

COLUMNS AND ESSAYS | PEER REVIEWED

## The Social Model of Disability and Music Therapy: Practical Suggestions for the Emerging Clinical Practitioner

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### Abstract

More and more music therapists are becoming aware of the social model of disability. The social model of disability maintains that the locus of disability rests in the capacity for society to create barriers for people with physical or mental differences. Much of music therapy practice still invests in the medical model of disability, which maintains that disability is an inherent personal flaw in the individual which requires remediation. This paper argues that music therapy practice should adopt the social model of disability, and maintains that, in particular, music-centered music therapy is one theory of music therapy that resonates well with the social model of disability. The paper includes advice for the emerging music therapy clinician on how better to incorporate social model of disability perspectives in practice based on the work of previous scholars who have written extensively about the social model.

**Keywords:** *disability, social model of disability*

### Introduction

The social model of disability represents a great change in the way of thinking about the subject of disability. Since its inception, countless journal articles, presentations, books and book chapters have been devoted to its powerful critiques of 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<sup>1</sup> in society. It is incumbent, then, on the music therapy community to engage the social model of disability, since many of the clientele of music therapists are disabled people. It is particularly incumbent on the novice to be aware of issues surrounding disabled people, so this article is written by a novice music-therapist-in-training for other novices.

In 2014, *Voices: A World Forum for Music Therapy* published an issue devoted to music therapy and disability studies. Perspectives included those of Rickson (2014), who discussed the way in which disability studies orientation can influence music-therapeutic approaches to children with intellectual disabilities; Honisch (2014), who explored some of the “congruities and tensions” (para. 1) between the fields of music therapy and disability studies; LaCom and Reed (2014), who discussed “how the illusion of (st)able bodies can reinforce hierarchies (between therapist/client, teacher/student, helper/helped, ablebodied/disabled)” (para. 2); Bassler (2014), who examined invis-

ible illnesses; Rolvsjord (2014), who challenged the dichotomy supposedly between competent therapist and incompetent disabled client; Bakan (2014), who discussed autism and neurodiversity from an ethnomusicological perspective; Cameron (2014), who brought a feminist perspective on disability to the discussion; Metell (2014), who argued that disability studies in music therapy would promote social justice; Miyake (2014), who discussed the power structures of the music therapy enterprise; and Straus (2014), who challenged the medical model of disability and contrasts it with the social model of disability.

## The Social Model of Disability

Kudlick (2003, p. 764) wrote: “Much of the new work [on disability] springs from disability studies, an interdisciplinary field from the mid-1980s that invites scholars to think about disability not as an isolated, individual medical pathology but instead as a key defining social category on a par with race, class and gender.” Thomas (2008, p. 15) succinctly defined the social model: “In short, the social model asserts that ‘disability’ is not caused by impairment but by the social barriers (structural and attitudinal) that people with impairments (physical, intellectual and sensory) come up against in every arena. The social model views disabled people as socially oppressed, and it follows that improvements in their lives necessitates the sweeping away of disablist social barriers and the development of social policies and practices that facilitate full social inclusion and citizenship.” Most accounts of the history of the social model trace its initial articulation to the work of 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 is rejected.

Nineteen ninety may strike 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 Kudlick (2003, p. 768): practically no one consciously professes to be against disabled people. However, she was quick to point out the ways in which media representations and everyday language demean disabled people (p. 768).<sup>2</sup> 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 (p. 769): “Compounded by disability’s absence from diversity discussions, the resulting invisibility of disabled colleagues reinforces the idea that the topic remains marginal to academic inquiry, being instead a condition to be fixed by installing ramps and special mechanisms on doors.”

Oliver and Barnes (2012, p. 80) 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 (1991, 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).

Oliver and Barnes (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)

They maintained that medicalization has escalated to intrude upon almost every aspect of everyday life: “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” (p. 84). This has led to the inevitable takeover of perceptions of disabled people by the medical model. Of course, 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,” which is an important distinction (p. 84).

In this author’s view, Oliver and Barnes (2012) are not so much anti-medicine as they are 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 maintain that the social model of disability has proved its usefulness in facilitating pragmatic policy adjustments, and that social policy, and not abstract theorizing, is their end goal (indeed, the final three chapters of the book are 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 is 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 is their argument following Derrida (Oliver & Barnes, 2012) that critiques 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 (p. 89). “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” (p. 121). “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 named 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.

Oliver and Barnes (2012) critique the “dependent/independent” duality. All human beings are dependent on other humans for survival. Therefore, the dependence of disabled people only varies by degree (p. 127) and so the construct of ‘dependence’ is not binary. Oliver and Barnes also question the ideological rhetoric that maintains that dependence is bad in the first place, noting that “the culture of dependency” has become

a bugaboo for politicians to rail against (p. 124). They pointed 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 (p. 139).

It is important to be careful to understand what the social model of disability does and does not do. Bradley Lewis (2007) pointed out that disability critique is not a true/false binary. He says that the “evidential structure of biomedicine” is not what is resisted *per se*, but rather the exclusive nature of the biomedical frame as it “individualiz[es], normalize[es] and medicaliz[es]” (p. 367). Disability is therefore to be reframed as a social restriction and oppression, he asserted, and not simply a biological problem. Different bodies suffer, Lewis wrote, because of the “social [emphasis added] exclusion, isolation, and lack of opportunity.” Lewis also launched a salvo against the “pernicious side effects” of the medical industry itself, which markets “aggressive intervention” in order for the disabled to attempt to achieve “normal” bodies.

The social model of disability has its critics. Perhaps the most forceful among them is Tom Shakespeare (2010), who acknowledged the simplicity of the social model, but maintained that its simplicity is also its “fatal flaw” (p. 6). Shakespeare argued the social model neglects impairment itself as an important aspect of disabled people’s lives (p. 6); the social model tautologically assumes the conclusion that disabled people are oppressed (p. 7); the distinction between the medical perspective of impairment and the social perspective of disability is a crude one (p. 8); and a “barrier-free utopia” is difficult to realize (p. 8).

I am sympathetic to a point with Shakespeare’s criticisms, which are all reasonable. Shakespeare is certainly an honest broker, as a sincere and thoughtful writer and disabled person. However, there are some aspects of his criticisms which fall short of the mark in my view, and I would like to discuss these.

Shakespeare’s first criticism more specifically suggests that the social model risks implying that impairment is not a problem. However, there is a tension in Shakespeare’s argument: if the conclusion that disabled people are oppressed is tautological, as he contends, so too is the assertion that impairment is a problem. Shakespeare is willing to assume what he must prove, that impairment is an integrally located problem that inheres in disabled people, not a problem that is constructed socially.

The second argument itself, that the social model must prove that disabled people are oppressed, strikes as unhelpfully pedantic. Perhaps there is a circularity of argument, but then, as pointed out, Shakespeare is not immune from his own similar tautologies.

The distinction between the medical impairment model and the social disability model is an analogy to the feminist distinction between sex and gender; Shakespeare’s third argument maintains that this is crude. Shakespeare (2010, p. 8) said that “in practice” it is difficult to see where impairment (which inheres in the disabled person) ends and disability (which is socially constructed) begins. Again, the onus is on Shakespeare to show that impairment inheres in the disabled person at all in order for his argument to survive accusations of tautology. “In practice,” Shakespeare (p. 8) wrote, “social and individual aspects are almost inextricable in the complexity of the lived experience of disability.” Shakespeare relies heavily on the self-evidentiary basis of what occurs “in practice,” but this is not a sufficient argument to demonstrate the inherence of impairment, really the inherence of *defect*, in the disabled person. What occurs “in practice” amounts to so much anecdotal data.<sup>3</sup>

Perhaps Shakespeare’s most successful argument is the impossibility of a barrier-free utopia. Still, the difficulties that lie in the construction of a barrier-free utopia do not negate the central core of the social disability model, which is that society constructs the barriers to begin with. Perhaps some barriers are necessary, even inevitable, to promote the greater good— imagine a world without stairs. Stairs are beneficial to most, but they create barriers for some. Nonetheless, stairs serve in a *social* dimension. They are a help to most, a hindrance to some, but they are *always societal* in function. Therefore, the pragmatic difficulties that ensue in the creation of a world with fewer

barriers for disabled people do nothing to undermine the theoretical soundness of the social model in any important sense.

Shakespeare (2013) gets one thing absolutely right in this author's opinion: his observation that the scholarship of Jenny Morris, for one example, emphasizes the degree to which representations of disabled people in the media foster prejudice even more so than physical barriers, the latter of which tend 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.

Shildrick (2007) maintained that the concept of disability is "slippery, fluid, heterogeneous and deeply intersectional"<sup>4</sup> (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, p. 225) think of the social model, however, as an important "starting point": it is 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 social model of disability and most other critical disability theories that may have since evolved essentially reject the medical model as the prevailing, standalone approach to disability. That is what is most important here. As DeVolder (2017, p. 21) 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.

### Music-Centered Music Therapy as a Model

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 (2006) wrote:

[Other] practitioners and theorists, the present writer included, have a different view of the nature of science, seeing it as being defined more by its *principles* [emphasis original] of systematic inquiry rather than by adherence to specific *practices* [emphasis original] that can vary according to time and place. In this view, there is no problem with practice leading theory because it is recognized that there are different ways of demonstrating the effectiveness of music therapy practices.

Hence, as the discussion of theory... demonstrates, to argue for and create music-centered theory is not to be anti-intellectual or antiscientific when it comes to conceptualizing about music therapy. Music-centered thought can be subject to the same level of intellectual rigor and systematic investigation that typifies other types of music therapy theory. (p. 3-4)

I chose the model of music-centered music therapy as an example of one model that is sensitive to the social model of disability not because I am a particular expert in music-centered music therapy; I am not. Rather, I chose the model because it is relatively well-known, because it is easily referred to by name as a published volume, and because it correlates with the principles of the social model of disability nicely. However, it must be stated that music-centered music therapy is by no means the only form of music therapy that promotes social justice; indeed, many other forms of music therapy perhaps more explicitly embrace social justice as a formal goal than does music-centered music therapy. Tsiris (2013, p. 338–339) cited community music therapy, creative music therapy, and culture-centered music therapy all as concerned with social justice aims and opposition to the "normalizing" process. It will be argued, however, that music-centered music therapy powerfully addresses social justice concerns even in the absence of explicit language to that effect.

Music-centered music therapy was created by Kenneth Aigen,<sup>5</sup> articulated in his 2006 volume *Music-Centered Music Therapy*. It has its origins in the thinking that underpins Nordoff-Robbins music therapy (Aigen, 2006, p. 47). It is an expansion of the

*music as therapy* concept initially put forward by Bruscia (Aigen, 2006, p. 48). Aigen added that the term *music-centered* is possibly applicable to clinical practice, theory, education, training, and research.

Aigen (2006) 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). Let us try anyway, though, to briefly summarize 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, cited in Aigen 2006, p. 58). Second, music-making (or *musicing/musicking*) promotes “self-growth, self-knowledge and enjoyment” according to Elliot (1995, cited in Aigen 2006, p. 68). Third, and most germane to the present article, 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 music-making/musicing/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 (2006):

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 musicing 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 (2006) also pointed out that music-centered music therapy promotes communal dimensions. “Creating music together provides one of the only ways— sometimes the only way— that certain people can engage in meaningful, constructive activity with others,” he said (p. 101). 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* is powerful, operating spontaneously through music: altruistic sacrifice for the sake of the group’s community music making; coordination of individuals; group creation of an aesthetic product; experience of group enjoyment through the application of skill (p. 103). 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):

The most detrimental consequence of the therapist’s location in ableist culture is that the therapist may in fact be dis-abling. As disturbing as this suggestion might be, it is crucial to consider to what degree the therapist contributes to the demoralization of the client through her/his good intentions of ‘fixing’ the client.” In the music-centered music therapy model, thankfully, music-making, rather than “fixing” the client, is the prime mover of the therapeutic enterprise. (para. 48)

This author proposes then that subsequent formulations and editions defining music-centered music therapy formally and explicitly embrace the social model of disability. Chapter 5 of Aigen’s (2006) *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.

It is proposed 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 writ large 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.<sup>6</sup> 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. Rather than seeing the client as possessing a problem to be solved through music-therapeutic intervention, which hierarchizes the therapist as superior and the client as inferior, music-centered music therapy sees the therapist and client as equals, including, significantly, disabled clients. Because the music-centered model sees music-making as its own legitimate therapeutic goal, the traditional oppressive hierarchies and dualities of the medical model are abandoned in favor of an egalitarian approach. Music-making in an egalitarian setting explicitly embraces the social model of disability by breaking down these oppressive hierarchies and by facilitating the removal of barriers to musical access for disabled people.

It should be emphasized here that 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 meant in any way to suggest any sort of error-by-omission on Aigen’s part.

### Takeaways for the Emerging Clinical Practitioner

Music-centered music therapy shows that sensitive music therapy that bears in mind the social model of disability can be accomplished. In Hadley’s (2014) editorial initiating the *Voices* special issue on disability studies and music therapy, she cautioned some readers that some concepts will find concepts expressed in the issue challenging. She warned against readers dismissing the critiques therein reflexively. She instead encouraged readers to be open to the critiques.

I concur completely with Hadley. Instead of being defensive, it might be worthwhile to consider ways that clinical practitioners— particularly practitioners at the beginning stages of careers in music therapy (like myself) — can incorporate the lessons of the *Voices* critiques and the example of music centered music therapy in order to be aware of and more sensitive to the social model of disability.

Let us see if we can correlate some practical takeaways to each scholar that wrote in the *Voices* Vol. 14, No. 3 edition.

1. LaCom and Reed (2014) reminded us to be aware of hierarchies. The illusion that we the practitioners are able-bodied (whether we actually are or not) reinforces hierarchical dichotomies such as “therapist/client, teacher/student, helper/helped” and importantly, “ablebodied/disabled” (para. 2). They continue, “Upon that privilege rests an array of power dynamics,” (para. 2) and it is important for even the beginning practitioner to be aware that she or he will wield a great deal of power in the therapist/client dynamic.

2. Bassler (2014) told us that invisible disability “poses a unique problem vis-à-vis disability and society, since invisible illness does not present itself outwardly and does

not easily mark a person as having a disability” (para. 1). My practical suggestion here: never assume the extent of one’s disability by outward appearances alone.

3. Rolvsjord (2014) pointed out that in a therapist/client binary “the client is defined in terms of weakness, pathology and passivity, while the therapist is described in terms of strengths, expertise and activity” (para. 1). The suggestion here: Do not participate in this paradigm. Respect your client for her or his inherent abilities, and acknowledge your own limitations.

4. Regarding music therapy for intellectually disabled young people, Rickson (2014) said “Young people would have the opportunity to set their own goals, and to self-refer to a community music therapist/s who would organize and run music programs as needed, but would connect the young people with community musicians, teachers and so forth, and work with those professionals, to ensure that young people could access and transition to typical music services” (para. 33). The suggestion here: allow clients some authorship in their own goals.

5. Straus (2014) maintained that “Music therapy has positioned itself squarely within the medical model of disability, arguing that many sorts of human variability should be understood as illnesses, diseases, or other sorts of pathological medical conditions, and offering music as a source of normalization, remediation, and therapy toward a possible cure” (para. 1). My suggestion: Don’t participate in this paradigm either. Consider clients to be equals with you, not lesser beings who need to be “cured” of anything. This for some may strike as a radical proposition that flies in the face of much training, but it is necessary if we are to avoid condescending inequalities in our therapist/client relationships.

6. “If we were to privilege listening to what our Autistic interlocutors had to say about what *they* think they need,” wrote Bakan (2014, para. 91), “and what matters to them over acting on the assumption that our main responsibility is to change them ‘for the better’ in accordance with the conventions of a pathology-based model of wellness and functionality, think how radically altered the landscape of therapeutic interventions might become.” So listen to your client.

7. Honisch (2014) observed: “How exactly it is that music prevents some people from accomplishing a full, normal selfhood, and, in related how it is that music can be used in support of pervasive dichotomies inclusive of ability and exclusive of disability, are some of the troublesome questions frequently absent from popular invocations of the power and transcendence of music” (para. 5). Furthermore, he added, “From further within Disability Studies we find many ripostes, pushing back against years, decades, and centuries of well-intentioned work to normalize the lives of people with disabilities” (para. 17). A blunt suggestion is made here: do not assume you are there to normalize your client. Celebrate your client for his or her diversity.

8. Cameron (2014, para. 1) expressed skepticism that music therapists will listen to critiques of the profession. My suggestion: Listen to critiques of the profession, particularly those critiques offered by disability studies scholars.

9. Metell (2014) “would like to argue that music therapy, as a field, would benefit from collaboration with disability scholars and activists in general. This applies, for example, to the development of curriculum of music therapy courses that should be informed by a disability studies perspective in contrast to a medical model of disability” (para. 44). This leads to my next suggestion: If your music therapy curriculum is not discussing the social model of disability, then educate yourself about it. These scholars provide extensive bibliographies and are a great place to start.

10. Miyake (2014), like other authors, recommended the deconstruction of the power dynamics and hierarchies implicit in the therapist-client relationship. “In order to do this, the music therapist must put him/herself at a critical point beyond professional identity, and tell his/her own experiences as an individual. This is different from a narrative of ‘therapy’; it demands that we take off our ‘professional’ armor and reconsider the musical process resulting from the subjective reality of his/her own sensory experience” (para. 34). I would recommend then, do not become too invested in pro-



fessional identity; remember instead that equitable, egalitarian musicking with your client is the important thing.

## Conclusion

Let us close on this note:

Everyone, disabled or not, should have access to music, and music therapists are ideally suited to provide this access. But to do so, they may have to be willing to detach themselves from the medical model, which typically undervalues the sorts of [musical] pleasures I have just enumerated. (Straus, 2014, para. 7)

Straus (2014, para. 6) emphasized that we should value music not because it is good for our health (“Eat your vegetables, Jonny,” he quips), but for all the intrinsic values of music we celebrate. Here Straus and I could not agree more.

To review, the music-centered model breaks down the hierarchy of superior therapist and inferior client in favor of egalitarian music-making, and in opposition to the medical model. The music-centered model values music for its own sake, and as its own music-therapeutic goal. Therefore, the music-centered model is neatly commensurate with the goals and aims of the social model of disability. Several practical guidelines are suggested here based on the work of disability scholars and music therapists whose scholarly work is informed by disability studies.

It is to be hoped that the present article more forcefully articulates the way in which the social model of disability is supported by a major music-therapeutic model in currency. This is important as music therapists endeavor to avoid oppressing anyone and to promote social-justice aims in earnest. Because the music-therapy clientele is comprised of a great many disabled people, it is particularly imperative that music therapists seriously engage those voices critiquing the prevailing medical orthodoxies of the field.

## Notes

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. An interesting alternative response to this criticism is articulated by Colin Barnes (2012), an exponent of the original social model of disability, who said “...[T]he claim that the impairment/disability distinction is false is to suggest that the division between the biological and the social is false. Whilst such assertions may be of interest to philosophers and some social theorists, they have little, if any, meaningful or practical value in terms of research, policy *and practice* [emphasis added]” (p. 19). In other words, Barnes refuses to cede ground on the front of which approach to disability is actually the more pragmatic. Elsewhere Barnes asserted: “Consequently now more than ever we need to build on the insights of the social model and uncover the reasons why the policies to address disability have been unsuccessful, and so contribute to the on going struggle for change. To shy away from this task and focus instead on abstract and obscure theorising that has little or no relevance beyond the sterile confines of university lecture theatres and seminar rooms will almost certainly usher in the demise of Disability Studies as a credible and meaningful academic discipline” (p. 22).
4. I should like to thank Melissa Murphy for suggesting this quotation to me.
5. 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 article music-centered music therapy refers to Aigen’s construction.

6. LaCom and Reed (2014) noted: “We use the terms ‘able-bodied’ and ‘disabled’ with reservations, recognizing that they shore up a binary way of understanding embodiment 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.

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