Voices
A WORLD FORUM FOR MUSIC THERAPY

OPEN ACCESS

COMMENTARY

"But Where are you Really From?":

Approaching Music Therapy Research and Practice as an Australian of Indian Origin

Tanya Marie Silveira [1] *

1 University of Melbourne, Australia

*tanya.silveira@gmail.com

Received: 13 October 2020 Accepted: 19 October 2020 Published: 1 November 2020

Editor: Juan Zambonini

Abstract

I have always been passionate about my work and research in stroke rehabilitation but never truly understood where this stemmed from. Drawing upon accessible music making, my PhD research developed and trialed a novel approach for post-stroke rehabilitation: an intervention created to simultaneously address arm/hand function and well-being outcomes. The focus of the research was to empower stroke survivors with limited to no movement in their arm/hand, as this subset of survivors are generally overlooked by the medical system (due to a projected poor prognosis of recovery). In 2020, during my engagement with the PhD research, the Black Lives Matter movement was reignited in response to the death of George Floyd. As a Woman of Colour, this movement deeply impacted me and led to reflection about my personal experiences of adversity. Through deep reflection, I started to understand the impact of my adverse experiences on my passion for advocacy in stroke rehabilitation. This paper explores the impact of my complex identity on my current approach to music therapy research and advocacy in stroke rehabilitation. Positioning myself as an Australian of Indian origin, I share personal reflections about my journey to research with the intent of highlighting the importance of visibility and change in music therapy research and practice.

Keywords: *music therapy, research, intersectionality, adversity, advocacy, representation*

Acknowledgement of Country

It is necessary to recognise that this paper was written on the lands of the Eora Nation. I would therefore like to acknowledge the Gweagal, Bidjigal and Gadigal People of the Eora Nation, and pay my respects to their elders, past, present and emerging. I acknowledge that sovereignty was never ceded. Positioning myself as an Australian of Indian origin, I recognise that I have personally benefitted from the colonisation of this country and its rightful custodians. This is a heavy reality that I must consciously reflect upon, especially as a PhD graduate researcher affiliated with a tertiary institu-

Publisher: GAMUT - Grieg Academy Music Therapy Research Centre (NORCE & University of Bergen)

DOI: https://doi.org/10.15845/voices.v20i3.3171

tion. It is therefore necessary for me to acknowledge the opportunities that I have been afforded over the course of my life. With these opportunities come the immense gratitude that my family and I have to the traditional custodians of the land; we are grateful for our life on this land and, as a result, our opportunity for accessing education and healthcare. However, along with our feelings of gratitude, we continue to experience ongoing racialized adversity.

The fundamental notion of this paper was conceived as a direct response to the widespread media coverage of the reignited Black Lives Matter protests of 2020, following the death of George Floyd. Whilst I acknowledge that I will never understand the hardships faced by those central to this movement, both in Australia and overseas, it led me to more deeply reflect upon my own adverse experiences as a Person of Colour…more specifically, as a *Woman* of Colour.

It is important for me to make clear that the intent of this reflective piece is to highlight the importance of education, advocacy, and change within the profession of music therapy. With this in mind, I have purposefully chosen to redefine my adverse encounters in an attempt to rewrite the narrative and therefore take the power back. And so, this paper will explore my life-long experience with societal assumptions ("Do you speak ***Indian***?"), my perceived positioning in the world ("Isn't it ***obvious***?"), the origins of my underlying passion for advocacy through research ("But where are you ***really*** from?"), and my thoughts on future approaches for instigating change in the profession of music therapy ("What did ***you*** say?" "What did ***you*** do?").

"Do you speak *Indian*?"

I cringe at the thought of being asked "Do you speak Indian?" for the umpteenth time. Why? Because the question itself is problematic on so many levels. Firstly: the assumption that I am of Indian origin (though true) is generally based upon my physical appearance alone. Secondly: there is the assumption that my interest in learning another language would have to be linked to my cultural heritage (for those wondering, my second, not-so-fluent, language is French). And thirdly: there is the ever so strange assumption that Indians speak "Indian"…"Indian" isn't even a language (please take a moment to reflect upon that).

Assumptions are a part of our very existence. Historically, such thought patterns played a role in humankind's protection of the self, specifically in relation to the identification of danger in the environment (Bellack, 2015). The Oxford Learner's Dictionary's current definition of assumption is: "a belief or feeling that something is true or that something will happen, although there is no proof" (2020). Reiterating the notion that an assumption has "no proof" is significant to consider. Through the absence of proof, the biased *beliefs* or *feelings* "exist in our minds without knowledge or consent" (Erikson, 2015, p. 2, as cited in Bellack, 2015). And so, the process of making assumptions about people and/or situations are unconsciously embedded in our thoughts and actions. It is only as an adult that I realised the impact of untrue assumptions: they lead to the questioning of my identity and self-worth in society. However, having had the values of gratitude and humility instilled in me from an early age, I was generally able to reframe my thinking through my Mother's consideration of society's lack of understanding about our cultural heritage. This lack of understanding could be explained through the diversity paradigm of unconscious bias (Hassouneh, 2013) whereby the mind strongly aligns with what is familiar, and in doing so, develops subtle biases against the unfamiliar (Erikson, 2015, as cited in Bellack, 2015).

In reviewing the literature surrounding unconscious bias, there is much discussion about its unintentional nature (Bellack, 2015; Moule, 2009). Whilst Bellack (2015) identifies unconscious biases as a reflection of innate prejudices or biases as a result of *unintentional* and insensitive attitudes and behaviours, Moule (2009) draws direct links to its eventuation of *unintentional* racism. This is a significant link because the notion that racism can be *unintentional* means that it can be invisible to its perpetrators (Moule, 2009).

Within the context of my clinical work and research, I have been subject to untrue assumptions by peers, colleagues and patients[1]. In these situations, I would have to momentarily sit with the inner conflict of wanting to advocate for myself as an individual versus the need to maintain a professional presence (the need to maintain a professional presence always won…always). As a result, I have often wondered whether my response to these situations would have been different had I been briefed, as a student, about the potential for this type of an encounter to occur in my work.

Music therapy courses all over the world foster the development of the students' clinical skills through the use of scenarios and case studies. Predominantly centred around the patients, the family/caregivers and the treating team, this approach to learning is beneficial to the student music therapist as it helps them to gain confidence in working with the various networks and thus different aspects of their work. However, this approach is also missing a central element: the therapist's unique identity. Even though our role as music therapists is centred around our patients, we need to remember that we are people too…many of whom have incredibly complex identities. Take me for example: my identity encompasses both historical colonisation (Goa, India) and immigration (Sydney, Australia).

In considering my complex identity, I wanted to learn more about the history of music *as* therapy within the context of my cultural heritage: India. I reflected upon my learnings about the importance of the rāga (melodic framework) and its place in Indian Classical Music. I reflected upon the spiritual significance of this music and how it was embedded within the Indian culture. In learning more about the music of this incredible culture, a feeling of discomfort arose through the questioning of why the spiritual significance of music from various cultures is not covered in any depth as part of the formal education in music therapy in Australia, and perhaps elsewhere. In sharing this with fellow music therapists across the world, I soon learnt that I was not alone in my thinking. This was particularly pertinent for my music therapy peers who identify as People of Colour. Embedded within many cultures, musical practices have been around for a lot longer than the formalised "Music Therapy" profession…so what does that mean for us as music therapists? In my opinion, learning more about the history of music *as* therapy across cultures is necessary for our understanding of the profession. Not only will this learning help us to more deeply consider and recognise the origins of our work in order to guide our clinical approach, but more importantly, it will encourage us to show respect to the cultures from which our profession originated.

As a minority profession within the medical model, assumptions are often made about what music therapy entails. It seems that many hospital-based music therapists work hard to explain what we do so that our profession may become identified as equal to that of the other disciplines. In striving toward greater music therapy understanding and access in this setting, we make an effort to attend more team meetings and push for collaboration. In doing so, we are able to challenge and potentially change the incorrect assumptions made about the profession of music therapy in the hospital context…And so I ask you this: if we are already equipped with the capacity and thus mindset to challenge untrue assumptions about the profession of music therapy, then why not channel this skill by taking a stand against the biases experienced by our fellow music therapists who experience adversity? This can be your small step toward social change.

"Isn't it *obvious*?"

I recall a time not so long ago when a patient offered an interesting view of me: "your name doesn't match your face." We were cramped in an elevator with other patients and staff and not one person seemed to know what to do or say…they all remained silent. In wanting to maintain a sense of professionalism, rather than using my words, I responded to this comment with a confused expression on my face. The patient then looked around and further inferred: "Isn't it obvious?"

Up until recently, I had not consciously considered that the colour of my skin had certain implications in the modern world. Without even realising, I started to ask myself: "why was my experience of the world so different to my Caucasian counterparts?" In an attempt to make sense of it all, I decided to share these thoughts with my close friends and family. In doing so, I started to feel validated and understood. Through the process of sharing and reflecting upon our adverse experiences as People of Colour, we became unified: we each possessed the all-to-familiar feelings that were directly related to racialized bias.

Through my brown skin and big dark brown eyes, I have been told that my cultural heritage has been somewhat *obvious* to those with vision. Upon reflection, I now realise that there have been moments in my life for which the colour of my skin had determined the way in which I had been characterised by society. This characterisation was generally presented in the form of untrue assumptions about myself and my family—from the food we ate, to the language we spoke, to the religion we followed, to the music we learnt … and ultimately to what our unique identity entailed. Seemingly non-invasive in nature, such encounters continued to challenge and consume my every thought. In comparison to the *obvious* verbal and physical forms of mistreatment, these subtle encounters had a heavier and more long-lasting impact on me. The reason for this impact is now *obvious* to me: the characterisation of an individual based upon their physical appearance has roots in discrimination, and thus systemic racism.

Even though discrimination had a presence in the context of my personal life, I never felt equipped to respond to it in the context of my work as a music therapist. During these moments, I would either try to awkwardly laugh it off or pretend it never happened, and in doing so, somewhat validate the instigator. In my mind, this was the only way forward for me—this was the only way for the inappropriate moment to conclude so that I could do my work as a music therapist. Over time, I started to realise that the more subtle encounters of discrimination came in the form of my opinions, knowledge and clinical experience being overlooked. In challenging why this was the case to those more senior, my being overlooked often became *obvious* to them. Though this generally resulted in shock, a potential solution and on the rare occasion an apology, I couldn't help but ask myself "*Isn't it obvious?*".

As music therapists, we tend to look deeper than the *obvious* when working with our patients. Even though we consult medical files to help inform our clinical delivery, we centre our approach around the individual qualities of the person. We try our best to alter our approach to meet the patients' unique self in the moment. We don't get caught up in the patients' perceived positioning within the medical world: we advocate for them as a unique individual…And so I ask you this: if we are already equipped with the capacity and thus mindset to look beyond the perceived positioning of our patients, then why not channel this skill into deepening our understanding of our fellow music therapists who experience adversity? This can be your small step toward social change.

"But where are you *really* from?"

Them: Where are you from?

Me: Australia.

Them: …

Me: I was born and raised in Sydney, Australia.

*Them: No, but where are you **really** from?*

Me: Oh…do you mean my cultural background?

*Them: Yes! Where are you **really** from?*

Me: Oh. My parents are from India.

Them: I thought so!

My sense of curiosity seems to now extend whenever my place of origin is questioned. Though the posing of this question fills me with discomfort, my inner self wants to learn why it is so frequently asked. With this in mind, the inclusion of the term "really" is worth dissecting further. In asking someone where they are really from, assumptions are made. In asking someone where they are really from, judgements are made. In asking someone where they are really from, a person's sense of self is being questioned. Even though we know that this question is based upon the unconscious bias of an individual, the fact that many people constantly ask this question to People of Colour highlights that it is a pervasive issue. Though my response to this interrogative question is generally consistent (as above), the overwhelming confusion of being perceived as untruthful is consuming: if I respond by identifying that I am from Australia, what warrants further questioning? After much consideration, the only possible explanation seems to (once again) be in relation to the colour of my skin. The fact that I speak the national language (English) with an accent that is somewhat typical of the nation seems to (once again) be overlooked.

In returning to the Oxford Learner's Dictionary, to "overlook" is "to fail to see or notice something" (2020). From an early age, my parents always encouraged us to work hard in whatever we do. However, no matter how hard we worked, there would be many times for which others would "fail to see or notice" us. The moments in my life where I had been overlooked have left me feeling disappointed and disheartened. As a teenager, these feelings were masked by my overwhelming need for acceptance. Up until recently, these feelings had been locked away in a metaphorical box that lived deep within my heart. It was only after the reignited Black Lives Matters movement of 2020 did the deep sadness and confusion that lived within that box suddenly emerge. In closely following the movement across the world, the issues of adversity, visibility, and access strongly resonated with me. For the first time, I started to think about these issues in the context of my WHOLE life. As a result, I more consciously reflected upon these issues in the context of my clinical work and research in music therapy. In doing so, I began to realise that the issues of adversity, visibility, and access were also the basis of my research in stroke rehabilitation. In order to explore this further, I searched for my unconscious motivations for the research, asking them: "but where are you *really* from?".

The first step toward discovery was to look within. In considering the origins of my researcher self, and thus where these motivations were *really* from, I looked to Kimberlé Crenshaw's work on Intersectionality. Intersectionality is now identified as a framework that helps us to understand how the various aspects of our identity intersect, influence one another, and merge together to eventuate at our unique experience of the world (Collins & Bilge, 2020). These unique experiences are complex as they are a result of the individuals marginalized or privileged positioning within society (Collins & Bilge, 2020). In reflecting upon my own unique researcher identity, it seems that my marginalization in society is positioned at the intersections of my age (being perceived as young), gender (identifying as female), and ethnicity. In reflecting upon my ethnicity, I have realised that it is rather complex.

Looking back in history, I have now learnt about the presence and impact of colonisation in India. From the years 1858 to 1947, India was under the direct rule of the British ("The British Raj"). Though the documented intention of this rule was to increase Indian participation in governance, it dismissed the voice of the Indian citizens and, as a result, led to a national independent movement to reclaim the country (Wolpert, 2020). With the British Raj ending in 1947, it took 89 years for India to reclaim independence. Along with this, Goa, the place of my family's origin in India, was under the rule of the Portuguese for as long as 450 years, reclaiming independence quite recently in 1987 (Williams, 2008). Now having this knowledge, I don't just consider India as place of my familial origin but also as the site where my ancestors were colonised. To add to the complexity of this identity, and as a result of colonisation, my ancestors were converted to Christianity, positioning our family as a minority within the Indian community.

When I think about the stroke survivors who have been part of my research, I can't help but consider the impact of their intersectional identities within the context of the medical system. Those who were central to my PhD research had limited to no functional movement in their arm/hand. Through discussions with clinicians working in this area, I started to learn that this subset of stroke survivors are generally overlooked by the system as a result of the intersections of their age, level of active movement (in the arm/hand), and time since their stroke onset. The alarming reality is that if a stroke survivor has limited to no active movement in their arm/hand, if they are older, and if it has been quite some time since the onset of their stroke, they do not receive as much care and attention for the recovery of their movement in comparison to someone who is younger, has more active movement, and has had a more recent stroke onset.

Upon reflection, I now feel as though my lived experiences of adversity led to my growing passion for advocacy in stroke rehabilitation. In understanding what it is like to be overlooked by society, I feel driven to instigate change for others. As therapists, it is important to use our voices to empower and thus advocate for the people we work with, especially if they too are being overlooked by the system. And so, I now believe that my adverse experiences are my strength and superpower in approaching music therapy research and practice: it is through these moments of adversity that I have become who I am today.

Since commencing my PhD research, I have noticed a change in the way that others in the medical field engage with me. The same people who seemed to overlook my contributions now listen with open ears. The title of "PhD Graduate Researcher" (if it is even a title) has now afforded me a sense of visibility within the wider medical field. In working hard to be seen, I have consciously chosen to draw upon my adverse experiences to advocate for both the patients that I work with and my fellow music therapy colleagues who experience adversity. Now visible, I feel a sense of responsibility to ensure that others too are seen and heard. As music therapists, we are able to draw upon our unique knowledge and skill-set to give space to our patients' unique "voices", whether this be in a musical or verbal manner…And so I ask you: if we are already equipped with the capacity and thus mindset to creatively advocate for the unique voice of our patients, then why not channel this skill into taking the time to learn from the unique stories of our fellow music therapists who experience adversity? This can be your small step toward social change.

"What did *you* do? What did *you* say?"

*Whenever I've recounted my adverse experiences, I am often met with the questions: "What did **you** do? What did **you** say?" What you might not realise is that responding to these questions as a Person of Colour is emotionally and mentally exhausting. People of Colour cannot be expected to do the work by ourselves. As a community, we need to unite and consider "What **will we** do…What **will we** say?"*

Music therapists are great collaborators. Many of us collaborate with other disciplines to advocate for the people we work with and, in doing so, the profession of music therapy. The intervention that was created as part of my PhD research encapsulates just that: this intervention combines music therapy, physiotherapy, and occupational therapy approaches to advocate for stroke survivors with very limited arm/hand function. It is through this collaborative approach that I have made stronger connections with other disciplines, which have resulted in more music therapy advocacy opportunities.

Working within a strengths-based model, we, as music therapists, see the person for who they are: the person behind the condition. We draw upon their strengths to drive the therapeutic process. So, if one of our strengths, as music therapists, is in collaboration, then why not follow this model in combatting racialized bias in the profession? This time, instead of collaborating with other disciplines, ***we will*** collaborate with music therapists who identify as People of Colour. How will we do this? ***We will*** listen to them, learn from them and take the time to continue our own learning. ***We will*** ad-

vocate for them by giving space to uncomfortable discussions, by actively challenging discrimination, and ensuring that we continue these necessary conversations. ***We will*** more consciously consider our choice of words and our use of music as therapy. ***We will*** advocate for the profession by taking a stand against racialized bias.

In order to recognise the complexities faced by many music therapists all over the world, we need to unite. Based on my experiences alone, I would like you, the reader, to consider how you can start to:

- Actively collaborate with your music therapy colleagues who identify as Indigenous, Black, and/or People of Colour
- Actively dialogue about the issues related to racialized bias
- Actively expand your understanding of cultural competency
- Actively encourage clinical placement supervisors to extend their understanding of potential cultural differences with student music therapists
- Actively recognise the significance of music in other cultures, as part of our music therapy training
- Actively learn how to stand up to biases for our colleagues who experience adversity

The year 2020 presented circumstances that forced the world to think more consciously about the systemic nature of racialized biases. We took the time to learn how to unlearn. We marched as one to push the urgency of social change. We paused, reflected and gave space to others…and now, on some level, we know that the only way forward is through change. The fact that many of these thoughts and reflections are not unique to me warrants a call to action for us as a music therapy community to more actively instigate changes at a systemic level. Given that many music therapists, such as myself, experience adversity as part of our professional roles, we do not have the luxury to separate or compartmentalise the burden of complexity that we are left with. Therefore, we must unite together, on all fronts, because "…to think that we can keep our professional roles separate from the political is to come from a position of privilege in our society" (Hadley, 2013, p.375). I hope that in reading this article, you too feel the urgent responsibility for us to come together in our strive for social change, access, and visibility in the profession of music therapy and beyond.

About the author

Tanya Marie Silveira is a Registered Music Therapist and PhD Graduate Researcher based in Sydney, Australia. Tanya's PhD research examines how accessible music-making can impact the hand function and wellbeing of stroke survivors. In 2019, Tanya was invited to speak about her PhD research at the inaugural TEDxNewtown event. Over the years, Tanya has presented internationally and nationally on her research and clinical work. Her publications can be found in academic journals and books. Tanya has also established multiple ongoing music therapy programs in Australia and India. Identifying as an Australian of Indian origin, Tanya is now working hard to advocate for the importance of visibility and representation in music therapy.

Notes

1. I have purposefully used the term 'patients' as I work predominantly within the Medical setting

References

Bellack, J. P. (2015). Unconscious bias: An obstacle to cultural competence. *Journal of Nursing Education*, *54*(9), S63-S64, https://doi.org/10.3928/01484834-20150814-12.

Collins, P. H., & Bilge, S. (2020). *Intersectionality*. John Wiley & Sons.

Hadley, S. (2013). Dominant narratives: Complicity and the need for vigilance in the creative arts therapies. *The Arts in Psychotherapy*, *40*(4), 373-381, https://doi.org/10.1016/j.aip.2013.05.007.

Hassouneh, D. (2013). Unconscious racist bias: Barrier to a diverse nursing faculty. *Journal of Nursing Education*, *52*(4), 183-184, https://doi.org/10.3928/01484834-20130322-10.

Moule, J. (2009). Understanding unconscious bias and unintentional racism. *Phi Delta Kappan*, *90*(5), 320-326.

Oxford Learner's Dictionary. (2020). Assumption. *Oxford Advanced Learner's Dictionary*, . , Retrieved October 23, 2020, from https://www.oxfordlearnersdictionaries.com/definition/english/assumption?q=assumption.

Oxford Learners Dictionary. (2020). Overlook. *Oxford Advanced Learner's Dictionary*, Retrieved October 23, 2020, from https://www.oxfordlearnersdictionaries.com/definition/english/overlook.

Williams, C. (2008). *Goa in Historical Companion to Postcolonial Literatures – Continental Europe and its Empires*. Edinburgh University Press.

Wolpert, S. (2020). *Britannica*. Retrieved October 23, 2020, from https://www.britannica.com/event/British-raj.