Able-Diverse Music Therapy: Toward a New Model of Disability and Music Therapy

Robert Gross

Social model of disability

- transcends traditional perspectives on disability
- Focuses on oppressive assumptions on normativity and hierarchy

Music therapy has a responsibility to engage the social model of disability.

What is the social model of disability?

Thomas (2008, p. 15) gives a definition.

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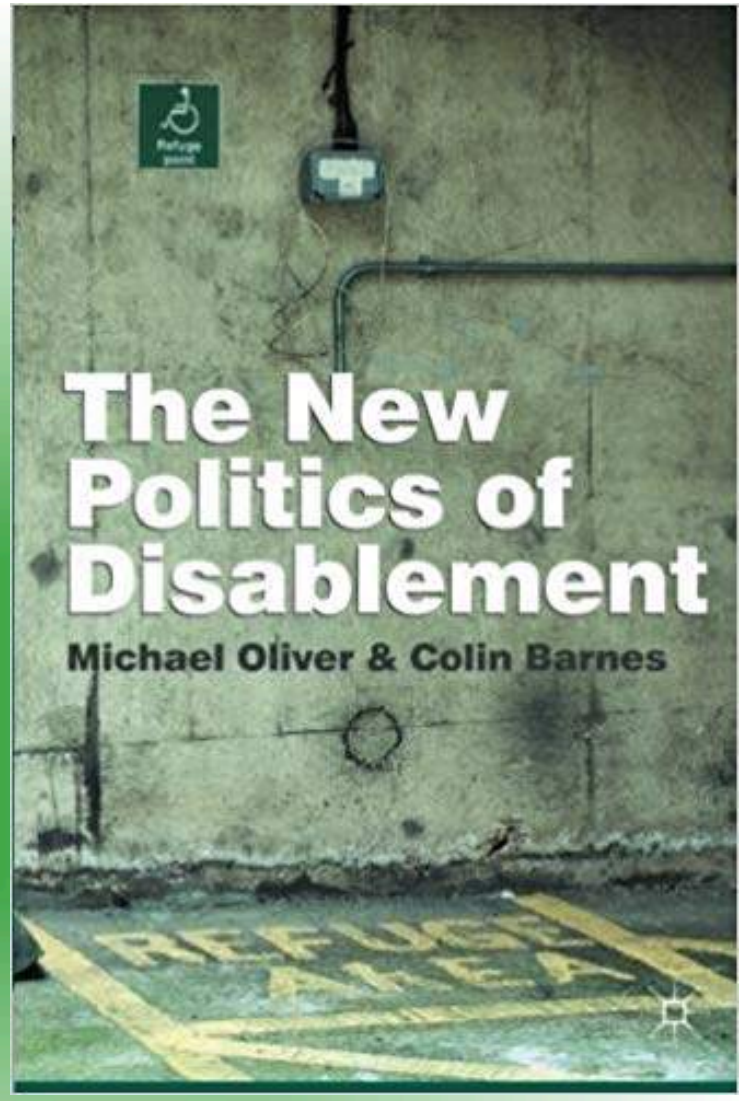
Deconstruction of false dichotomies:

- disabled/normal
- victim/survivor
- weak/strong
- ill/healthy
- client/therapist

Colin Barnes



Oliver and Barnes (2012) offer their critique.

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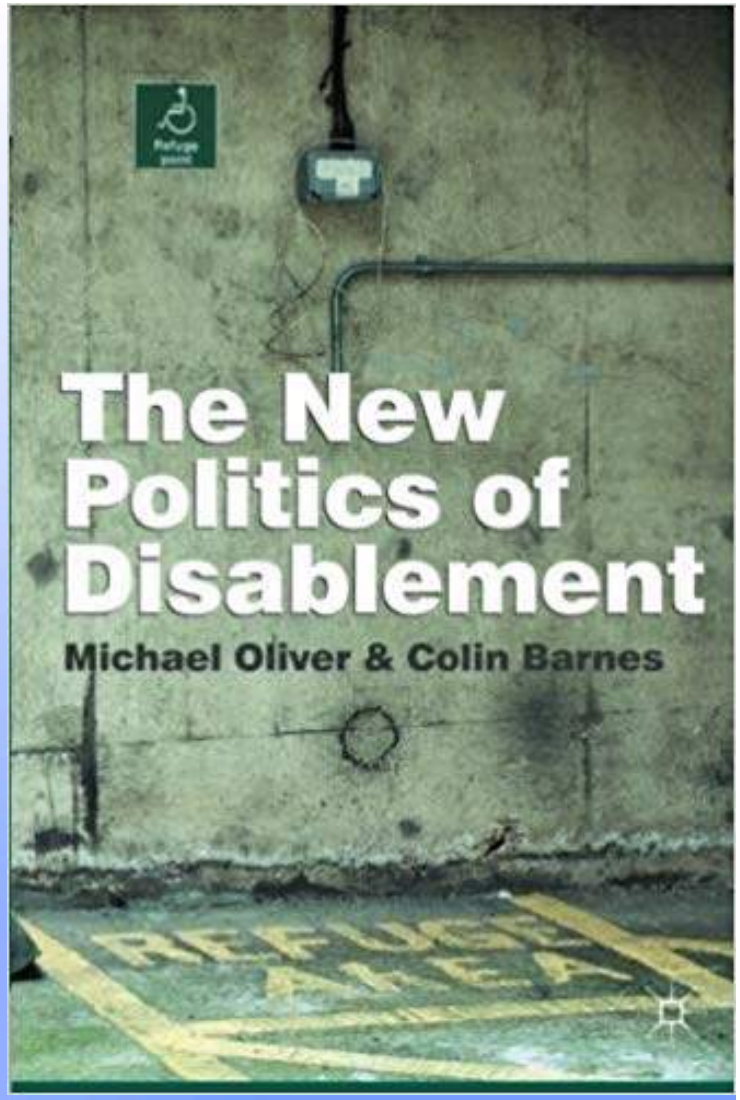
Those with impairments are socialized into a negative self-outlook and therefore often see themselves as completely dependent on the charity of others for survival (p. 139).



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The Social Model has its critics.

Tom Shakespeare

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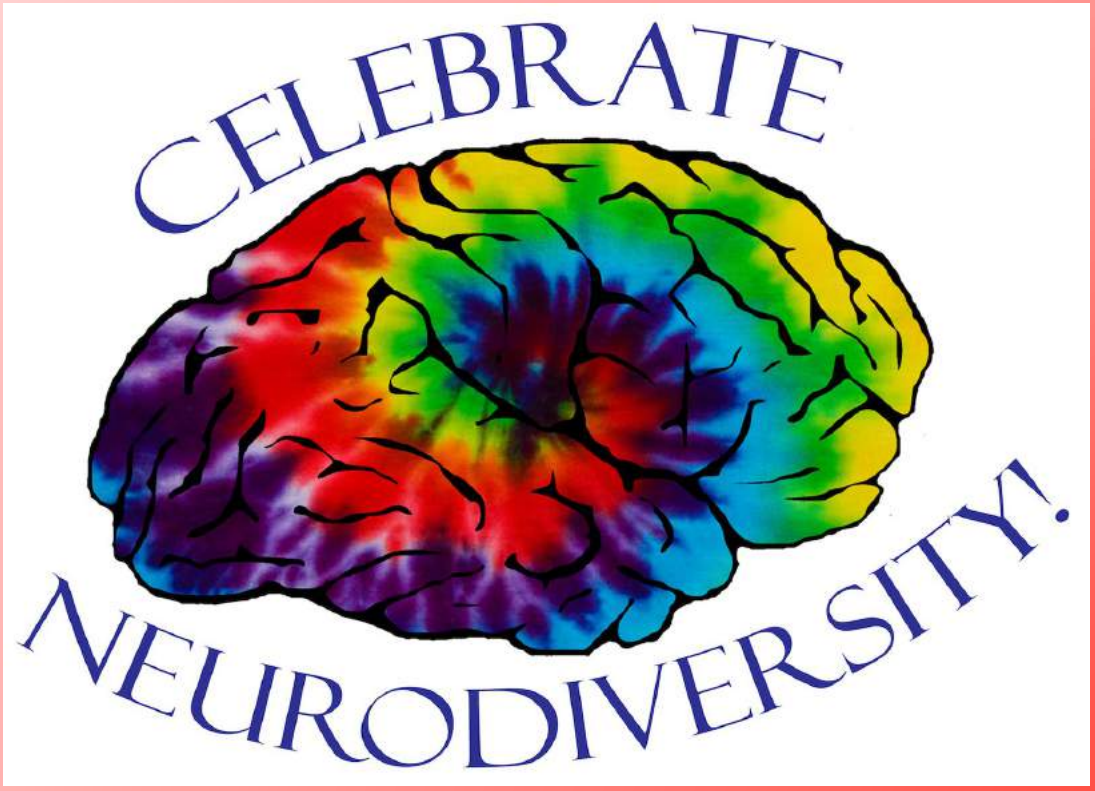
In light of these critiques, in my view, the social model may be due for a slight upgrade.

The upgrade I'd propose is to base disability theory on the successful model of neurodiversity, which in a very short time has become a formidable international movement.



(There's even a logo)

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Thomas Armstrong

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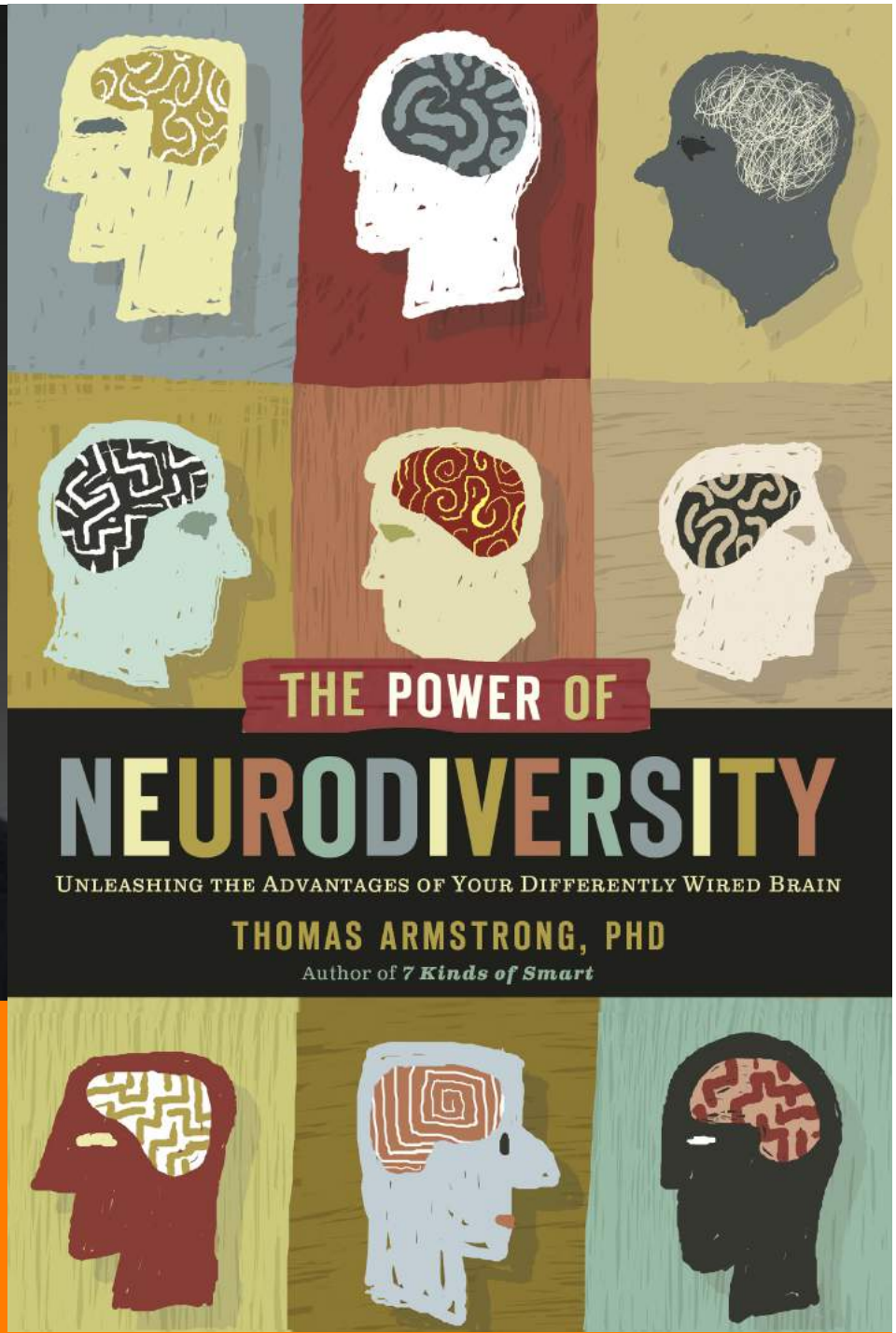

The essential premise of neurodiversity is that neurological difference is a manifestation of human diversity, and not a pathology *per se.*

So why can't we extrapolate this mode of thinking to *all disability*?

This is the model I call able-diversity.

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Does ableism in music therapy exist?

Yes.

Joseph Straus

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* Level I: Evidence from a systematic review or meta-analysis of all relevant RCTs (randomized controlled trial) or evidence-based clinical practice guidelines based on systematic reviews of RCTs or three or more RCTs of good quality that have similar results.

* Level II: Evidence obtained from at least one well-designed RCT (e.g., large multi-site RCT).

* Level III: Evidence obtained from well-designed controlled trials without randomization (i.e. quasi-experimental).

* Level IV: Evidence from well-designed case-control or cohort studies.

* Level V: Evidence from systematic reviews of descriptive and qualitative studies (meta-synthesis).

* Level VI: Evidence from a single descriptive or qualitative study.

* Level VII: Evidence from the opinion of authorities and/or reports of expert committees. (Ackley, Swan, Ladwig & Tucker, 2008, p. 7).

Notice that qualitative research, the type of research most readily associated with searches for meaning, is relegated to the sixth tier.

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The British Association for Music Therapy defines music therapy as such:

Music therapy is an established psychological clinical intervention, which is delivered by Health and Care Professions Council (HCPC) registered music therapists, to help people of all ages, whose lives have been affected by injury, illness or disability through supporting their psychological, emotional, cognitive, physical, communicative and social needs.

What would able-diverse music therapy look like?

Volume 14, No. 3 of *Voices: A World Forum for Music Therapy* featured a number of scholars discussing the social model of disability in relation to music therapy. I propose several practical takeaways from each article in order to better demonstrate able-diverse music therapy in practice.

(Logo used with permission.
The views expressed in this presentation are those of Robert Gross and not of *Voices.*)

Bassler (2014) told us that invisible disability "poses a unique problem vis-à-vis disability and society, since invisible illness does not present itself outwardly and does not easily mark a person as having a disability" (para. 1). My practical suggestion here: *never assume the extent of one's disability by outward appearances alone.*

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

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

Straus (2014) maintained that "Music therapy has positioned itself squarely within the medical model of disability, arguing that many sorts of human variability should be understood as illnesses, diseases, or other sorts of pathological medical conditions, and offering music as a source of normalization, remediation, and therapy toward a possible cure" (para. 1).

My suggestion: *Don't participate in this paradigm either. Consider clients to be equals with you, not lesser beings who need to be "cured" of anything.* This for some may strike as a radical proposition that flies in the face of much training, but it is necessary if we are to avoid condescending inequalities in our therapist/client relationships.

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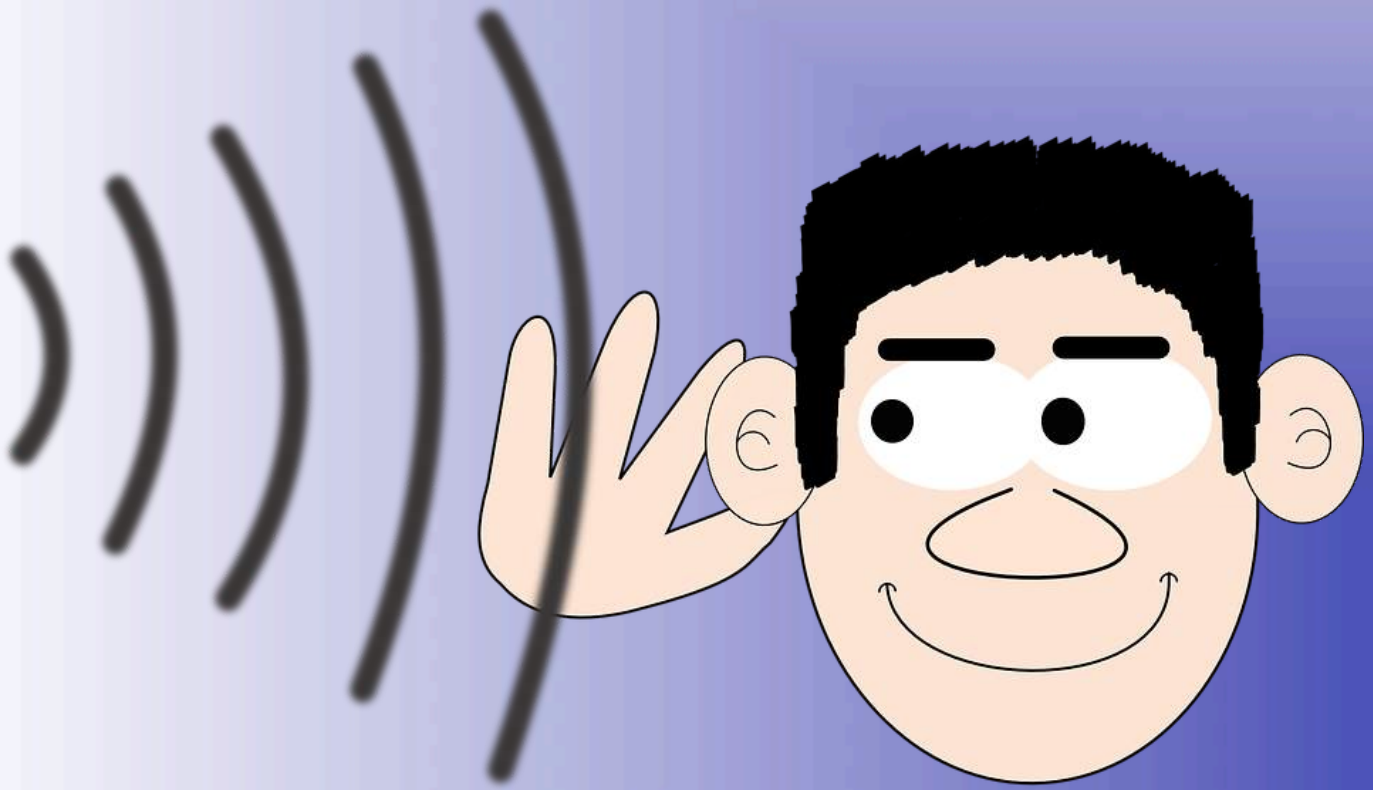
"If we were to privilege listening to what our Autistic interlocutors had to say about what *they* think they need," wrote Bakan (2014, para. 91), "and what matters to them over acting on the assumption that our main responsibility is to change them 'for the better' in accordance with the conventions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



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Stefan Honisch

A blunt suggestion is made here: *do not assume you are there to normalize your client. Celebrate your client for his or her diversity.*

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

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Hiroko Miyake

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I would recommend then, *do not become too invested in professional identity; remember instead that equitable, egalitarian musicking with your client is the important thing.*

Thank you so much.

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