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Disability in Music Therapy Education and Clinical Training

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Abstract

“Disability” is a label that has been politicized throughout the course of history in Westernized society due to the perseveration of the medical model of disability. The medical model of disability asserts that issues inherent in a disability are due to the affected individual and that one’s goal should be a complete “cure” to be compliant with the state of *normality* accepted by society. The profession of music therapy is rooted in the medical model of disability; therefore, it accepts human variability as a disease which requires remediation. In academia, the national policies in the United States related to disability such as the *Rehabilitation Act of 1973* (U.S. Department of Labor, 1973a), the *Americans with Disabilities Act* (U.S. Department of Justice Civil Rights Division, 1990), and the *Individuals with Disabilities Education Improvement Act of 2004* (Congress, 2004) ultimately fail in their efforts to protect disabled students from discrimination. Therefore, it would benefit the field to pursue the integration of disability justice principles in music therapy education and clinical training, to better support budding music therapists and the individuals with whom they work. To this end, the purpose of this paper was to investigate the effects of ableism on the experiences of music therapy students in the United States (U.S.) and suggest considerations that could be implemented to minimize ableism.

Keywords: disability; music therapy; higher education; disability justice

As a Taiwanese American woman with epilepsy, I have experienced discrimination and stigmatization in academic and everyday life. I have been pitied by my peers and instructors and have been treated as inferior by others. At the beginning of semesters, after disclosing my disability, some professors rejected requests for accommodations assuming the requests had ulterior motives, and it was only through assistance from my university’s disability office that I received my full accommodations. There have been individuals who

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prayed for my "recovery" and many avoided speaking about it, due to their discomfort. I have even been told to stop while actively experiencing a seizure. During my time working in student affairs at a prominent research university, I was denied the usage of my HR-approved disability accommodations and encountered individuals who belittled students with disabilities. Music therapy education and clinical training is affected to the same degree as that of other academic programs (and the environment of higher education institutions as a whole). Thus, I believe it is imperative to open conversations within the field of music therapy regarding disability and ableism to improve the education music therapy students receive and improve the inclusivity practices throughout the field. The purpose of this paper was to investigate the effects of ableism on the experiences of music therapy students in the U.S. and suggest considerations for educators and clinical supervisors to implement to better serve all music therapy students.

Disability

Defining the term "disability" is complex and, in truth, impossible due to the variability in the presentation of disabilities across individuals and conditions, such as intensity, severity, the age of onset (congenital or acquired during one's lifespan), and the episodic or progressive nature of the condition (Kattari et al., 2017). In addition, as Moore (1998) shares, the definition of "disability" throughout history is different based on the context of its use—whether it be an economic, medical, or socio-political perspective. At certain points in history, the term "disability" has been worn as a badge of pride while at other times it has been used as a method of insult. All definitions seek to benefit the situation at hand since "from the moment a child is born [they emerge] into a world where… [they receive] messages that to be disabled is to be less than, a world where disability may be tolerated but in the final instance is inherently negative" (Campbell, 2008, p.151). In the seminal work on music and disability, *Extraordinary Measures: Disability in Music*, Straus (2011) attempts to explain "disability" using a political and cultural lens by defining disability as:

> [A]ny culturally stigmatized bodily difference. By "difference," I refer to deviation from whatever is understood as normal at a particular time and place. As with gender, race, and sexual orientation, the construction of disability involves the opposition of a normative standard (e.g., male, white, straight, able-bodied) and a deviant Other (e.g., female, non-white, gay disabled). Indeed, femaleness, non-whiteness, and gayness can all be understood as forms of disability…. Disability is the "master trope of human disqualification," the fundamental form of deviant Otherness of which gender, race, and sexual orientation are specific manifestations. (p. 9–10)

In the U.S., normality has historically been defined as physical and mental attributes which advance national progress (or did not impede it), while abnormality was defined as attributes which inhibit national progress and cause the nation to regress to its previous status (Baynton, 2001). As individuals with disabilities may not present to the level of normality accepted by society and are perceived as impeding the nation's progress, they are often stigmatized and discriminated against, or as shown from policies of the late nineteenth and early twentieth centuries, they may be completely barred from societal participation.[1]

In addition, all aspects of a disabled person's life are often medicalized. As the National Disability Arts Forum states, "There is a joke amongst Disabled people that non-Disabled people listen to music, do the gardening, hold down jobs, but Disabled people do music therapy, horticultural therapy, occupational therapy. Where Disabled people are involved, almost every activity of life seems to have to be justified in terms of its medical and therapeutic benefits" (cited in Hadley, 2014, p. 4). As Ettinger et al. (2019) asserted:

> Disabled people are almost certainly all survivors of abuse at the hands of medical institutions and health insurers either through neglect, withholding of care, coercive treatments, or due to the dangerous ignorance of our bodies and health conditions. Finally, those of us with visible or invisible disabilities live under an unspoken apartheid in every place on the planet in which we face multilayered isolation, social rejection, stigma or threat of forced institutionalization. (p. 94–95)

In other words, individuals with disabilities face rampant abuse, which manifests as ableism due to the resulting discrimination caused by the Westernized binary perception of healthy/unhealthy, in all areas of society.

Medical Model of Disability

The contemporary medical model of disability,[2] sometimes called biomedicalism (Campbell, 2019), has influenced the mainstream culture in the U.S. (Mackelprang & Salsgiver, 2016). The medical model of disability is the core of all ableist thought and action (Bruce, 2022). It suggests that the problems inherent in a disability are to be attributed to the associated individual and that, if the condition is cured, the disability would be remediated through medical interventions (Patel & Brown, 2017; Scully, 2003). In other words, as Linton (1998) asserted, the medical model pathologizes disability and establishes it as a "tragic consequence of war, fate, modern technology, God's will, poverty, or the failure of medicine's omnipotence" (p. 97). The medical model of disability can be seen in literature over many centuries. For example, in a Voice from the South, Anna Julia Cooper (1892), one of the most notable founders of Black feminism, wrote:

> It is not the intelligent woman vs. the ignorant woman nor the white woman vs. the black, the brown, and the red, it is not even the cause of woman vs. man, Nay, 'tis woman's strongest vindication for speaking that the world needs to hear her voice… The world has had to limp along with the wobbling gait and the one-sided hesitancy of a man with one eye. Suddenly, the bandage is removed from the other eye, and the whole body is filled with light. It sees a circle where before it saw a segment. The darkened eye restored, every member rejoices with it. (p. 121)

Although powerful, the passage leads readers to the belief that an individual with the use of one eye sees only a segment of the world, is hesitant, unsteady, and functions in a body full of darkness. As Linton (1998) points out, the parallels drawn between disabled men and silenced women, then between women given a voice and a "cured" man are as meaningful today as they were in the late nineteenth century. It shows the crux of the medical model, which asserts that the ultimate goal of disability is becoming "cured" to society's definition of behavioral, intellectual, and social "normality" (Holler et al., 2021; Moore, 1998; Shyman, 2016). The medical model relies on the intervention of healthcare professionals (e.g., physical therapists, physicians, occupational therapists; Mackelprang & Salsgiver, 2016). Individuals disavowing the "deficit-oriented" medical model of disability state the medical model results in psychological, emotional, and social costs for individuals with disabilities (Mackelprang & Salsgiver, 2016). Instead, they assert disability should be reconceptualized as a multifaceted form of social oppression that parallels sexism, racism, and other sources of social disadvantage (Liasidou & Mavrou, 2017), and be used as a platform to advocate for social change.

Ableism

The implicit importance placed on “normality” in society in the U.S. has a detrimental effect on all individuals with disabilities, as it results in pervasive ableism and stigmatization. “Normal” is a dominant organizing force that has power due to the belief that human intelligence, behavior, and ability clusters around or markedly deviates from a certain statistical norm (Dudley-Marling & Gurn, 2010). As Keller and Galgay (2010) state, in “normative” societies, ableism often manifests as beliefs and assumptions that fuel negative behavior and attitudes towards people with disabilities; however, they are often outside the level of awareness of the well-intentioned perpetrators. Lewis (2022) provides a thorough and clear definition of ableism:

> A system of assigning value to people’s bodies and minds based on societally constructed ideas of normalcy, productivity, disability, intelligence, excellence, and fitness. These constructed ideas are deeply rooted into eugenics, anti-Blackness, misogyny, colonialism, imperialism, and capitalism. This systemic oppression leads to people and society determining people’s value based on their culture, age, language, appearance, religion, birth or living place, “health/wellness,” and/or their ability to satisfactorily re/produce, “excel” and “behave.” (para. 3)

Ableism includes strategies for fixing individuals who do not fit within the norm and/or strategies to reduce or prevent the number of people who would be classified as “less-able” (Rolvsjord, 2014). Ableism is tacitly present in all aspects of Westernized civilization, with numerous heinous and devastating implications across time. For instance, the Nazi-Germans murdered individuals with mental and physical disabilities (Snyder & Mitchell, 2006). Domestically, “unsightly beggar ordinances,” colloquially called “ugly-laws,”[3] existed throughout the U.S. from 1881 and a movement to overturn them did not arise until 1973 (Coco, 2010). A widespread ableist issue more relevant to the field of music therapy is the drastic increase in the number of people diagnosed with mental health disorders. The *Diagnostic and Statistical Manual of Mental Disorders 5th Edition* (DSM-5) was a reaction to the increase in the number of mental health diagnoses, which limits the range of “normativity.” It has narrowed the definition of “normal life” by defining typical challenges as pathology, in need of remediation by certified healthcare professionals (Rolvsjord, 2014). As Davis (2013) asserted, the DSM-5 “has elaborated a dizzying display of lifestyle illnesses that demands medical treatments to cure and normalize people. Sadness, shyness, obsession, sexual desire, anger, adolescent rebellion, and the like now fall under a bell curve whose extremes become pathologies” (p. 8).

Since music therapy is firmly grounded in the medical model of disability, clinicians embody a power structure in which the music therapist has more authority than the person they are “helping” and the goal in many cases is to eliminate “problematic” behaviors or work as part of interdisciplinary teams seeking to “cure” the affected individual. Therefore, there are many instances of harm. Historically, music therapy has been publicized as a healing modality which cannot cause harm due to the lack of “medical intervention.” In their landmark publication, Murakami (2021) detailed how harm can be caused within therapeutic relationships due to inappropriate or unhealthy interactions. Similarly, within higher-education atmospheres, harm can be caused due to unhealthy ableist relationships between instructors and students. These ableist actions and attitudes can hinder the learning environment and may lead to the attrition of students with disabilities.

Disability Justice

Due to the ableism inherent in the field of music therapy, it would be highly salient for the profession to integrate disability justice into academic programs and clinical practice to improve the experience of budding music therapists, practicing Board-Certified Music Therapists, and the individuals with whom music therapists work. Disability justice is a framework that connects individuals from the disability community and their allies to advocate for systemic change. It acknowledges the systems that do not consider disabled persons' wholeness and establishes disability as a positive cultural identity (Muster, 2023; Sins Invalid, 2015). Disability justice practitioners recognize that the disabled community is often hypervisible and invisible at the same time and denotes how there are few instances when "care" is unabusive (Piepza-Samarasinha, 2020). It puts forth the assertion that ableism makes racism, sexism, Christian supremacy, and queer- and transphobia possible, and that all these systems are deeply embedded in the fabric of the U.S. To combat current inequities, Piepza-Samarasinha (2020) noted that "new collectives, led by disability justice principles and disabled Black and brown people, are popping up everywhere… marking a new generation of disability justice activism" (p. 255). As Akemi Nishida says, "Disability Justice has a wide entry point. I can talk about disability justice with anyone, it gives us a way for all of us to be in conversation and try to figure out how we meet each other's needs without burning out or exploiting anyone" (Sins Invalid, 2019, p. 114). If the principles of disability were accepted in the profession of music therapy, representation of individuals with disabilities among leadership positions would be apparent and budding music therapists would experience "collective liberation" which would free those within the music therapy community and the individuals we serve.

Disability and Music Therapy

As an established healthcare profession that uses music within therapeutic relationships, music therapy is directly positioned within the medical model of disability (Miyake, 2014; Straus, 2011). In the U.S., music therapy accepts that human variability is understood as a disease, illness, or other pathological medical condition; therefore, it offers music as a source of remediation, normalization, and therapy toward a desired cure (Straus, 2014). Ableist sentiments and statements are commonly found in previous and current music therapy codes of ethics, practice standards, and literature, all of which have yet to be acknowledged to interrogate the violence of ableism and address the resulting trauma within the music therapy community or to those that music therapists serve (Shaw et al., 2022). Bruscia (1998) developed a definition of music therapy[4] that built on the medical model, as indicated by the term "intervention" and the idea that a "client" needs the assistance of a therapist.

From my review of the extant literature, I identified few studies specifically investigating the phenomenon of disability in music therapy. Disability regarding the clinician themselves is a phenomenon rarely discussed, and there is little representation of individuals within the music therapy community who have experienced living with a disability or chronic illness. In fact, the AMTA does not collect demographic information about the number of music therapists with disabilities in their annual workforce analyses (AMTA, 2020; AMTA, 2021a). Of the articles found, most of them focused on the experience of currently practicing music therapy clinicians. For instance, in two autoethnographic investigations, Carolyn Shaw described her journey as a chronically ill music therapist, which culminated in the genesis of Post-Ableist Music Therapy (Shaw, 2019, 2022). As Shaw (2022) indicates, Post-Ableist Music Therapy is:

> A creative process that seeks to work with a person and community to provide an environment and experience that is less disabling through addressing ableist barriers, exploring connections, and providing new and less restrictive spaces through primarily musical or music related experiences. It welcomes different ways of being and resists a one-size fits all approach. Instead, the people we collaborate and work with and contexts guide

> the process. (p. 9)

In other words, Post-Ableist Music Therapy seeks to break down the barriers that lead to disability discrimination, explore connections, and provide new musical opportunities to explore one's identity.

In another study, Pickard et al. (2020) provided an introduction to the Neurodiversity Movement[5] in relation to music therapy clinical practice, to provide an opportunity for music therapy community members to reflect on the ways that they conceptualize music therapy and to advocate for a critical reflection on the assumptions we make in our work. Kapp et al. (2013) indicate that the neurodiversity movement "challenges the medical model's interest in causation and cure, celebrating autism as an inseparable aspect of identity" (p. 59).

Music Therapy Education in the United States

With extensive academic coursework, clinical practicum experiences, and a clinical internship, music therapy education in the U.S. is rigorous. Following the *American Music Therapy Association (AMTA) Standards of Education and Clinical* Training, music therapy education is offered at the levels of a bachelor's degree, a master's degree, or a doctorate (AMTA, 2021b). At the bachelor's level, music therapy education entails four years of coursework and a minimum of 1,200 clinical practicum hours (with no more than 300 hours concurrently occurring with coursework and a clinical internship of at least 900 hours) centered on three main competency areas; music therapy foundations, clinical foundations, and musical foundations. During practicum and internship clinical experiences, undergraduate students apply the information learned in coursework to a clinical setting, under the supervision of a Board-Certified Music Therapist (AMTA, n.d.). By the time students complete their undergraduate education, they must be able to plan and conduct music therapy sessions and assessments; be knowledgeable about a variety of populations and understand the effects of psychotropic medications; understand the role of other therapies; understand the basics of research design and implementation; and have skillful interpersonal skills (Maranto, 1987). Ableism is prevalent in music therapy education in both classroom-styled courses and in practica/internship clinical experiences. Music therapy students with disabilities often face polarizing experiences due to the interactions of music therapy curricula with their disability which leads to a subpar educational experience and potential physical and/or psychological harm.

Disability in the Academe

Disability has historically been an untenable issue in the academe. As Chen et al. (2023) share:

> Academia, ableist to its core, rejects *disability* in its love for *abilities* (read: merit, excellence, rigor, achievement, productivity, and so on), a preference so strong that disability is lost and, with it, sick and disabled people… Disability is to be tamed through the expectation of "reasonable accommodations" as conceived within the narrow bounds of legislation like the ADA (Americans with Disabilities Act) and its amendments. The typical negative framing of disability—as aligned against, opposed to, and the absence of ability—reveals abledness as the liberal foundations of equality. (p. 4)

Currently, most students with disabilities present with specific learning disabilities such as Attention Deficit Hyperactivity Disorder, Attention Deficit Disorder, psychiatric or psychological conditions, or other health impairs/conditions (Abreu et al., 2016). Although the *Individuals with Disabilities Education Improvement Act* (Congress, 2004) provided students with disabilities more opportunities to pursue higher education, disabled students still face a plethora of challenges in achieving academic success and are less likely to graduate than their nondisabled peers (Abreu et al., 2016). For example, as of the date this article was written, most universities in the U.S. require that applicants submit standardized testing scores, which are used as an integral part of the vetting process (Banerjee et al., 2020).

For all students, but especially students with disabilities, lack of success may result due to the challenges associated with college life such as forging new relationships, greater academic demands, and increased independence. Historically, institutions have proven to be unaware of environmental and cultural factors that make it difficult for members of underrepresented groups, such as disabled individuals, to feel welcome. These barriers, such as negative attitudes of peers and instructors may inhibit the learning atmosphere (Fleming et al., 2017) and may undermine students' willingness to seek assistance (Michaels et al., 2015). As Mitchell (2016) stated:

> Given higher education's emphasis on producing normalization professionals (special educators, doctors, lawyers, social workers, therapists, psychologists, psychiatrists), disability continues to appear as antithetical to traditional academic diversity missions—an object to be adjusted rather than subjecthoods with which to contend in the ongoing struggle to diversify a stagnating cultural knowledge base about differential embodiment. (p. 19)

In fact, using the college preparedness index, researchers found that only 13.9% of students who are visually impaired/blind are considered to be adequately qualified to attend four-year colleges. The remaining 86.1% of students who are blind/visually impaired were reported to be minimally qualified or minimally to somewhat qualified (Schuck et al., 2019). Although there have been efforts to equalize the experience of students with disabilities using federal mandates seen in the *Section 504 of the Rehabilitation Act of 1973* (U.S. Department of Labor, 1973b) and the *Americans with Disabilities Act* (U.S. Department of Justice Civil Rights Division, 1990), only "reasonable" accommodations are provided in academia, following each institution's rules as determined by their student disability services departments.

Student Disability Services in Higher-Education

As of the date this article was written, to provide support to students with disabilities in higher-education institutions in the U.S., the U.S. Department of Education (1998) mandated universities must provide students with disabilities the necessary resources to equalize the experience and provide adequate support to promote academic success. Despite this requirement, studies have shown that while 87% of students with disabilities received disability accommodations in high school, only 19% of these individuals who continued on to college received disability-related accommodations or supports (Schuck et al., 2019), and the supports received are insufficient to ensure full accessibility (Valle-Flórez et al., 2021); therefore, students with disabilities have yet to achieve academic parity with students without disabilities (Parsons et al., 2021). In fact, these accommodations address inequities and inaccessibility in a manner that "reinforce[s] ableism, turning disabled people into charity cases or villains, while situating teachers… [and] administrators… as heroes" (Dolmage, 2017, p. 70).

Barriers to accessing the supports are multi-layered, such as the policies of the institution, navigating the process for requesting accommodations, the marked difference between accessing disability-related services in universities compared to high school, or issues surrounding disclosure (Abreu et al., 2016). Many students with disabilities are wary of disclosing their disability due to the potential negative consequences associated with stigma (Bulk et al., 2017). In fact, Mamboleo et al. (2020) found that only 35% of students who received disability services in high school self-disclosed their disability in post-secondary institutions and one third of students with disabilities believed faculty members would view them negatively if they did so. As Dolmage (2017) pointed out, students with disabilities "must catalogue their deficits, and then… [be] granted access through a finite range of legally and institutionally sanctioned accommodations, doled out carefully by professors and instructors under pressure and circumscription of the law" (p. 61).

Students may also choose not to register with their university's disability office due to the power imbalance created, in which the helped (student with the disability) is reliant on the helper (staff member) for accommodations (Shaw, 2019). The disparity of experiences between students with disabilities and students without disabilities is a phenomenon which requires additional study. This issue is especially salient in healthcare degree programs, such as music therapy, which incorporate both academic and clinical practica (i.e., clinical experiences in community placements) into the educational plan.

For those students who choose to register with their respective university's disability office, they must go through a process of gaining access to paperwork from a certified medical professional proving their disability status, submitting it and any other necessary forms to their university, and meeting with their disability advisor. Depending on the university, these requirements may be required up to once per semester. If a student is approved for accommodations, they are provided a "menu" of accommodations of which to choose, rather than having the ability to define the accommodations that will best help them succeed. Past survey studies have demonstrated that extended testing time accommodations (e.g., 150% of the standard testing time) is the most frequently provided accommodation, regardless of its efficacy for the particular student due to the limited options students are provided. As Dolmage (2017) said:

> What we get, then, are blanket or rubber-stamp accommodations, one size fits all- and yet even these accommodations must be asked for, over, and over again, by students who are forced to hold their hand out for something that we cannot even prove helps them. (p. 91)

University disability offices treat disabilities in the same fashion as a game of Whack-a-Mole, in which accommodations are provided when requested by students with the hope that no further issues will arise, in contrast with doing an in-depth analysis to determine what supports would best assist their long-term success (Dolmage, 2017).

Disability in Music Therapy Education

Although the purpose of music therapy education is to train students to become future clinicians, there exists a lack of understanding as to the experience of having a disability, and students must interact with many professors and other individuals outside of the field of music therapy with even less knowledge. As Hsiao et al. (2018) indicate, students with disabilities who pursue a major in music have to master "components of coursework such as performance, composition analysis, and music dictation and notation [which] pose unique demands" (p. 245) that professors do not know how to support. For instance, in their qualitative study, a student disability service provider indicated that the typical academic accommodations provided to students who register with their respective university's disability office (e.g., extended testing time, note taking support) is not effective in music classes and practicum situations. In addition, many professors demonstrated a lack of disability awareness (Hsiao et al., 2018). As Fansler et al. (2019) indicate, music therapy educators should be educated in and encourage their students to learn music that reflects the experiences of disabled people, people of color, non-Christians, and queer people to deconstruct the concept of fixed identities and introduce a range of human variability that transcends understandings reinforced by heteronormative supremacy, white normative supremacy, patriarchy, capitalism, cisnormative supremacy, and ableist normative supremacy. This altered understanding of music will shift music therapists' understandings of the field's potential and will create a new way to understand disability, both in respect to those we work with and with our colleagues (Hadley, 2014).

In my experience in music therapy education, there were many instances in which I became entangled in situations in which professors blatantly indicated they have never and will never provide accommodations to students with disabilities in their classrooms. For example, one such music professor demonstrated a lack of belief in the fact that I have a disability due to my ability to express myself effectively using written and verbal means, and initially did not allow me to have a notetaker in the classroom or to receive additional testing time. With the assistance of my disability advisor in my respective university's disability office, the professor was mandated to provide the accommodations. Similar situations recurred throughout my undergraduate and graduate school years, with a mix of positive and negative effects. A better understanding of the disabled experience and how it manifests in academia, and society as a whole, would be helpful to improving the experience of budding music therapists and the care provided to those music therapists work with, regardless of the clinical setting. Thus, it may be beneficial to weave many of the concepts of disability justice into music therapy curricula.

Disability Justice in Music Therapy Education

As previously mentioned, to encapsulate the needs of both budding music therapists and pave the way for improved education and clinical training, it is imperative to incorporate disability justice into music therapy education and clinical training. The current system, which enshrines the medical model of disability and asserts that it is the *individual*'s failures which causes illness, not the environmental structures surrounding them, harms budding music therapists and the individuals with whom we work. In building a framework to reconceptualize disability justice in healthcare education, Jain (2020) developed a framework which increases in inclusion ranging from strict compliance[6] to the spirit of the law[7] to a transformative approach.[8]

In my experiences within academia, I have yet to experience a university which treats disability using a "spirit of the law" or a "transformative" approach. For example, upon matriculating into a higher-education institution and beginning the registration process with the respective university's disability office, I disclosed my identity to my assigned disability advisor. Following the "compliance" approach, as I have epilepsy, the disability advisor informed me of the accommodations they would approve based on my diagnosis, including a seizure statement that would be sent to professors at the start of each semester, which had language approved by their legal department. When I requested to provide a seizure statement that I had previously authored which better described my seizures and what to do if one occurred, the disability advisor became frustrated, but eventually gave in due to my argument that the university's approved statement only pertained to tonic clonic seizures,[9] which I do not experience.

Within the example provided above, a philosophy of social justice was not embraced since the disability advisor's focus was on decreasing the university's liability rather than determining how my individual needs differed from that of other students with epilepsy and developing a plan to best support my needs. As described by Dolmage (2017), "accommodations are actually designed only to meet the legal standard and actually serve to mask other forms of discrimination, prevent positive and ongoing change, and encourage teachers and administrators in their game of make-believe" (p. 74). If a "spirit of the law" approach was used, the disability advisor could have engaged me in a conversation determining the necessary accommodations to "level the playing field" with other students in my cohort (Jain, 2020). In other words, grounded in an understanding of *Section 504 of the Rehabilitation Act of 1973* (U.S. Department of Labor,1973b) and the *Americans with Disabilities Act* (U.S. Department of Justice Civil Rights Division,1990), the disability advisor could develop accommodations rather than define them based on an established set they are instructed to provide students with epilepsy with the purpose of mitigating future legal concerns. Alternatively, if a "transformative approach" was used, the purpose of the initial conversation between the disability advisor and me, in addition to subsequent meetings with a broad range of individuals (e.g., program faculty members) would have been to "dismantle ableist conceptions of 'standard' learners by embracing the actual complexity of human abilities and ways of being in the world" (Jain, 2020, p. 8). In an ideal world, forced intimacy[10] such as disability disclosure would no longer be required in academia as the transformative approach requires the re-conceptualization of the teaching environment and teaching pedagogy, with mechanisms for ongoing feedback and evaluation to consider further inclusion and learning outcomes. For instance, it allows learners to demonstrate proficiency in variable ways (Jain, 2020). Therefore, the necessity for academic accommodations approved through a bureaucratic system that is entrenched in harm would no longer be necessary.

When looking for solutions that can be adopted at the current moment to benefit current students, the "transformative approach" developed by Jain (2020) is not feasible. It will require the elimination of the competency system required by the *American Music Therapy Association* and entrenched in the *Certification Board for Music Therapists* method of evaluating one's effectiveness to provide services as a Board-Certified Music Therapist. In addition, it will require the higher-education landscape to have a stark shift to a collaborative approach in which university administrators, faculty members, and individuals of leadership work together to develop a system to support all students, rather than using a "band-aid" approach that seeks to provide "reasonable" accommodations on an individual basis. Students will need to be given the opportunity to be evaluated in different ways, which will eliminate the grade point average [GPA] system currently used by all universities in the U.S., and teaching pedagogy will change to create flexible options for all learners, not just those with disabilities. Universities will need to wish to improve the academic experiences of students rather than focus on the bottom line.

Nevertheless, there are several ways in which universities and individual instructors can make alterations to improve the student experience and decrease the stigmatization of students in the classroom and in clinical experiences, especially pertaining to the academic and clinical training of students pursuing healthcare professions, such as music therapy. First, instructors can provide various ways of engaging with and participating in classroom discussions and activities. For example, following the transformative approach which seeks to embed social justice in all facets of healthcare education, instructors can adopt a "tolerance for error" methodology in the classroom. This method is ideal for students who do not wish to raise their hand in the moment or, following an understanding of crip time,[11] would like additional time to process the information previously imparted to provide an educated response. This may manifest in opportunities to write questions and comments down on notecards to hand in at the end of class, submit responses via an online electronic form after class, or to send an email to the instructor with any thoughts or follow-up questions (Dolmage, 2017). For instance, in my personal experience, I sometimes face difficulties in group classroom discussions. Due to the manifestation of the side effects of the medication I take to address my disability, I have a delayed processing time, which equates to approximately 2 seconds. Therefore, one of the best experiences I had in my tenure as a student was in a course where the instructor allowed students to email any thoughts we had from in-class discussion questions that we did not have a chance to share in class.

Second, the academic accommodation process should remain between a disability advisor and the student's instructors. Rather than giving students the responsibility of sending accommodation letters to their instructors and asking them to handle all verbal and written correspondences in relation to the accommodations, each institution should have an automated system which sends accommodation letters to instructors. Any questions or concerns instructors have should be funneled to the disability advisor who has the authority to advocate on behalf of the student, rather than placing the burden of advocacy on the student who must balance their access needs with potential retaliation through in-class/ after-class interactions or their grades. The power imbalance inherent in higher education, in which instructors are given the authority to pass or fail students with little oversight, creates an environment in which students, especially students with disabilities, must cautiously approach all interactions with their instructors with any request. The system in place in many higher-education institutions, which requires students to send their academic accommodation letters to instructors and meet with them at the start of each term, places students in a potentially harmful situation. Instead of teaching "advocacy" (as disability offices claim), students learn that even when they put their effort into advocating for their accommodations, there is little they can do to help themselves if the other party (i.e., instructors) refuse. Students learn that they must stay quiet and participate in the class without their academic accommodations; thus, many students ask themselves why they should disclose their disabilities at all. Instead of aiding them to reach a point of equity, it often leads to discrimination and a smaller number of opportunities.

Third, in courses which are based on lectures provided by instructor, regardless of if the class is offered in-person or online, universities may consider instituting systems which create closed captioning and automatically video record classes. These closed captioning and video recordings would be accessible to all students, regardless of if they have an approved academic accommodation that warrants it. Research demonstrates that over 65% of the general American public are visual learners (Jawed et al., 2019); therefore, the addition of visual cues and video recordings that could be accessed later, would enhance all students' learning experiences. This addition will also assist students with disabilities who did not register with their respective university's disability office.

Fourth, many music therapy programs and internship sites have a policy in which students or interns are required to appear to all music therapy sessions, supervision meetings, and other relevant trainings unless they have a fever of 100.4 degrees Fahrenheit or can display a note from a medical doctor demonstrating illness. Although this policy was initially created to ensure that students did not skip meetings and/or music therapy sessions, it further perseverates the current system of academia which is built for the achievement of nondisabled students. Students with a variety of disabilities may not be able to appear for their sessions and/or meetings due to various situations related to their disability (e.g., migraine, seizure, fibromyalgia flare up) without satisfying either one of the requirements. To gain a doctor's note, one must make a doctor's appointment, navigate to the appointment, and pay the necessary fee for the appointment. The cost and/or transportation may not be possible on the given day. In addition, due to the variety and multifaceted natures of disabilities, they may not manifest in fevers. For instance, individuals with endometriosis may face situations in which they cannot ambulate and cannot notify their supervisor or professor of the absence due to severe pain; therefore, would be marked as absent and lose points based on current requirements. Also, the requirements of students to disclose their disability to their instructor requires forced intimacy, which should not be required. To build a field which embraces disability justice, there must be a system of implicit trust between instructors and their students in which students are not required to prove their illness to miss a meeting or session.

Lastly, for disabled music therapy students and interns, and practicing disabled music therapists, to truly maintain their positions within the field of music therapy without forced intimacy (Mingus, 2017) or hiding their disability to the best of their ability, disabled budding music therapists (and practicing professionals) should consider the creation of care webs. Care webs are based on the concept of mutual aid and connectedness rooted in interdependence (Piepza-Samarasinha, 2020, 2022) in which each member provides the support they can on any given day based on their current financial state or health. They contain the amalgamation of access created by disabled and nondisabled individuals through the lens of solidarity, not charity. As a member of the music therapy disability community myself, I have yet to find any care webs (i.e., care collectives) within the US music therapy community. The creation of such resources would greatly benefit budding music therapists, as they navigate a field which defines a proper clinician as one who is white, cis-gender, nondisabled, and female.[12]

The recommendations indicated in this paper include a non-exhaustive list of possibilities which could lead to the improvement of music therapy education and clinical training in the U.S. Therefore, I encourage future researchers, instructors, and universities to continue dreaming of possibilities which would improve the experience of music therapy students with disabilities. If we truly seek to build a diverse body of Board-Certified Music Therapists who understand how to provide music therapy services in a respectful and safe manner and mitigate opportunities of harm, we must first begin with revising the system that people are first exposed to upon entering the field.

Conclusion

In Westernized societies, "disability" is an attribute which has been condemned and used as ammunition by nondisabled people. Historically, individuals with disabilities have experienced discrimination to the perseveration of the medical model of disability. The medical model of disability is the core of ableist actions and suggests that the problems inherent in a disability are attributed to the affected individual and that one's goal should be to cure the disability to reach a state of normality accepted by society. The profession of music therapy is deeply rooted in the medical model of disability; therefore, like other medical fields, it accepts that human variability is understood as a disease or other pathological condition which needs to be remediated. Disability in relation to clinicians themselves is a topic rarely discussed, as evidenced in the absence of demographic information about the number of music therapists with disabilities in the U.S. in the AMTA workforce analyses, to date (AMTA, 2020; AMTA, 2021a). In the academe, although the *Americans with Disabilities Act* (U.S. Department of Justice Civil Rights Division, 1990) and the *Rehabilitation Act of 1973* (U.S. Department of Labor, 1973a) sought to provide additional opportunities to students with disabilities and protect them from discrimination, individuals of this social group still face copious challenges in the social sphere and adjusting to the challenges of postsecondary education. In addition, numerous environmental and cultural factors make it difficult for minoritized groups to thrive in academia (Fleming et al., 2017). To this end, the purpose of this paper was to investigate the effects of ableism on the experiences of music therapy students in the U.S. and pose considerations that could be implemented to minimize instances of ableism. To remediate the systemic issues in higher education which make it difficult for students with disabilities to thrive, it would be highly salient to integrate disability justice into curricula and clinical practice. Disability justice can help deconstruct the profession's grounding in the medical model of disability and better appreciate human variability. To begin the process of addressing inaccessible aspects of music therapy education and clinical training and making alterations to improve access, I recommend the following: (1) Adopt a "tolerance for error" methodology in the classroom which allows several different ways to participate; (2) keep interactions about academic accommodations between a student's disability advisor and instructors rather than shirking responsibility to the student; (3) integrate closed captioning and video record all class sessions; (4) reevaluate the policy inherent in many institutions in which students receive approved absences only if they have a fever of 100.4 degrees Fahrenheit or higher or can display a note from a medical doctor proving illness; and (5) develop an interdependent system of music therapy students with disabilities and disabled practitioners to support each other through the trials and trivializations to be faced throughout one's career.

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[1] For example, one of the most common disability arguments for slavery was that "African Americans lacked sufficient intelligence to participate or compete on an equal basis in society with white Americans… which was sometimes attributed to physical causes… or lesser intelligence" (Baynton, 2001, p. 37).

[2] The medical model of disability embodies the philosophy that an individual is disabled when they have a health condition or disease that impairs their ability to carry out activities of daily living, without attention to societal or environmental models which can also affect the experience of a disability (Patel & Brown, 2017).

[3] The ordinance from Chicago, IL, that was called the "ugly-law," read: "Any person who is diseased, maimed, mutilated or in any way deformed so as to be an unsightly or disgusting object, or an improper person to be allowed in or on the streets, highways, thoroughfares or public places in this city shall not therein or thereon expose himself or herself to public view under penalty of one dollar for each offense" (Coco, 2010).

[4] Bruscia's (1998) widely used definition is: "Music therapy is a systematic process of intervention wherein the therapist helps the client to promote health, using music experiences and the relationships that develop through them as dynamic forces of charge" (p. 20).

[5] The "*neuro* in *neurodiversity* is most usefully understood as a convenient shorthand for the functionality of the whole bodymind and the way the nervous system weaves together cognition and

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embodiment. So, neurodiversity refers to the diversity among minds, or among bodyminds" (Walker & Raymaker, 2021, p. 6).

[6] The strict compliance approach requires one to perform a strict interpretation of legal requirements regarding the environment and the individual with disabilities, a risk orientation to inclusive action, and a basic understanding that disability is an individual, medical problem, not a social one (Jain, 2020).

[7] The spirit of the law approach prioritizes the substantive intention that animates disability rights legislation by: (1) Liberally interpreting legal requirements; (2) evolving practices or environments to suit learners with disabilities; and (3) disability is seen as a product of individual impairment in interaction with the social environment (Jain, 2020).

[8] The transformative approach is a philosophical possibility that would ideally move beyond both the spirit of the law and compliance approaches by: (1) Utilizing social justice as a guiding principle; (2) imagining a social world where differences in the human condition are assumed and honored, and institutions are built with this assumption; and (3) creating an educational system that ensures health professionals reflect the totality of societal variation. This approach challenges us to embrace the full complexity of human ability and ways of being in the world (Jain, 2020).

[9] Tonic clonic seizures are colloquially known as "grand mal" seizures.

[10] Forced intimacy requires the daily experience individuals with disabilities experience in which they are required to share personal parts of themselves with the public to survive in a world built for individuals who identify as nondisabled. The most frequent form of forced intimacy is the requirement to share personal information with nondisabled individuals to gain access to services that satisfy *basic* needs (Mingus, 2017).

[11] Crip time is a relational phenomenon which denotes the various temporalities by which disabled people live their lives, which may be distinct from normative linear time. It accounts for the natural variations in temporal and other related resources individuals may need and can access to accomplish everyday tasks (Katzman et al., 2020).

[12] According to the *2021 AMTA Workforce Analysis*, 88.34% of practicing music therapists identify as female and 86.44% identify as White.