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Postmodern Music Therapy:

A Proposed Paradigm Shift Away from the Medical Model of Disability and Toward an Intersectional Understanding

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Abstract

Postmodern music therapy is an approach to music therapy that defines itself in diametric opposition to modernist, or medical-model, music therapy. Where modernist music therapy ignores power dynamics and assumes itself to be value neutral, postmodern music therapy is concerned with power dynamics between client, therapist, and broader society. Postmodern music therapy is based on the theories of Bradley Lewis: Lewis (2006) believes that a postmodern psychiatry (or as he calls it, *postpsychiatry*) will be more aware of politics and social structures in general and will move toward democratization. This article proposes a postmodern music therapy in parallel to postpsychiatric ideas and ideals. Further, the article explores the intersectional nexus between postmodern music therapy and critical race, disability, queer, and feminist studies.

Keywords: postmodernism; critical race theory; critical disability theory; critical gender theory; critical queer theory

Introduction

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. Because of my disability, I became interested in music therapy precisely because I thought my expertise as a disabled person who has worked in music with other disabled people would bring some benefit to bear professionally. However, shortly into my

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immersion in the world of music therapy, I discovered a profound disconnect between critical disability studies and the profession of music therapy in which the vast majority of clients are disabled. 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. This line of thinking led to the present article which is about something I call "postmodern music therapy."

Postmodern music therapy is an approach to music therapy that defines itself in diametric opposition to modernist, or medical-model, music therapy. Where modernist music therapy ignores power dynamics and assumes itself to be value neutral, postmodern music therapy is concerned with power dynamics between client, therapist, and broader society. Where modernist music therapy is predicated on hierarchy (the inferior client, the superior therapist, and the expert field of music therapy in general), postmodern music therapy is predicated on egalitarianism. Where modernist music therapy is founded on the unilateral and unidirectional theory of treatment, of fixing defective bodies and minds, postmodern music therapy is built on a foundation of multilateral collaboration between client, therapist, community, and society. The music therapist is a facilitator, and the client is the expert. Where modernist music therapy is built on localized individualism (the problem resides in the patient and is best addressed by fixing the patient), postmodern music therapy focuses instead on communitarianism (the problem is best seen as a complex nexus between the client, the community, and society). Finally, postmodern music therapy critiques neoliberal ideology and offers community music therapy as a remedy for some of the ills of neoliberalism. Postmodern music therapy will also exhibit intersectionality with critical disability studies, feminist studies, queer studies, and race studies.

Part One: Goals of Postmodern Music Therapy

In *Moving Beyond Prozac, DSM, and the New Psychiatry: The Birth of Postpsychiatry* (2006), Bradley Lewis outlines the mechanisms by which psychiatry as a profession can comport more closely with postmodern principles. In my opinion, a similar overhaul is overdue for the profession of music therapy. Lewis critiques the over-prescribing of medicine in lieu of the development of new ways of working through the human experiences of suffering, anxiety, grief, depression, etc. Music therapy is often deployed as a means by which medications can be reduced, in its adjunctive capacity for mitigating depression, anxiety, and other psychiatric conditions (see for instance Stefani & Biasutti, 2016). However, music therapy rarely replaces medication altogether, and the overall aim remains the same: fix the client's defective brain. The adjunctive deployment of music therapy in addition to (sometimes reduced) psychiatric medication still maintains the unidirectional poise, the medical model gaze, that seeks the remediation of the intrinsic pathologies of the individualized client. The Stefani and Biasutti article is illustrative: published in *Frontiers in Psychology*, its general tenor is firmly steeped in the medical model in its philosophy that individuals must be remediated with a combination of music therapy and medication.

It must be acknowledged early on here that not all models of music therapy are rooted in the medical model of disability. Examples of models that are not so rooted include music-centered music therapy, community music therapy, post-ableist music therapy, and resource-oriented music therapy. (I thank the reviewer of this article for pointing this out.) Another example not rooted in the medical model is the Bonny Method of Guided Imagery and Music. (I thank Lindsay Mohler for pointing this out as well.) However, the overwhelming posture of music therapy as a profession is the poising of itself as a medical-model-based health- care profession (at least in the United States and the United Kingdom).

This tone can be seen within the official definitions of music therapy by the credentialing professional organizations of various countries: the American Music Therapy Association says "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" (AMTA, 2018, para. 1). Notice the assertion that music therapy is "clinical," it is "evidence-based," and is accomplished by a "credentialed professional"; all these reinforce its claim to the legitimacy of being a health-care profession. The British Association for Music Therapy is similar: "Music therapy is an established psychological clinical intervention, which is delivered by HCPC registered music therapists to help people whose lives have been affected by injury, illness or disability through supporting their psychological, emotional, cognitive, physical, communicative and social needs" (British Association for Music Therapy, 2020, para. 5). Here music therapy is firmly rooted in the medical model by definition, since music therapy is a "psychological clinical intervention" which must be delivered by credentialed and registered professionals. The people to whom music therapy is delivered are pathologized people who "have been affected by injury, illness or disability." (Of course, AMTA and BAMT are specific to the United States and United Kingdom respectively, and their tenets may not be generalizable elsewhere.)

Lewis (2006) points out that psychiatry is a product of Enlightenment thinking: that through reason and rational discourse we can solve the problem of defective bodies and minds. Music therapy in its commitment to scientism, to loudly proclaiming itself time and time again as an "evidence-based practice," fully co-signs to the Enlightenment ideals of reason and rational discourse as well. Lewis observes that medical institutions are isolated on college campuses from their counterparts in the humanities, which accounts for the degree to which the medical sciences have perhaps missed the proverbial memo about the postmodern revolution in thinking that has in many ways advanced academic discourse beyond the Enlightenment. However, music therapy cannot excuse itself in the same way. Music therapy has had a conundrum: is it *music* therapy, or is it music *therapy*? The profession—generally—has squarely opted for the latter, not even achieving a modest hybridization of arts/science/humanities (as Bruscia, 2014 would have it). Instead, a lot of music therapy is heavily medicalized and modernist, and has somehow escaped the influence of postmodern thinking that has clearly proliferated the music world. The music world is pluralist, constantly entails the hybrid vigor of cross-pollination of styles and influences and is a platform for a global exchange available to cross sections of the world's societies, including availability to marginalized communities and to the poor. Despite many ways music continues to be an arm of oppressive situations around the world, nonetheless, music is postmodern. Music therapy, however, remains predominantly modernist.

How did this come to pass? My suspicion—and it is only a suspicion, I will readily admit—is that the profession is oversensitive to the degree to which it is associated with the woo-woo "health" practices mentioned in conjunction with repositories of holistic speculations like the Top Holistic Directory (n.d., e.g., palm reading).[1] The term "woo-woo" here is used to describe pseudoscientific health-practitioner claimants. It is defined by the *Skeptic's Dictionary* as follows: "*Woo-woo* (or just plain *woo*) refers to ideas considered irrational or based on extremely flimsy evidence or that appeal to mysterious occult forces or powers" (Skeptic's Dictionary, 2016).

As Lewis (2006, p. 65) observes, "the principal villains for Enlightenment modernism [are] religion and myth," upon which many of the Top Holistic Directory practices are built. Eager to be legitimate in the eyes of paying clients, reimbursing insurance companies, and prestigious medical fields, music therapy protests too much in terms of distancing itself from what it considers to be woo-woo nonsense. By contrast, Lewis (2006, p. 63) claims that postmodern theory "frees [modernist practices] from enslavement to Method

and Objectivity, and it allows more humane perspectives and approaches to emerge as valued and respected." If the move from superstition to science is a modernist advancement, the move from science to humanism (or better yet, posthumanism, as Carolyn Shaw [2019] would suggest) is as much a postmodern advancement. Postmodern ideals do not require a regressive embrace of woo-woo; however, they do rather require an admission of the political and subjective structures surrounding the collection of evidence.

Lewis (2006) anticipates that moving toward a postmodern approach to psychiatry will see a shift in knowledge structures away from the qualitative realms of neuroscience and social science, and toward various forms of cultural studies. Lewis (2006) also anticipates clinical activities turning away from concepts of objective truth in favor of knowledge coming out of practice. Lewis (2006) finally believes that a postmodern psychiatry (or as he calls it, *postpsychiatry*) will be more aware of politics and social structures in general and will move toward democratization.

In the year of this writing, 2022, I would anticipate all this and more for music therapy. After all, psychiatry does not have a necessary artistic component as definitive the way that music therapy does. Inevitably, as pluralist musicians join the ranks of the music therapy profession more and more, the twin ethos of pluralism and democratization will take hold. This is not to say we will ever see a day where music therapy will cease to be an "evidence-based practice," but what is significant is that questions about what constitutes evidence—and who it is doing the counting of the evidence—will now come into play. (It should be noted that others have also questioned the nature of evidence; one thinks of Aigen [2015] as an example.) An "evidence-based practice" need not pretend that evidence is truly objective or value-neutral. An equal status of qualitative evidence alongside quantitative evidence is indeed a postmodern ideal that will serve to enrich the evidentiary basis of the music therapy profession.

Lewis (2006, p. 65) in his construction of postpsychiatry rejects what he considers the three primary tenets of modernist thought: "the quest for objective truth, faith in method, and a telos of progress and emancipation." I would argue at this point that these tenets can be bad fits for music therapy regardless. First, what constitutes an objective truth about music? Major mode always makes people happy? Minor mode always makes people sad? These are absurd. It is incumbent on music therapists to be aware at all times of the subjective nature of the primary vehicle by which they are delivering therapy: the *music*. Second, regarding *faith* in *method*, aside from the obvious tension in the argument (is the therapeutic enterprise faith-based or is it methodical?), music is too subjective to lend itself to hard-and-fast methodology. Where one can prescribe an SSRI and expect a certain adjustment to mood, one cannot prescribe a piece of music and expect the same mood adjustment. People will respond more variably and less predictably to music than they will to psychotropic medications. Third, a telos of progress and emancipation comes into question because much music today is not intrinsically teleological. For instance, new age music, which sometimes is used in music therapy to engender relaxation, meditation, and/or calm, is distinctly non-teleological in its tonal structures and textures. Even if we as therapists have goals of achieving calm, or reducing anxiety, we often take musical journeys in which the journey itself along the way, and not the terminating arrival point, is the true purpose of the therapeutic enterprise.

Lewis (2006) observes that psychiatry subscribes to the modernist tenet of Universal Truth. Schizophrenia, for instance, has always existed and is the same across cultures and eras (2006). He observes that psychiatry too adheres to the scientific method as the primary vehicle for arriving at Universal Truth (2006); however, he objects on the grounds that "this ideal has had a chilling effect on all nonscience knowledge" (2006, p. 67). For music therapy, this is doubly dubious, because musical responses, which are to be expected and encouraged, are nonscience responses. Yet, we objectively measure them anyway (e.g.,

"how many times did the client speed up the tempo?"). How do we quantify subjective responses to music? At best, we can crudely direct a client to a Likert-like scale and go from there ("Today's music made me feel better: strongly agree / neutral / strongly disagree"). Finally, Lewis (2006) critiques the telos of liberation from mental illness as contingent on the existence of Mental Illness as an Objective Truth (capital letters intended).

Postmodern theory that provides an alternative to these modernist strictures is notoriously heterogeneous, as Lewis (2006) observes, and that is really the point. Postmodern theory does not posit Truth (capital-T, singular), but rather truths (lower-case-t, plural). Lewis (2006, pp. 68-69) sees essentially three definitions of the term *postmodern* that usually appear:

1. "[P]ostmodern art, literature, or architecture"—which refers to creative works showing distinctive breaks from their modernist heritage, such as the pop-art work of Andy Warhol;
2. "[P]ostmodern culture"—which refers to the recent explosion in world cultures of mass-media influence, global-village cosmopolitanism, and transnational capitalism and globalization; and
3. "[P]ostmodern theory"—which refers primarily to recent Continental "theory" critiques of Enlightenment philosophy and epistemology.

Regarding the lattermost, Lewis (2006) names many philosophers with whom we should be acquainted, including Jean-François Lyotard, Roland Barthes, Jacques Derrida, Michel Foucault, Richard Rorty, and Zygmust Bauman. By relying on these philosophers, Lewis proposes to "rewrite" psychiatry, creating his model of *postpsychiatry*, in the following ways (2006): first, a quest for objective truth for Lewis becomes a "crisis in representation" (p. 69); faith in method morphs into "incredulity toward metanarratives" (p. 69); and a telos of progress and emancipation becomes a "telos of struggle and compromise" (p. 69).

What do these changes, or "rewrites," mean for music therapy? Regarding the crisis in representation, Lewis (2006) proposes that we deploy Derrida's concept of *sous rature*, or *under erasure*, which means to write a word, cross it out, and represent the word and the deletion simultaneously. The concept that is under erasure is seen as incomplete, inaccurate, unstable, and dynamic. It still retains some import—we can see the word through the cross-out—but the cross-out also has import, rendering a once solid concept as fluid. Lewis (2006) suggests that diagnostic categories with sharp delineations in psychiatry such as "mental health" and "mental illness" be crossed out under Derrida's schema and replaced with a fluid and dynamic continuum between the two.

I would propose on this basis other cross-outs. I would propose for music therapists fluid and dynamic continua between mental health and mental illness; between physical health (or wellness) and physical illness; between client and therapist; between helper and helped; between improvisation and composition; between creative and re-creative; between performance and audition; between individual and community; and between nonmusical sound and musical sound. Indeed, proto-postmodern composers like Edgard Varèse and John Cage were keenly interested in the non-delineation between music and environmental noise and incorporated the latter into their compositions with some frequency.

Perhaps the most disturbing or daunting cross-out for music therapists would be the breakdown of the distinction between therapist and client. Music therapists, after all, are instructed in their schools to be professionals, and not to cede this authority very often. It is here, then, that I propose in addition to Lewis's three shifts, an additional shift: under a postmodern paradigm, *hierarchy* is replaced with *egalitarianism.* In my model, the client and the therapist are intertwined in an equal relationship, in which the therapist stands to

gain as much from the relationship as the client. (I use the term "client" with reluctance as it still designates a power imbalance; see McFerran 2012 for a discussion of similar concerns.) Mere convention and the unfortunate necessity of professional considerations demand that we have any distinction between therapist and client at all. Still, it is my contention that when therapist and client engage in music-making as equals, with music *qua* music being the order of the day, a deeper engagement with music occurs, and the music therapy itself has a greater capacity to be an agent of change for the client (as well as for the therapist). Much of this concept is owed to Kenneth Aigen's construction of *music-centered music therapy* (2005).

Further resonances with this concept of putting the therapist-client relationship "under erasure" include Randi Rolvsjord's concept (2016) of *resource-oriented music therapy*, which is defined by the Oxford Handbook of Music Therapy as follows:

> Resource-oriented music therapy emphasizes the development and stimulation of client's strengths and resources rather than the reduction of symptoms or cure of pathology. Thus, the focus in therapy is positive experiences, mastery, and coping rather than on difficult emotions, psychological conflicts, and problems. Collaboration and user-involvement is highly emphasized. Resources-oriented perspectives in music therapy are linked to movements and theoretical perspectives in an interdisciplinary field, such as the philosophy of empowerment, positive psychology, salutogenesis, recovery, and various perspectives on music and health. The emphasis on aspects of resource-orientation can be traced back in the history of music therapy, and be described as a general feature of music therapeutic practices. Yet more recently resource-oriented music therapy has been developed as a more specific approach in mental health care. In this chapter a broad "family" of perspectives within the music therapy work that highlights resource-orientation will be presented. (Rolvsjord, 2016, p. 557)

Here, notice that rather than seeking pathologies and deficits in the client, instead, the client's strengths are highlighted. This is not quite the model of equitable collaborative exchange that I would seek, but it is a decisive improvement over models that see individual pathology in clients. (Thanks are due to the reviewer for suggesting the resonance of resource-oriented music therapy with concepts presented here.)

Another shift I propose is that *treatment* be replaced by *collaboration*, as we see in other music therapy models (e.g., music-centered music therapy, etc.). In this model, the music therapist becomes a facilitator, and the *client* is the expert of his/her/their life. This is an echo of psychotherapeutic modalities in which the client is thought to be the expert of the client's own life, such as Solution-Focused Therapy (sometimes called Solution-Focused Brief Therapy), the brain-child of the late married therapists Steve de Shazer and Insoo Kim Berg (see de Shazer & Berg, 1997).

Is the power differential between client and therapist inevitable anyway? Rizkallah (2022) writes:

> The power dynamic in favour of the therapist during therapy is inevitable as the therapist bears ultimate responsibility for the time, space and boundary around the session and therefore has more variables around a session which are ultimately in the therapist's control. This takes into account the therapist's theoretical and musical expertise, neither of which is demanded in the patient. (Rizkallah, 2022, pp. 9–10)

Perhaps, but I would argue that the time, space and boundary around the session are essentially ancillary, and have less to do with the *content* of a session. Even if, for the purposes of logistics, the therapist is in control of scheduling matters, the content of the session can nevertheless entail a far more equitable exchange. (Thanks to the reviewer for pointing me toward Rizkallah's thoughtful article.)

Still another shift I would propose would be the replacement of *individualism* (especially *rugged individualism*) with *communitarianism* in music therapy. Individualism per the medical model locates pathology in the client, and the purpose of therapy is to fix the client; this, however, as previously noted, ignores the degree to which medical pathologies may also entail social construction, especially for disabled persons. Rugged individualism encourages individuals to "pull themselves up by the" proverbial "bootstraps," and finds fault and shortcoming in the individual when the individual fails to comport to standards of the ideal or even the normative. This is to be rejected as oppressive, and largely inaccurate. A wheelchair user does not have an inherent impairment when a ramp is available alongside the forbidding set of stairs. The individualist model, in a world of nothing but stairs, would coerce the wheelchair user to undertake possibly years of expensive and invasive surgeries, procedures and treatments. Yet, this still would probably fail to remediate the individualized pathology of paraplegia. By contrast, society can build ramps. In music therapy, *community music therapy* such as that espoused by Ansdell and Pavlicevic (2004) can exist alongside individualized music therapy sessions. Community in their construction (2004) is broadly defined, and can include therapist(s), client(s), and even an audience before which musical performance takes place. Community integration in music therapy serves to break down barriers and prejudices between therapist, client, the broader participating community, and possibly even society writ large.

Another shift proposed here would be the replacement of *certainty* with *reflexivity*. Instead of objective reality that would be posited by an allegedly value-neutral research agenda, *reflexivity* positions the author in relationship to the subjects and to the subject matter. An example of this is seen in Zanders et al. (2018), who study the use of music therapy with foster-care youth from a reflexive standpoint. In it, Zanders and colleagues "explicitly acknowledg[e] the involvement of the researcher, to the extent that the lived experience of the researcher becomes the main focus of the research" (2018, para. 4). This reorientation would have a profound impact on the nature of music-therapeutic research, which maintains the posture of objectivity, value neutrality, and positivism. By contrast, reflexive research admits qualitative, non-positivist and subjective research that is filtered through the lens of a situated author or authors. For instance, this article is reflexive in that I situate myself as a disabled author, and therefore possibly more sensitive than some to issues of hierarchy in music therapy.

Finally, postmodern thought can be used to critique neoliberalism vis-à-vis music therapy. This is stated with a caveat: critics often charge anything they do not like with the tag of "neoliberalism" without first defining it. Nevertheless, the following definition by Harvey (2005) is used for the purposes of this article:

> Neoliberalism is in the first instance a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets and free trade. (p. 2)

This definition is important because under the paradigm of neoliberalism, a medicalized music therapy must take place in a marketplace. Music therapy is commodified and sought out by the individual consumer. Because of this, the orientation of music therapy vis-à-vis the individual usually finds itself inextricably bound to the medical model, because all the medical model can do is attempt to remedy the pathologized individual. The neoliberal perspective does not readily admit alternatives that are communitarian in nature, or which resist the commodification of the individual in the marketplace (specifically in this case a music therapy marketplace). Music-centered music therapy, post-ableist music therapy, and community music therapy are best positioned in my view to resist the marketplace-driven commodified individualism of the neoliberal medical model. Music-centered music

therapy sees a collaboration among equals in a musical landscape and breaks down the neoliberal medical model hierarchy of superior-provider-professional and inferior-consumer-client. Community music therapy relocates music therapy as a complex nexus between client, therapist, community and broader society, and thus breaks down model of the individual-with-pathologies that is the only model with which the neoliberal marketplace-driven medical model seriously engages.

Part Two: Intersectionalities with Critical Disability Studies, Feminist Studies, Queer Studies, and Race Studies

This part explores critical studies in the dimensions of disability studies, feminist studies, queer studies, and race studies. Other markers of identity of course exist (e.g., class, age), but these four categories have had the most writing vis-à-vis music therapy so far. It occurs to me that classism and ageism in music therapy could be fruitfully investigated, but space precludes that investigation here.

Disability Studies and Music Therapy

Disability studies is a field of keen interest to me as I situate myself as a disabled person (chronic clinical depression being my disability). As I state in my master's thesis (2020, p. 10), "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)." In other words, disability is a social construct, like race. A wheelchair user is not disabled until they encounter a building that fails to make available an entrance ramp.

One of the foundational works in disability studies is the 1990 publication of the late Michael Oliver's *The Politics of Disablement*. In the second edition (2012), retitled *The New Politics of Disablement*, Oliver and his new co-author Barnes illustrate one of the essential points of the social model of disability (as distinguished from the medical model): disabled people are only barred from participating in essential functions of society, such as paid work, not because disabled people inherently lack the capacity to undertake these roles. Rather, society through its own physical and attitudinal barriers creates the impediments that disabled people face. Oliver and Barnes argue that the unemployment rate being higher for disabled people is a direct expression of social, societal, structural barriers being in place for disabled people (2012).

I point out (2020) that the development of the social model of disability in 1990 is a rather late point of entry compared to the emergence of other liberation movements such as race, gender, or sexual orientation. I speculate (2020) this is due to something observed by Kudlick (2003), which is that very few people *consciously* profess to be against disabled people. However, I point out (2020) that it is precisely because the prejudice is unconscious that it is also so insidious. This is perhaps the reason why the widespread acceptance of the social model of disability took so long. Kudlick (2003) also observes that academia tends to believe disability is a marginal matter, and that disability is best addressed with entrance ramps rather than academic inquiry.

I observe (2020) that Oliver and Barnes (2012) following Derrida critique Cartesian dualism as one of the Enlightenment thoughts that has gone unchallenged. Cartesian dualism is responsible for sharp delineations such as mind/body, individual/society, normal/abnormal, etc. Because of the normal/abnormal dichotomy, for instance, ingrained deeply into culture, prejudice becomes common sense, and disability becomes a personal tragedy. I observe (2020, p. 13): "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.)". Shaw (2019) further comments on dualism. She points out that dualist delineations are made from "specific socializations, social expectations, and ideological constraints (p. 109)." She also points out that poststructuralists and Black feminists have emphasized "both/and" thinking as a remedy for dualist thinking.

The social model of disability is not a monolithically agreed-upon document. Tom Shakespeare, for instance, who is a significant disability studies scholar, believes that there is an important distinction between impairment, which locates individually, and disability, which is a social construct (2010). I would add that the relationship between impairment and disability, lest we fall into the trap of Cartesian dualism yet again, is a fluid, interdependent, and dynamic circuit rather than a sharp and discrete distinction. However, even though there are variations and distinctions made by various scholars about the social model of disability, it is my opinion that the social model is still an advancement over the medical model of disability.

Another foundational understanding of disability studies is the concept of ableism. Ableism is the nexus of prejudice and power in the dimension of ability/disability, much as racism is the nexus of prejudice and power in the dimension of race, misogyny is the nexus of prejudice and power in the dimension of gender, and so on. Ableism constructs the barriers that the social model of disability seeks to deconstruct.

Goodley et al. (2014) investigate the idea of *posthumanism* also as fundamental to disability studies. They write: "Critical disability studies, we argue, are perfectly at ease with the posthuman because disability has always contravened the traditional classical humanist conception of what it means to be human" (p. 3). Posthumanism is a concept primarily investigated by Rosi Braidotti (2022) and explores the following themes: "I. Life beyond the self: Rethinking enhancement; II. Life beyond the species: Rethinking animal; III. Life beyond death: Rethinking death" (p. 3). A thumbnail accounting of Braidotti's concept of the posthuman follows:

> *The Posthuman* offers both an introduction and major contribution to contemporary debates on the posthuman. Digital 'second life,' genetically modified food, advanced prosthetics, robotics and reproductive technologies are familiar facets of our globally linked and technologically mediated societies. This has blurred the traditional distinction between the human and its others, exposing the non-naturalistic structure of the human. The Posthuman starts by exploring the extent to which a posthumanist move displaces the traditional humanistic unity of the subject. Rather than perceiving this situation as a loss of cognitive and moral self-mastery, Braidotti argues that the posthuman helps us make sense of our flexible and multiple identities. Braidotti then analyzes the escalating effects of post-anthropocentric thought, which encompass not only other species, but also the sustainability of our planet as a whole. Because contemporary market economies profit from the control and commodification of all that lives, they result in hybridization, erasing categorical distinctions between the human and other species, seeds, plants, animals and bacteria. These dislocations induced by globalized cultures and economies enable a critique of anthropocentrism, but how reliable are they as indicators of a sustainable future? *The Posthuman* concludes by considering the implications of these shifts for the institutional practice of the humanities. Braidotti outlines new forms of cosmopolitan neo-humanism that emerge from the spectrum of post-colonial and race studies, as well as gender analysis and environmentalism. The challenge of the posthuman condition consists in seizing the opportunities for new social bonding and community building, while pursuing sustainability and empowerment. (Braidotti, 2022, para. 1)

Braidotti and Goodley et al. (2014) all challenge the duality of dependence and independence. In a posthuman society, independence is in a constant state of negotiation.

It is in a fluid state, one in which humans are interdependent in a global ecosystem—both a literal ecosystem, and a virtual ecosystem of information. The concept of ableism enters when one considers what it means to be disabled in a world of universal co-dependence. Ableism itself becomes absurd when one considers the idea that *everyone* in a posthuman world is interdependent and not at all independent.

I also observe (2020) that other therapeutically oriented professional organizations similar to music therapy engage in language that conspicuously resists ableism, and that music therapy as a profession should consider modeling upon these. I (2020) point to one such organization: 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. (Therapist Diversity Collective, 2018, para. 1)

Notice here the assumption that Applied Behavior Analysis is oppressive, and therefore ableist. I call upon music therapy *also* to advocate for neurodiversity, self-determination, inclusivity, dignity, respect of individual rights, sensory preferences, and the power to say "no." Instead, I point out (2020) that music therapists (at least in the United States) periodically embrace language like this:

> 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 individuals to reduce negative and/or self-stimulatory responses and increase participation in more appropriate and socially acceptable ways. (American Music Therapy Association, 2012, p. 2)

Regarding this I opine (2020, p. 19):

> 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 nexus between neurodiversity and music therapy has exploded in recent research. The work of Jessica Leza (2020) proposes to *neuroqueer* music therapy: this is “disrupting any stigmatizing and oppressive ‘standards of practice’ by inviting the neurodiversity paradigm *in* and leaving the pathology paradigm *out*” (Leza, 2020, cited in Pickard, 2020, para. 28). Beth Pickard (2020) takes an explicitly critical-disability-studies-based approach. She (2020) directly confronts an outmoded model of expert practitioner in the United Kingdom and suggests that critical disability studies be engaged by current and future generations of music therapy practitioners. Laurel Young (2020) shows how a community music therapy approach can support the neurodiversity movement by involving autistic clients in group singing. Hilary Davies (2021) suggests that music therapy should relinquish its grip on the medical model of disability and instead should engage what she calls a *cultural* model, in which disability is seen as a cultural construct. Davies (2022) furthermore situates herself as an autistic music therapist and maintains that autism is

simply another "way of being" (Davies, 2022, p. 16), strongly embracing the neurodiversity concept. Significantly, Susan Hadley's edited volume *Sociocultural Identities in Music Therapy* (2021) presents 18 different accounts of culturally reflexive processing, including neurodiverse narratives. (Thanks to the reviewer for suggesting these scholars to consider.) Finally, Carolyn Shaw's work (2019) on post-ableist music therapy must be mentioned. Shaw's ambitious Ph.D. dissertation envisions a world in which "voices that are often silenced" are heard, (Shaw, 2019, p. 7), and in which the viewpoints of the practitioner-patient (PP) are valued (Shaw, 2019). Shaw (2022) furthermore deploys a posthumanist lens to critique the humanist value of individualism and independence to which disabled people are often coerced to aspire.

Regarding music therapy pedagogy, it is imperative that at least one unit on disability studies is included in every music therapy program. Notice that this is *not* a unit on special education, but rather an earnest immersion into the robust scholarship about and by disabled people themselves.

Feminist Music Therapy

The primary touchstone with Feminist Music Therapy here will be Hadley and Hahna (2016), who point out that feminism is not a monolith and might be better thought of as *feminisms* plural. They suggest (2016) that feminist therapy is more a lens or framework, rather than a unifying approach. This framework incorporates many themes that by now should sound familiar to one interested in a postmodern approach to music therapy: "the importance of valuing women's perspectives, egalitarianism, collaboration, mutuality, examining social constructs, examining the flow of power in relationships, examining discursive practices, representation, and empowerment" (2016, p. 428).

Hadley and Hahna (2016) note that feminism has no single founder, and instead is a pluralistic field with multiple sources of thought. They discuss early contributors to feminist thought in the field of music therapy, such as Heineman (1982) who examined the underrepresentation of women in supervisory and administrative positions in music therapy. Heineman (1982) concludes:

> There are forces operating in our society which define rigid roles for both women and men. The same barriers which exist to prevent women from holding supervisory positions also exist to prevent men from being successful in a helping profession. It would seem that there is a need in our educational process to encourage individual achievement rather than sex-stereotypes roles. (p. 32)

Hadley and Hahna cite Baines (1992) as another early exponent of the importation of feminist thought into music therapy. Baines's work over the course of twenty years would grow into her formulation of anti-oppressive music therapy (2013). Anti-oppressive therapy is one of four models I draw upon (2020) in creating my own model of able-diverse music therapy, a music therapy that proactively resists ableism (the other three models being community music therapy, music-centered music therapy, and culture-centered music therapy). Anti-oppressive music therapy is premised on the existence of power imbalances based on "age, class, ethnicity, gender identity, geographic location, health, ability, race, sexual identity, and income" (2013, p. 2). Baines's work is built on the work of Freire (Baines, 2013), who deconstructs power relationships between students, teachers, and society, and also based on Carolyn Kenny (Baines, 2013), whose work is critical of the centrality of the white male to music therapy and who proposes an "ecological paradigm" (Baines, 2013, p. 2) that is more inclusive.

Around the turn of the 21st century, several scholars were on board. Hadley and Hahna (2016) cite Curtis (2000) as developing a model of music therapy specifically designed to empower women; Ruud (1998) is cited by Hadley and Hahna (2016, p. 430) for describing

feminism as a primary influence on his thinking about "relationality, empowerment, reflexivity, and other postmodern currents." Hadley and Hahna (2016) furthermore in their historical overview discuss Hadley and Edwards (2004), Adrienne (2006), McFerran and O'Grady (2006), and several others.

I would observe that from the beginning of feminist investigations in music therapy (starting probably with Heineman's 1982 study) to the feminist music therapy of today, the questions asked have evolved from the very practical (are there enough senior-level career opportunities for women in the music therapy profession?) to the highly theoretical (what is the nature of power and privilege in an unjust society, and how do we extricate marginalized communities from this enmeshment?). Both questions are of course important and valuable, but the narrative one imposes upon this observation is subjective. One could cast the narrative as the evolution of feminist thinking from the directly practical to the highly complex, which shows a progression of sorts. Or one could cast the narrative as the march of feminist thinking from the directly relevant into the highly abstract and rarefied, representing more of a regression. In my view, it is some of each. Investigations into the power dynamics of an unjust society and the building upon relevant postmodernist theories (e.g., Foucauldian theory) definitely have their places and are important works. Still, one wonders whether there are currently enough senior-level career opportunities for women in the music therapy profession. An investigation of the latter question would still have its place in 2022.

Even while acknowledging that feminism is diverse, Hadley and Hahna (2016) identify nine areas of common investigation for feminist music therapy. They are: "(a) believing that the personal is political, (b) striving to create egalitarian relationships, (c) respecting and valuing a person's lived experiences, (d) examining power differentials, (e) consciousness raising, (f) decentering, (g) examining social constructs, (h) valuing diversity and examining the intersection of various identity markers, and (i) working toward social justice" (p. 435). Hadley and Hahna cite Enns (2004) and Worell and Remer (2003) in the construction of this list.

While all these items are commensurate with postmodern music therapy, the three that strike me as most directly relevant and most deeply intersectional with postmodern theory are "(b) striving to create egalitarian relationships," "(d) examining power differentials" and "(i) working toward social justice." These three happen to be mutually reinforcing as a triad. In order to create egalitarian relationships, we must examine power differentials. By examining power differentials in society, we work to create a more just and equitable society (i.e., we work toward social justice). By working toward social justice in society broadly, we recreate structures that make egalitarian relationships possible. Thus, a mutually reinforcing circularity is created.

This triad should be examined more closely. What is meant by egalitarian relationships, anyway? In my view, egalitarian relationships are those relationships that minimize hierarchy as much as possible. Little wonder that feminist thought would be interested in breaking down hierarchies, because dyadic hierarchies abound in broader society, in which men tend to be the winners and women tend to be the losers. Such dyads include superior men vs. inferior women; superior patriarchy vs. inferior matriarchy; superior masculine vs. inferior feminine; superior mannish vs. inferior womanly; superior strong man vs. inferior weak woman; and so on. Therefore, it is little wonder that women tend to be more sensitive to power dynamics such as superior therapist vs. inferior client, superior doctor vs. inferior patient, etc. The superior vs. inferior dyad itself is a template with which women are all too familiar through subtle, insidious socialization and through the direct experience of prejudice and oppression.

I would argue that in a truly egalitarian therapeutic relationship, the client is less likely to find therapy oppressive and therefore counterproductive. Furthermore, a positive, mutually reinforcing cycle is more likely to come into play: as the client gets more out of

therapy, the therapist *also* gets something out of therapy because the relationship is inherently collaborative rather than directive. When the therapist is also getting something out of the therapy, the therapist is reinvigorated and aspires to their best self. The best-self therapist is likely to deliver a better product that is still egalitarian in nature, encouraging collaboration, and which inspires investigation into still further vistas of rewarding therapy for both client and therapist, and so on.

(Of course, it is not a guarantee that the therapist will gain something positive from every collaboration. Inevitably, interpersonal dynamics will vary. Therefore, it does not follow that the therapist should expect positive results for the therapist in every case. However, a mutually reinforcing positive circuit does not occur in the context of unidirectional therapy in which the client is there to be "fixed" by the therapist. I maintain that *even though* the therapist will not always "get something out of therapy" in every case, it is still better to assume a posture of mutual reinforcement and exchange as to allow for the *possibility* of mutual benefit for therapist and client alike. This issue was raised by the reviewer and is appreciated.)

Power differentials abound in society and must be proactively critiqued because they are so insidiously accepted by the unconscious. I grew up in the late 1970s and throughout the 1980s in a family unit in which both my mother and father were capable of driving. If my mother happened to be alone with me in the car, she would drive. However, if both my mother and my father were together in the car, my father would drive. It was never the reverse. The message here was subtle and insidious: the father is in charge of the family unit. This is patriarchy: it is something that barely goes noticed, but its messages are received generation after generation. (I cannot take credit for this observation; it is an old feminist saw, but I cannot honestly remember where I first read it. Nonetheless, Green [2013] explores the issue.) This is something we have to especially remember as *music* therapists. Imagine an orchestra conductor in your mind. Is that person female? Is that person Black? What is the model for "conductor" in our mind's eye? More often than not, I would (anecdotally) speculate that our mental picture of a conductor is that of a white male. Furthermore, do we question the need for a conductor at all? So much of music-making is unquestioningly hierarchical. Could we imagine a more egalitarian model of rotating facilitation rather than a single directive person to undertake therapeutic music-making?

Still a more recent investigation into feminist music therapy (FMT) was conducted by Bodry and Schwantes (2021). They were interested in the work of Curtis (2006) who articulated the following goals for FMT:

> In her chapter, Curtis (2006) defined specific FMT goals, "The focus of these goals is threefold: to eliminate the oppression of women; to enable women to recover from the specific harm of oppression; and to enable women to deal with the internalization of this oppression" (p. 228). These overarching goals and the following subsequent goals provided us with parameters by which we could more fully interrogate the literature. Therefore, we outlined how each of the articles described the following goals:
>
> 1. to *empower* women and increase their independence, developing their personal and social power;
> 2. to increase understanding of the *sociopolitical* context of women's lives and problems; to increase understanding of the interaction of multiple oppressions (e.g. sexism, racism, classism, heterosexism, etc.);
> 3. to achieve optimal functioning as *defined by* each individual woman, rather than by the therapist or society; and
> 4. to initiate necessary *social change* (Burstow, 1992; Worell & Remer, 2003) (emphasis added; Curtis, 2006, pp. 228–229, cited in Bodry & Schwantes, 2021, p. 112)

Bodry and Schwantes (2021) found in their review of 11 articles that fit the criteria for inscribing FMT: "Most (nine out of 11) articles included understanding the sociopolitical aspect of the clients' experiences, including the intersection of multiple points of oppression" (Bodry & Schwantes, 2021, p. 115). They also found that most articles comported to most of Curtis's FMT goals most of the time (see Bodry's and Schwantes's Table 2, 2021, pp. 118-120). Bodry and Schwantes (2021) in their study notably include as an FMT goal that of *egalitarianism* in addition to the original four Curtis goals. This is very much commensurate with the aims of postmodern music therapy here. (It should be noted that the reviewer suggested the Bodry and Schwantes for my consideration.) I would observe that Bodry's and Schwantes's study demonstrates that a consensus is developing around the goals of FMT. While "feminisms" may be suitably plural in their origins and trajectories to this point, it is still remarkable how galvanized around central tenets such as *egalitarianism* and *empowerment of women* the studied articles are.

Regarding the music therapy curriculum, thankfully, we have Susan Hadley's edited 2006 volume *Feminist Perspectives in Music Therapy* from which to draw. Some of the writings may be by now outmoded, but the book is foundational, well organized, and lends itself to chapter-by-chapter assignment for music therapy students. One could easily imagine a class in which one student presents a summary of each of the 21 chapters. If time allows, more updated papers on feminist music therapy can be included (e.g., Bodry & Schwantes, 2021) for student presentations.

Queer Studies and Music Therapy

I situate myself as a bisexual man who passes for straight because I have been in a monogamous relationship with a woman for 25 years. Until the 2016 publication of "Toward a Queer Music Therapy: The Implications of Queer Theory for Radically Inclusive Music Therapy" by Candice Bain, Patrick Grzanka, and Barbara Crowe, there were no studies exploring the intersectionality of queer theory and music therapy. However, Bain, Grzanka, and Crowe note that the history of the medicalization of sexuality and gender is "complicated and fraught" (2016, p. 22), necessitating their project. They further note a dearth of writings about the development of multicultural competencies surrounding LGBTQ populations.

They observe (2016, p. 23) that "Foucault (1978) situates sexuality within historical and cultural struggles over power and knowledge…." Of course, Foucault's importance to postmodern thinking cannot be understated. Foucault, himself a queer theorist, deconstructs binaries. Schmidt (2014) pulls out this important quotation of Foucault:

> The freeing of difference requires thought without contradiction, without dialectics, without negation; thought that accepts divergence; affirmative thought whose instrument is disjunction; thought of the multiple—of the nomadic and dispensed multiplicity that is not limited or confined by the constraints of the same; thought that does not conform to a pedagogical model (the fakery of prepared answers) but attacks insoluble problems—that is, a thought which addresses a multiplicity of exceptional points, which is displaced as we distinguish their conditions and which insists upon and subsists in the play of repetitions. (Foucault as cited in Schmidt, 2014, p. 358)

It is incumbent on scholars to become comfortable with seemingly contradictory binaries occurring in balance. This is particularly relevant to queer studies, because when Foucault was writing, it was "obvious" that queerness was (supposedly) binary: one is either heterosexual or homosexual. It was not obvious at the time to one and all, various studies in human sexuality notwithstanding, that human sexuality exists on complex continua. Furthermore, because queerness was seen in Foucault's time largely as a binary, hetero-

sexual vs. homosexual, it was all the easier to map that binary onto other binaries such as superior vs. inferior, or normative vs. deviant, which is now to be avoided.

Bain, Grzanka, and Crowe (2016) propose receiving LGBTQ music therapy clients with what they call "radical inclusivity" (p. 23). Radical inclusivity is the deployment of theoretical insights from diverse fields that are synergized to empower queer youth (though I would extend the concept to queer people in general) in an inclusive environment. They use the term "radical" in opposition to the word "superficial" (2016, p. 23). They list (2016) the best practices compiled by Whitehead-Pleaux et al. (2012). These are, according to Bain, Grzanka, and Crowe (2016, p. 23) "inclusivity, creation of a safe space, preferred language, knowledge of LGBTQ culture and music, and affirmative therapy."

It is wholly incumbent on the music therapy profession to practice radical inclusivity with LGBTQ clients, because so long as music therapy as a profession wishes to align itself with the medical model, it inherits the medical model's unfortunate and storied history with queerness. In the United States, for instance, the American Psychiatric Association considered homosexuality a mental disorder and listed it as such in the original *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1952 (Baughey-Gill, 2011). In a revision to the original *DSM*, homosexuality was reclassified as a sexual deviation. In 1973, the APA concluded that homosexuality was not a mental disorder, with a vote in 1974 upholding this decision. The plurality amounted to merely 58%, necessitating appeasement of the minority. In *DSM-II*, published in 1974, homosexuality was replaced with Sexual Orientation Disturbance. In 1980, *DSM-III* replaced Sexual Orientation Disturbance as Ego Dystonic Homosexuality.

This is significant because *DSM-III*, according to Bradley Lewis (2006), represented a sea change in United States psychotherapy. *DSM-III* was a shift from the alleged superstition and woo-woo of the psychodynamic/psychoanalytical approach, birthing the so-called new psychiatry, which was predicated entirely on the scientific method, and (supposedly) value-neutral evidence-based practice. Yet, this asserted breakthrough document listed Ego Dystonic Homosexuality among its pantheon of disorders. We can recognize in retrospect that the tenuous politics of the rather infamous 1974 vote necessitated a concession to the large 42% minority that wanted to see homosexuality remain stigmatized and degraded as a matter of official APA policy. This is precisely why music therapy must maintain a skeptical posture toward the allegation of the value-neutrality of science, the scientific method, positivism and quantitative research. Ego Dystonic Homosexuality was removed from *DSM-III* in 1987 (Baughey-Gill, 2011), and in 1992, the World Health Organization removed homosexuality from its *International Classification of Diseases* (Drescher & Merlino, 2007, cited in Baughey-Gill, 2011). This formally ended an embarrassing chapter for psychiatry around the world.

Finally, some mention of music therapy interventions with LGBTQ people, particularly LGBTQ youth, is in order. Bain, Grzanka, and Crowe (2016) recommend musical autobiography assessment, gender-bending song parodies and performance, transitions (music and creative arts), critical lyric analysis, and group anthem writing. These interventions in my view are effective particularly in their resistance to stigma, embrace of difference, and promotion of a truly anti-oppressive music therapy as outlined by Baines (2013). Bain, Grzanka, and Crowe (2016, p. 28) observe that "[q]ueer theoretical perspectives have been criticized as jargon-laden and unintelligible." Bain, Grzanka, and Crowe are therefore to be commended for creating a queer music theory that is both theoretically sound but also accessible and practical.

The music therapy curriculum could benefit from an immersion into the music of queer composers and songwriters, including the music listened to by queer youth, which includes crossover music between pop and video game music (e.g., Lemon Demon). Music therapy ignores the music of queer youth at its own peril, as many queer clients will be young clients.

Race Studies and Music Therapy

According to Hadley and Thomas (2018):

> A therapist wishing to work from a critical race framework will need to recognize that racism is a foundational aspect of the client of color's experience, and that as such, space must be allowed for racism to be addressed in the therapeutic relationship (Taliaferro et al., 2013). Additionally, within this space, therapists working from a critical race perspective will need to be able to guide the client in exploring all the ways in which their lived experience is shaped by both overt and covert forms of racism, explore internal resources that they possess, and carefully consider how they utilize these resources effectively to meet their needs. (p. 171).

To say "I don't see color" is an erasure—it is an erasure of the lived experiences of the person of color for whom color is an inherent marker in a racist society. In her landmark document "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics," Kimberlé Crenshaw (1989) brings to us the crucial concept of intersectionality. In her case, she describes the intersectionality of race and gender, but since then, intersectionality has been shown to apply to race, gender identity, sexual orientation, disability, age, class, and still other markers of identity. Any analysis of the postmodern condition of intellectual inquiry that omits the intersectionality of race with these other identity markers is derelict. It is the academic equivalent of "I don't see color."

Intersectionality describes the degree to which we can cross-domain map *some* aspects of identity demarcations—but not others. Black men and White women, for example, both experience workplace discrimination and may find difficulties being promoted into senior positions. That is a mapping. However, Black men may still find the advantages of patriarchy that White women do not experience. Meanwhile, White women might find the advantages of Whiteness that Black men do not experience. Thus, the allegorical cars in the intersection meet at the locus of work discrimination, and then sail onward along avenues of race advantage (in the case of the White woman) and gender advantage (in the case of the Black man).

Why should music therapists care about the intersection of critical race studies with other identity markers? As Bain, Boggan, and Grzanka (2018, para. 6) observe, "Because… facets of identity consist of interwoven relationships, consideration of intersectionality is crucial to meet professional standards of practice." But more than that, I would argue that music therapists have an *ethical* obligation to engage with critical race theory and its intersectionality with other identity markers. Not all clients are going to be members of a privileged race, any more than all clients will be members of a privileged gender, privileged sexual orientation, privileged set of abilities, etc. To fail to be competent as a music therapist in addressing the lived experience of an unprivileged race in a racist society is an erasure. Music therapists *have* to "see color." The shaping of life experience in the dimension of race is inevitable *in an inherently racist society.*

Some might object that racism is an individualized, localized problem—the case of one person exerting racism against another person—and that *society* is not inherently, structurally racist. In my opinion, any music therapist who fails to acknowledge the fact of societally broad structural racism needs to leave the profession. Racism is a global societal problem.

Bain, Boggan, and Grzanka (2018) suggest that music therapists become culturally responsive rather than merely culturally competent, and that music therapists engage in a lifelong process of self-reflection and critical engagement with different cultures. They emphasize that this is a *process*, not a *skill.* They offer four recommendations to this end (2018, para. 15-18):

1. Read and engage with the texts of critical theory scholars and activists;
2. Start or join in critical dialogues with colleagues about how we can make the profession more representative of marginalized and underrepresented groups;
3. Carry out and propel culturally responsive research, including through collaborations with members of underrepresented groups in the field; and
4. Insist upon anti-oppressive practice for marginalized clients.

In the dimension of critical race studies, I would add these recommendations:

1. Create a safe space for clients of color where their experiences of racism are engaged and validated;
2. Openly and proactively resist societal, structural, and interpersonal racism in all its forms;
3. Demand the promotion of music therapists of color to senior positions in the infrastructure of professional music therapy associations and in academia;
4. Create in music therapy academia a curriculum that engages multiculturalism as a minimum core competence, and goes beyond that by engaging critical race theory.

This last point is important, because not only is it the case that multiculturalism is not a universal fact of music therapy training, but when it is present, it is often treated as a box among a list of competencies to check off. As Mahoney (2015, para. 2) astutely observes, "While it seems that music therapy curricula are increasingly requiring students to demonstrate knowledge, respect, and skill in working with culturally diverse populations, programs may not always provide students with the tools they need to examine *their own* [emphasis added] cultural backgrounds and challenge the biases that accompany them." It is not enough to present a collection of African-American songs or songs by Latinos or Latinas to students for deployment with clients from those respective backgrounds. Without engagement with critical theories of race, music therapy students remain uncritical of their own intrinsic biases. Without this awareness, a music therapist could very well be insensitive, and may be doing more harm than good for clients from different backgrounds.

Mahoney (2015, para. 16) further observes that music therapy is "primarily white," and furthermore, "Race… can create and strongly influence the power differential in the therapeutic relationship, thus in addition to being educated about other cultures, it is so important to be aware of one's own…." Mahoney (2015) astutely notes that the impulse music therapists have to try to fix clients is doubly dangerous in the race dimension, because this impulse will inevitably entail impositions of belief systems. Mahoney (2015, para. 16) also discusses Michael Viega's 2013 comments about the term "at risk." Says Viega: "You know, I am calling everybody here 'at risk' just because they live in a poorer neighborhood and are from African-American and Latino communities. But who am I to say that they are at risk?" Viega significantly points out that he uses the term "at risk" specifically *to secure funding from funding sources.* This is *institutional* racism at play. In order to secure funding for services for marginalized communities, we must agree to label those marginalized communities with a pejorative label.

"Music therapy has adopted a very Eurocentric approach," writes Mahoney (2015, para. 17). Music therapy curricula from a musical standpoint tend to emphasize the European classical tradition as a common feature—certainly in the United States, if not the world over. If jazz, rap, or hip-hop is featured in the curricula, it is adjunctive at best. Yet, rap and hip-hop in particular are the *lingua franca* of not just many young people of color, but also youth culture in general. My suspicion is that the insistence, where it occurs, on four semesters of traditional music theory is a reflexive one, built on assumptions that have gone critically unexamined. What would be lost if we eschewed theory III (in the United

States traditionally devoted to advanced tonal chromatic harmony, with an emphasis on Romantic-era classical music) and theory IV (in the United States traditionally devoted to the language of post-tonal/post-functional classical music) in favor of a semester on jazz theory and a semester on rap/hip-hop? I am as much an exponent of Schoenbergian theory as the next former music theory college instructor, but I question how much Schoenbergian theory really helps *music therapists*. In as much as colleges and universities have the autonomy to make these curricular decisions, I call upon them to reconsider; in as much as professional sanctioning bodies are insisting upon the traditional four semesters of music theory in music therapy curricula (as is done uniformly in the United States), I ask that they reconsider as well. [2]

Hadley and Thomas (2018) similarly explore these four key areas of identity (though they refer to these with a humanist lens, e.g., *critical race humanism*, *feminist humanism*, etc.). Regarding intersectionality of these areas, they write:

> Given the intersectional nature of human beings, it is unlikely that we would draw exclusively from any of the above critical humanistic perspectives, but would fluidly move in and out of these frameworks as needed. The commonalities each share are the emphases on exploring how historical and contemporary marginalization of various categories of 'human' are experienced by therapy participants; honoring sociocultural political issues as legitimate topics in therapy; navigating difficult dialogues around sociocultural political issues; engaging in advocacy for individuals and groups; and, working towards systemic social change. Each of the outlined perspectives brings nuance to the ways in which we understand each other within the therapeutic relationship. (p. 18)

Bain, Boggan, and Grzanka (2018) argue forcefully that intersectionality in music therapy must be considered:

> It is essential for music therapists to actively engage with intersectionality in research and practice, with the ultimate goal of improving outcomes for all our clients. The only way for intersectionality theory to create any real change is to learn how to apply what we learn and begin to think more critically about putting intersectional principles into action. This can often be the most intimidating piece of working to improve our practice because it requires a great deal of cultural responsiveness, self-reflexivity, humility, vulnerability, and a willingness to unequivocally advocate for underrepresented voices within our client base and profession. (para. 12)

There are six possible intersectional dyads between race studies, feminist studies, disability studies and queer studies. How would these dyads inform music therapy? In the dimensions of race studies and feminist studies, centering the voices of nonwhite female musicians in therapy can be a start. Validating the experiences of nonwhite female clients is also an important step. Snell's 2018 dissertation provides an extensive investigation into Hip-Hop in particular for use in music therapy specifically with a mind toward empowering African-American women who may be clients. In the dimensions of race studies and queer studies, a similar centering of nonwhite queer musical voices is in order, as well as the similar validation of the thoughts, feelings, and perspectives of nonwhite queer clients. Kruse's 2016 study of the therapeutic benefits of Hip-Hop for a queer rapper of color is relevant here. In the dimensions of race and disability, the works of Sins Invalid (the dance-based performance project led by disabled people of color) and Leroy Moore (founder of the Krip-Hop movement) are both indispensable. Sins Invalid says of their vision:

> Sins Invalid recognizes that we will be liberated as whole beings—as disabled, as queer, as brown, as black, as gender non-conforming, as trans, as women, as men, as non-binary

> gendered—we are far greater whole than partitioned. We recognize that our allies emerge from many communities and that demographic identity alone does not determine one's commitment to liberation. (Sins Invalid, 2022, para. 3)

Krip-Hop Nation also states its goals:

> Krip-Hop Nation's Main Objectives/Goals are: To spread awareness about the history, arts, the isms facing musicians with disabilities along with getting the musical talents of hip-hop artists with disabilities into the hands of media outlets, educators, and hip-hop, disabled and race scholars, youth, journalists and hip-hop conference coordinators. Krip-Hop Nation have put out CDs, held conferences and spoke on issues from police brutality against people with disabilities to ableism in Hip-Hop, media and in our communities. (Krip-Hop Nation, 2022, para. 1)

In the dimensions of feminist studies and queer studies, the work of Baines et al. (2019) obtains here. They write:

> Being open to theories such as feminist, queer, and critical humanist theories that exist outside dominant cis- and heteronormative prejudice can expand therapists' promotion of wellbeing for individuals that is focused holistically rather than symptom oriented, with the broader goal of enhancing communities and society. In training the music therapist, any first green shoots of this capacity to engage in radical and alternative systems-thinking for music therapy practice should be encouraged. (Baines et al., 2019, para. 14)

As regards the dyad of feminist studies and disability studies, Wissink's 2020 master's thesis is instructive. She investigates the use of feminist music therapy specifically to address the pain of chronically ill women. Her perspective addresses "(a) unique psychosocial needs of women with contested chronic pain conditions; (b) music therapy interventions that can used to treat the psychosocial components of chronic pain conditions; and (c) advantages of group music therapy realized within a feminist approach for women with contested chronic pain conditions" (Wissink, 2020, p. iii). Lastly, regarding the intersectionality of queer studies and disability studies, Metell (2019) has this to say:

> Queer theories challenge the concept of normalcy and normativity, and this is why I explore queer theory as a critical perspective to inform discourse about disabled children. My curiosity in queer theory came from an introduction within disability studies. Queer theories, as I understand them and deploy them, are both methodology and ontology. They call to challenge all kinds of normative understandings of identity and their oppression. Queering music therapy in context of disabled children destabilizes established ideas, countering music therapy approaches that aim at cure or normalization of difference. (para. 5)

Obviously, these six examples are meant only to be starting points for an investigation into the intersectionality of identity; this is not intended to be comprehensive. Nonetheless, exploration of these intersectionalities is pivotal to a postmodern understanding of music therapy.

Part Three: How Would Postmodern Music Therapy Look in Practice?

How would a paradigmatic postmodern shift in music therapy occur in the practice of quotidian music therapy? First, let us consider what a typical music therapy session looks like now. Music therapy can be deployed for all ages and for any number of reasons. I will discuss three examples of music therapy in which I have been involved: for the very young, for young adults, and older adults. In the case of the very young, I was involved for a time

in speech pathology. My role was to write alliterative songs that emphasized “the phoneme of the day,” and sing these songs as singalongs with the kids. For example, one session focused on the “ch” phoneme, and I wrote this singalong call-and-response song.

“My Chihauhua”
Words and Music by Robert Gross

My chihuahua
Likes to play chess
Sometimes he cheats
Thinks he's the best
He thinks he's in charge
Does what he please
He eats my chocolate
He eats my cheese
Chocolate chip cookies
He eats those too
He eats my chex mix
What should I do?
So I got bird
A chick to keep
He likes to chirp
He likes to cheep
He watches my chihuahua
Like a hawk
Together they draw pictures
Using chalk
But now my bird
Does things to me
He changes channels
On my TV
Someday he'll be a chicken
For now he's a chick
When we go out to dinner
He picks up the check
I think I bit off
More than I can chew
Owning two pets
Is a lot to do
My little chihuahua
He's just a child
Sometimes he's cheerful
Sometimes he's wild
Sometimes he kisses me
On the cheek
When I'm in my chair
At the end of the week
So I was surprised
One day to see
That he chopped down
My cherry tree
So now I put him

On his own chain
Except when it's chilly
Or starts to rain
And that's my song
About my chick
And my dog
Who likes to lick

I sing the line, and then the kids repeat (Me: "My chihuahua" Kids: "My chihuahua" Me: "Likes to play chess" Kids: "Likes to play chess," etc.). The purpose is to acclimate the kids to the use the phoneme in a way that is fun, that does not focus on any particular individual (giving the kids a sense of strength in numbers), and which engages the musical parts of the brain. Scholars such as Cohen (1992), Leung (2008), and LaGasse (2013) report success in deploying music for improvements in speech development.

With young adults, I was involved in group music therapy for clients experiencing depression and anxiety. One activity I liked to do with this cohort was lyric analysis of popular songs with which they might be familiar, choosing songs with themes that might be helpful. For instance, we might analyze the lyrics to a song like *Believer* by Imagine Dragons, come to the conclusion that the song emphasizes themes of moving forward through pain, and discuss what that might mean for one in one's own life as one experiences depression. What are the strategies for moving forward that are suggested by the song? Then dovetailing that into a brainstorming session: what are some strategies that *you* (the client) can imagine?

With older adults experiencing memory loss, a common strategy is to introduce a particular topic or theme through a song. For example, I might sing a song they are likely to know, like *Bridge Over Troubled Water* by Simon and Garfunkel, and introduce the topic of frendship (which is what the song is about). We would then discuss various friendships that the client could remember, encouraging the client to reminisce and conjure as many details as the client could.

The key to success is the selection of appropriate music for the age group and the topic at hand. *Bridge Over Troubled Water* would be likely not to land with the kids or the young adults group, while *Believer* might fail to conjure memories for the older group (as it is a more recent song). The broader point here is that music therapy is multivalent, reaches any number of people, and can be deployed for any number of reasons.

Of course these are only three examples, and are hardly exhaustive. For a closer-to-comprehensive look at examples of music therapy, the American Music Therapy Association, for instance, has a list of fact sheets found at https://www.musictherapy.org-/research/factsheets/. These fact sheets include information about music therapy with child and adolescents; military populations; autistics; persons with Alzheimer's disease; persons in correctional facilities; experiencers of crisis and trauma; music therapy and medicine, mental health, music education, pain management, special education, and young children (American Music Therapy Association, 2021, para. 3).

So the question occurred to me, in light of what I have maintained in this article, how would I go about my "typical music therapy examples" differently?

In my example of generating alliterative songs for speech pathology therapy, my role was adjunctive to the speech therapists. Today, *if* I were amenable to an adjunctive role and *if* I were assigned a "phoneme of the day," I would consult my client-collaborators in a brainstorming session to create as many vocabulary words as *they* could conjure, an idea that relates to resource-oriented music therapy (as pointed out by the editor of this article). By contrast, in my experience described at the beginning of this part, I was assigned a vocabulary list by the speech pathologist in charge. Then I would challenge the client-collaborators to help me *co-author the song* that we would sing. This would give the client-

collaborators some ownership in the process and would break down the hierarchy of me as the expert imposing a pre-written song upon client non-collaborators. If I were not in an adjunctive situation, I might even be given to asking the client(s) themselves what phonemes the client(s) might be interested in exercising, and then going from there.

In my example of group therapy with depressed or anxious young adults, I would again allow for a brainstorming session in which the client-collaborators could identify songs that they think would be appropriate as aids to depression or anxiety. I also would not take for granted the idea that depression or anxiety were conditions to be eliminated. I would want to know if the client-collaborators felt like they wanted to eliminate, manage, confront, dialogue with, or create some kind of relationship to the anxiety and depression, so that they are co-authors of their treatment. Song selection would then be collaboratively directed toward these ends. Knowing that in a group situation there will be different responses and possibly even conflicts, I would try to hold space for a *both-and* approach that respects as many perspectives as is feasible. I should note that when I was involved in this kind of group therapy, it was in the context of a mental health institution. As a psychiatric survivor myself, I call into question the need for compulsory and incarceration-like experiences like these in the treatment of what some people simply call Madness. The Mad Pride movement is of keen interest to me, and its questioning of the compulsory elements of the typical mental health institutional experience is, at least to me, compelling. All in all, I would now prefer there not to be compulsory (or at the very least, coerced) group music therapy in institutions, like the one at which I interned, in the first place.

I have similar questions and concerns about memory care facilities and the degree to which these also are incarceration-like. In the case of the typical group memory care music therapy experience, I would now begin with asking what songs the client-collaborator remembers, and then I would create a singalong experience in which the client-collaborator leads. I would have songs on hand of my own if the client-collaborator needs them, but in any event, I would still allow for the possibility of client collaboration in this situation. I also would no longer *force* reminiscence, as can be the case in these contexts. I might more gently ask if there are any memories the client-collaborator would like to share that might be inspired by the music. Under no circumstances, though, would I insist upon sharing. The typical therapeutic enterprise demands this, but I would not. Music-centered music therapy wins the day for me here. I would prefer simply to make music with (or to *music with*) the client-collaborators, and *if* memories are triggered in the process, all the better.

Conclusion

Postmodern music therapy is a music therapy that is proactively concerned with the dynamics of power. It is predicated on the idea of egalitarianism rather than hierarchy, and as such expressly rejects the medical-model traditions of superior therapist and inferior client. Postmodern music therapy furthermore invites collaboration rather than imposing treatment. The music therapist in this case is merely a facilitator, and the client is the expert in his, her or their life. Postmodern music therapy rejects the so-called ideals of individualism, especially rugged individualism, in favor of a communitarianism that situates the delicate balances between client, therapist, community, and society. Postmodern music therapy critiques the degree to which contemporary music therapy is steeped in the neoliberal medical model, especially the degree to which clients are commodified in a medical marketplace. Music-centered music therapy, post-ableist music therapy, and community music therapy are best situated to alleviate the problem of client commodification.

Postmodern music therapy is deeply intersectional with four areas of critical study:

disability studies, feminist studies, queer studies, and critical race studies. Postmodern music therapy vis-à-vis disability studies favors the social model of disability, which is an advancement over the medical model which sees pathologies in the individual but ignores the social context with which individual pathologies are inextricably linked. Postmodern music therapy also borrows heavily from the observations about power dynamics from feminist, queer, and race theory, and affirms its stance as an anti-oppressive music therapy practice.

About the Author

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[1] A more complete list of practices listed by the Top Holistic Directory, though still not comprehensive, would include acupuncture, Akashic records reading, angel card reading, angel therapy, astrological reading, aura photography, Bach flower remedies, bioelectrography, Chakra aligning, crystal bath therapy, cupping, dowsing, ear candling, emotional freedom technique, energy and reiki healing, Feldenkrais method, hand analysis, holistic dentistry, homeopathy, integrated energy therapy, ionic cleansing, Jin Shin Jyutsu, LED light therapy, Mayan abdominal therapy, moxibustion, numerology reading, oracle card reading, palmistry reading, paranormal investigation, past life reading, past life regression, polarity therapy, pranic healing, proliferation therapy, psychic reading, Rune Stone reading, soul clearing, Tarot card reading, transference healing, vibrational medicine, and yoni steaming.

[2] Christina Shocklee (personal correspondence, 8 June 2020) suggests a further alternative: that we reduce by two semesters the number of piano courses music therapy students are required to take. In their place we add an extra guitar course and a course on music technology. Through these courses the non-classical, popular musics of youth culture could be heavily imported. This suggestion strikes me as having great merit as well, and under Shocklee's model, music theory III and IV could be maintained as-is.