When you're performing, the process is to rehearse and the goal is to perform a show. But to rehearse and perform takes individual skills that people with special needs often struggle with. To rehearse and perform also requires an accepting community, which people with special needs are not always readily welcomed into. So, then in our program, the processes are to rehearse and perform a show, and the goals are to increase those individual skills and develop community.

When we learn our lines, we read and speak; which develops cognitive, speech, and communication skills and memory recall. When we portray a character, we act and emulate them; which affords opportunities for emotional expression and empathy. When we do choreography, we coordinate our placements and move our bodies; [sic] which develops spatial awareness and gross and fine motor skills. When we sing and play instruments, we produce music in a group; which develops listening skills and attention span.

Last, but not least, by doing all of this with our friends and performance partners, we grow in community.

We break down the boundaries of disabilities, promote inclusivity, and give everyone a place to belong. (Banzon, 2019, para. 1-8).

APPENDIX C

Additional Organization Statements: Roman Music Therapy

This is from the Roman Music Therapy mission statement:

Our Approach

As a team, we stand united behind our values about music, music therapy and human-centered care.

We Believe

- Making music transforms lives.
- Music connects people.
- Everyone can make music.
- Making music builds bridges and creates community.
- Music therapy celebrates abilities and allows us to see beyond limitations.
- Music therapy provides a safe space to be who you are.
- As music therapists, it's our job and responsibility to make music accessible to people of all ages and abilities.
- Inclusive opportunities allow people to be music makers, to belong, to contribute, and to connect with others.
- Music making is a form of communication that fosters expression and understanding.
- Music can be used as a tool, empowering people in their daily lives.

Our Commitments

No two people are alike. At Roman Music Therapy Services, we recognize that each individual and organization we serve has unique needs. We have learned that with all things, a one-size-fits-all approach does not work!

To be grounded in the work that we do, we focus on three tenets in our work.

1. Our human-centered approach to music therapy requires that we thoughtfully adapt our responses and music interventions to the dynamic needs of the client.

One of our core beliefs is that as music therapists, it's our job and responsibility to make music accessible to people of all ages and abilities. In order to this, we firmly believe that our team needs to be flexible in the approaches and interventions we use with our clients, evolving to meet the dynamic needs of each client or group as they evolve in the therapeutic process. Rather than providing one particular technique or method for music therapy service delivery, we strive to be "integral music therapists" as Ken Bruscia, a music therapy writer, teacher and clinician, suggests.

"An integral therapist stays reflexive at the macro and micro level and thinks the way the client needs him to think, not the way of thinking the therapist has already adopted" (Bruscia, 2014).

2. As community music therapists, we focus on the two-way connections between individuals and communities in all that we do to help build bridges and social capital.

"Music therapy might be described as a music therapist engaging another person or persons in some form of musicking with the ultimate aim of improving their quality of life – thus including health, wellbeing and education outcomes.

Both sides of the social capital equation (the generation of social capital, and the benefits this brings) therefore have relevance for music therapy" (Procter, 2011).

When we talk about community, we are thinking about little "c" communities and big "C" Communities. A community could describe a small music therapy group, with two or three people who are loosely connected, or it could be a family unit or residential home or facility, or even an entire town incorporating all of the residents into the fabric of their community. Using the power of music, we can use live, in-the-moment music experiences to increase feelings of trust, reciprocity, security and belonging in our communities. And that is a win-win for everyone!

3. Music therapy serves our communities best with a continuum of options.

We recognize that while clinical, prescribed music therapy is beneficial and necessary for some, access to community-based, supportive services are vital to others in our community.

Inspired by The Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children and a lecture by Dr. Evan Ruud, our Founder, Meredith Pizzi, has developed a theoretical framework to understand music therapy within the context of meeting community and patient needs. Roman Music Therapy Services is moving into the new frontier of music therapy by recognizing the potential of music therapy as more than a treatment option or a field of clinical practice.

> Our innovative community programs reflect our model of care, understood through the Music Therapy Pyramid Framework. Learn more about the Music Therapy Pyramid Framework in practice. (Roman Music Therapy, 2019a, para. 1-11)

Furthermore, Roman Music Therapy proposes different ways to think about music therapy:

> Music Therapy, like other forms of therapy, does not conform its practitioners to one model. Here at Roman Music Therapy Services, we use an integrated model. Clients to come to us with unique needs and we work together with them to create a success-oriented plan that helps them meet their personal goals drawing from multiple ways of thinking about music therapy. There are many different models of music therapy that echo current research and evidence based practice. Our music therapist chooses a model of practice or uses a variety of music therapy strategies and interventions according to what benefits the client. It is also important that when seeking a music therapist, a client is well informed and can find a therapist that is right for them.

According to Meredith Pizzi, MT-BC, the way of practicing at Roman Music Therapy Services is also closely aligned with the needs of the community.

> Our work here at Roman Music Therapy Services is deeply rooted in the communities of the schools, agencies and families we serve. As a community music therapy agency, our clinical work tends to focus on the needs of the community or the individual within their community. Whether we are providing

individual services, family-based afterschool groups, or group music therapy services in a school, nursing home, adult day health program, our team is always considering the needs of the individual in relationship to the world and environment around them. We believe that our work in music therapy sessions with our clients can create ripple effects in the home, schools, and in all of our communities. We also believe that by providing services in community settings, we can better support our clients in their own personal and interpersonal growth with opportunities for engagement and meaningful relationships within their communities. Our work is goal driven, focused on the needs of the individual or group members and uses all of the tools of music to help our clients reach their goals. We believe that the work that we do can best be defined as Community Music Therapy. -Meredith R. Pizzi, MT-BC

As our Mission Statement says, Roman Music Therapy Services strives to meet the diverse needs of the community within schools, nursing homes, senior centers, and community health and service agencies through music therapy experiences, education, and resources. Our team of music therapists use the power of music to support personal and interpersonal growth and enhance the life of the community. Using musical tools, new possibilities and opportunities are created for our clients to reach their full potential.

(Roman Music Therapy, 2019b, para. 1-3)

APPENDIX D

Additional Organization Statements: Whole Notes

This is from the Whole Notes mission statement:

"People should not be able to profit from the wellbeing of others." This is the driving thought that prompted Christine Fry to quit her job in corporate healthcare and found Whole Notes in 2018 in order to provide quality music therapy to all those who would benefit regardless of an individual's ability to pay. The philosophy of social justice is integral to the identity of Whole Notes from our business practices to how we conduct sessions. Community music therapy offers a framework in which the therapist fulfills the role of a facilitator instead of an expert and the participants determine the direction and focus of sessions. This structure provides a more equitable environment for participants to explore and enact their own change and promote their own healing and wellbeing.

The name Whole Notes is a play on words which refers to both the musical notation but also the process through music therapy of becoming whole. Music therapy affects all facets of a person, physical, emotional, mental, and spiritual. At Whole Notes we truly believe that music therapy can help individuals become whole. (Whole Notes, 2019b, para. 1-2)

Finally, they say this "About Community Music Therapy":

Developed in part by Norweigian music therapist Brynjulf Stige, community music therapy (CoMT) is a method of music therapy based on the theories of social justice, resource-oriented therapies, and health promotion. In his book, *Invitation to Community Music Therapy*, Stige offers the acronym PREPARE as a way to describe CoMT.

P- Participatory

R- Resource-oriented

E-Ecological

P- Performance

A- Activist

R- Reflective

E- Ethics-driven

A quote from Stige regarding the difference between traditional therapies and [community music therapy] also serves to further the definition, “Rather than being based on expert-defined diagnoses of individuals, community music therapy processes grow out of negotiated understanding of specific situations. There is less focus on ‘fixing’ people’s problems and more focus on mobilizing resources that might help people to grow in the context of improved practices and policies.” It is these qualities that Whole Notes strives to embody daily. (Whole Notes, 2019c, para. 1-4)