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Reconsidering the Dominant Narratives of the Music Therapy Profession for the Future

Reconsidérer les paradigmes dominants de la musicothérapie pour assurer l'avenir

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Abstract

Music therapy has always been a research-based profession that is informed by theory. However, many of the theories that we rely on were proposed nearly half a century ago. This paper, which was presented as a keynote to the Canadian Music Therapy Association in 2020, provides one answer to the question of what theoretical perspectives we might privilege if the profession were established now, instead of at that time. Critical theories including intersectionality, post-humanism, and post-ableism are highlighted and practical suggestions are made about how these perspectives would alter the way we describe our practice as music therapists.

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Sommaire

La musicothérapie repose depuis toujours sur une recherche aux fondements théoriques. Cependant, nombre des théories sur lesquelles nous nous appuyons ont été formulées il y a près d'un demi-siècle. Le présent article, qui a fait l'objet du discours d'ouverture du congrès de l'Association canadienne des musicothérapeutes de 2020, propose une réponse possible à la question des perspectives théoriques qui seraient adoptées si la profession s'était établie aujourd'hui plutôt qu'il y a cinquante ans. On y aborde des théories critiques, portant notamment sur l'intersectionnalité, le post-humanisme et le post-capacitisme, et on y fait des suggestions pratiques sur les variations qu'apporteraient ces perspectives à notre définition de l'exercice de la musicothérapie.

Mots-clés: théorie de la musicothérapie, intersectionnalité, habilisme, post-humanisme

Reconsidering Dominant Narratives

Being invited to provide a keynote for the Canadian Music Therapy Conference in 2020 afforded me the opportunity to reflect on some of the persistent challenges facing our profession, as perceived from my position as a music therapy educator, researcher, and practitioner working with a range of young people in the multicultural city of Melbourne, Australia. I recognize that I have been afforded the opportunity to share my views because of my privileges, attributed to me partly because I have wielded the power of the pen, the typewriter, and now the keypad over the last 22 years, beginning with my PhD at the University of Melbourne in 1998. All those years spent writing and thinking, combined with the unearned privileges afforded by my white skin and middle-class background, have provided me with this opportunity to share my opinions; some are more substantiated than others, but all have been discussed in university classes and with professional colleagues around the globe, and some have been published. In acknowledgement of that, I would like to emulate the traditions of Aboriginal and Torres Strait Islander peoples in Australia and pay my respects to those whose ideas have informed me and to the audience and readers of this discussion. I pay my respects to the traditions of your lands, and to the many different theoretical positions that exist within music therapy in your place, including the diversity of approaches, beliefs, and values that go with them. Although I am challenging some long-held assumptions which may feel uncomfortable, I do so with respect and also with hope that the world is changing rapidly, and that it needs to.

Even as I take advantage of this opportunity to elaborate on my frustrations, I am conscious that my perspective may already be outdated in our rapidly changing world. I am, after all, a middle-aged, divorced, white mother of teenagers living in a country that was never ceded to the colonists and which continues to tolerate ongoing sexism, racism, and fear of minority groups but which affords me the status of professor. These contextual conditions inform my perspective and while I hope to contribute to the future of music therapy, I simultaneously believe it should be shaped by those who are fresher and less privileged than I. But I offer what power I have to advocate for a profession of music therapy workers who are:

- contextually sensitive
- arts-based
- negotiators
- with a change orientation
- and a deep respect for social justice.

This keynote has helped me to articulate my personal frustration with the language we use to describe the people with whom we work and our position in regard to them—and by we, I mean professional, qualified music therapists who have spent years and dollars to gain our qualifications and to position ourselves to be employed. It has also been an opportunity to challenge our continued reliance on the theories created in the middle of the last century by privileged white men, mostly from the USA. To quote the wise words of the notorious Ruth Bader Ginsberg (1933–2020), "I would like to dissent." This publication of my keynote address represents the details of my argument, as made to the conference attendees on the 20th of June in 2020.

> Dissents speak to a future age. It's not simply to say, "My colleagues are wrong, and I would do it this way." But the greatest dissents do become court opinions and gradually over time their views become the dominant view. So that's the dissenter's hope: that they are writing not for today, but for tomorrow. (Bader Ginsberg, 2002)

Where Are We Now?

Before making suggestions about how we might be able to evolve as a profession if we were to expand our theoretical influences, I will briefly outline what I consider to be the dominant theoretical positions and then focus on two critiques. Although many different words could be used to describe our major theoretical influences, I have used four categories in previous writing and teaching (McFerran, 2010) and find them to be a simplified but useful list of the dominant traditions in music therapy practice. The oldest are the psychodynamic theories, and although they have evolved from the 19th century psychoanalytic propositions of Sigmund Freud in Austria, the psychodynamic tradition is still an important influence. Behavioural theories emerged in the early 20th century and have been supplemented by what might be called developmental or medical approaches, both of which continue to focus on the therapist helping the individual to improve an area of deficit. Humanistic and person-centred approaches entered the stage in the mid 20th century in order to decentralize people's problems and highlight their abilities and have now been expanded to incorporate strengths-oriented approaches and positive psychology. Ecological, or systems-based, approaches have arrived most recently and are therefore less dominant but are still a noteworthy theoretical influence on the field with increasing emphasis on consultancy and family-focused models. It is immediately obvious that, although revised, the foundations of our profession were generated during different times, by privileged men. Their assumptions have subsequently been critiqued for their tendency to uphold the patriarchal, white, and anthropocentric social systems that have distributed power unevenly for centuries.

One example of how these theories have continued to be propagated is the continuing use of the term "clients," originally proposed by Carl Rogers, the key proponent of humanism, in 1951 as an alternative to the idea of treating "patients." His use of the term was intended to signify how we might see the "client" as the expert who has the most profound self-knowledge that will be of value in recovery, but even Rogers went on to develop a preference for seeing the "person" rather than the "client." Whilst the word might seem harmless, I believe there are a number of problems with using a single, convenient (to those in power) term to group people together in ways that disguise their diversity. It is similar to when we refer to "populations" of people with disabilities or mental and physical illnesses. One issue is that it suggests "clients" in music therapy are people who do not fit the humanist ideal of strong, resilient, independent, rational, heteronormative, white individuals. This post-humanist argument has been highlighted as a predicament for professions informed by key humanities scholars such as Braidotti (2013), following on Foucault's (1970) groundbreaking critique, and has slowly reached greater prominence in music therapy (Ansdell & Stige, 2018; Hadley & Thomas, 2018; Shaw, 2019). The key issue being highlighted by these discourses is our unconscious tendency to think of people in comparison to the traditionally dominant group. However, for me, these provocations raise an immediate counter-question: What is the alternative to this view of the people with whom we work?

Another example is our ongoing alignment with an "expert model" of "treatment" (Rolvsjord & Stige, 2015) where the "therapist decides what music would induce the desired therapeutic response" (Aigen, 2013, p. 40), often regardless of context. This positions the therapist as "well" and the client as "unwell" and therefore the nature of the relationship is of one human as superior to another. Although this may be necessary in some contexts, the use of the expert model has not been contained to certain places where people are acutely unwell and need to rely on the expertise of professionals to manage their immediate urgent needs. Our tendency to position ourselves as experts is taught as foundational in many training courses and reflected in introductory textbooks to music therapy where students are taught to write goals and objectives as a foundation for practice, demonstrating a direct alignment with the treatment model (Abbott, 2020; Thompson, 2020).

The goals are determined by the therapist, who has superior knowledge and insights about how to "fix" the client.

In my experience, the ways people react to my explanations of the work I do with adolescents in diverse contexts offer some insight into how my language must suggest certain power dynamics and comparisons between myself and others. These reactions have often assumed that the people with whom I work (my "clients") have either been unlucky or difficult, and their view of me, as the "clinician" who is helping to fix them, varies from seeing my work as meaningful and rewarding to generous and challenging. For example, outsiders often respond to my descriptions of work with marginalized youth by congratulating me on how generous I am to spend time this way, despite the fact that I am clearly paid to do so. I sense through people's well-intended responses that society sees my clients as "difficult" and the unspoken, humanist assumption is that they could "try harder" to conquer their challenges by being tougher, stronger, more rational, or more determined. This is confirmed if I describe how they "fail to attend" sessions, or when they are present, how they may be "defensive," "resistive," or "non-compliant." In contrast, when I describe my work in children's hospitals or pediatric palliative care, it is as though I am the one who is lucky to be doing such meaningful work. The unlucky people we find in rehabilitation, oncology, palliative care, neonatology, and other contexts seem to have arrived there by "accident" and are often considered "blameless." This illustration reflects the kinds of unconsciously held views about different humans, which are the basis of the post-humanist critique. The language we use to describe people within a treatment model is well suited to medical contexts, but once we move beyond that context, it is inherently flawed and reflects poorly on "clients" who do not achieve their "goals and objectives" and perhaps never will.

A specific example of how we diminish people through the use of outdated language is a "population" who have patronized music therapy from its beginning as a profession, and who are one of the largest groups of consumers of music therapy services in countries such as Australia and the USA according to national surveys (AMTA, 2018; Jack et al., 2016). These are people with disabilities, or disabled people as some prefer to be called (Pickard et al., 2020). The Ableist movement highlights how this particular group of clients are marginalized because they are imperfect and make people feel uncomfortable (Rolvsjord, 2014). Although people with disabilities may enjoy music therapy and enjoy their therapeutic relationships with us, our alignment with a medical model that offers to fix people is becoming increasingly problematic (Strauss, 2014). As Honisch (2014) suggests, they are questioning why other people do music, but they do music therapy.

It is important to acknowledge that people who are described as having "problems" that take a long time to "fix" create excellent conditions for our employment as ongoing service providers of long-term therapy. And since these people are disabled in ways that do not result in a lack of musicality or ability to engage meaningfully in relationships, we are able to music together easily. But because we profit from describing this musicking as "building skills" in order to justify our ongoing tenure with them, we have a problem. So, in continuing with this specific illustration of the dilemmas created by our continuing alignment with outdated theoretical models, we can perhaps see why we, as a group of professionals who have also paid money to a different system to acquire skills from which we could then make a living, seem to be stuck. And why, despite our positive feelings about the clients we work with, some, more than others, are further marginalized by our traditions of practice.

In the second part of this paper, I attempt to complement critical perspectives by offering a pragmatic answer to the questions they raise by focusing on the usefulness and application of this knowledge (Rosenthal & Thayer, 2017). For the purposes of this discussion, I am also thinking about the potential benefits to the music therapy profession as a whole if we can discover what needs to be done in response to the array of critiques that might be made of a profession that still relies on dominant theories of the past. I have been grappling with how to respond to these critiques in my

practice and in teaching music therapy students at university. I have found that once seen (and heard), these critiques of dominant traditions are difficult to unsee. And whilst emerging demands for greater systemic equality initially seem to align easily with the basic tenets of the humanist movement and its emphasis on inherent potential and relationships that express the natural mutuality of our union (Abrams, 2011), this is perhaps naïve given more recent critique. The post-humanist position warns that our good intentions are founded on certain assumptions about equality that cannot be sustained in our contemporary world and require reconsideration (Ansdell & Stige, 2018).

I believe that we are standing in a very challenging position, and I suspect we have become stuck in our subscription to aging theories and that now is a good time to question our traditions and our heritage. It has led me to wonder what we might see if we were to look with fresh eyes, where we might go, and what we might do as a group of professionals. The "doing" is of particular interest to me, as I have frequently aligned with critical ideas only to find myself stuck in not knowing how to actually change my practice whilst it is enmeshed in an economic system that makes demands for evidence of improvement. This is why I have positioned myself as a pragmatist—out of necessity and a yearning to know how I might "do" better. As noted at the outset, I believe we all might benefit from reconsidering our assumptions.

So, where are we going and what should we do differently? I would like to answer that question by exploring another question that I have taken from an esteemed art therapy colleague, Shirley Riley (2009), who asked: Where would we choose to go if we were starting out now? She concludes her article by saying:

> The historical "founding parents" of our profession established our identity in the face of disbelief from many professionals. However, they took the encouragement they received from others and held on to their own convictions. They believed in the positive qualities that art therapy could bring to treatment. We face a different challenge in the preservation of our identity. We can do it best by recognizing that although change is threatening, it also offers new opportunities to redefine our profession and continue to offer our unique talents to clients and the profession of mental health. (p.138)

This seems an excellent beginning point for the next stage of the conversation.

Where Could We Go?

The conversation about where we might go needs to begin by considering whose voices we would privilege, if not the medical profession (Rolvsjord, 2010), and how we could avoid further oppressing people through our own practices as music therapists (Baines, 2013). In alignment with my pragmatic intentions, I do not suggest there are singular answers to the questions I am posing, and acknowledge that my own answers reflect my beliefs and values without any intention for this to represent those of others.

What Might We Call the People with whom We Work?

In answer to this question, all I can say is: not "clients." I think the words we use should reflect the context in which we meet people, and therefore the values that are considered important in that context. This is often recognized by music therapists who work in particular contexts, but once they begin discussions, writing about the field more generally, or training music therapists, there is a tendency to revert to the language of clients (McFerran, 2019). Patients belong in hospitals, students in schools, service users in services, clients in private practice, etc.

Language is powerful but varied in its use in different cultural contexts. For example, a survey of 336 service users in the UK mental health system (Simmons et al., 2010) concluded that "patient" was the preferred term when consulted by psychiatrists and nurses, but it was equally preferable to "client" for social workers and occupational therapists. "Service user" was disliked more than liked overall, particularly by those who consulted a health professional, but not by those who consulted a social worker. A significant minority wished to be regarded as a "survivor" or "user." Clearly, there are many opinions and no single answer.

My rationale for why music therapists should stop using the word "clients" as though it is all-encompassing is simply because it is not. It centralizes our needs as a professional group over the diverse identities of the people with whom we work. There is no literature justifying this selection of terminology and my persistent questioning of colleagues over the past decade suggests that most believe it is simply cumbersome to use specific language when they are focusing on the practice of music therapy, rather than the specific person experiencing it. Superficially, this convenience may seem aligned with pragmatic choices. However, the understanding that knowledge is contextual is key to the approach for which I am advocating. If we need to use a word to refer to the people who legitimize our income, then the word we choose should at least reflect the context in which that income is generated. It should not rely on the homogenizing language used in training when lecturers are referring to a generic "client" in need of our professional help.

The disability movement has been leading this discussion for some time. Beginning in the 1970s, there was a challenge to the ways people were described and movement towards emphasizing individuality and personhood over impairments through the use of person-first language. This is still strongly advocated for in many allied health fields (Crocker & Smith, 2019). However, there has been a more recent counter-challenge against this universalizing tendency, which is based on an assumption that people do not take pride in their disability and do not wish to be identified by it (Goodley, 2011). Identity-first language has therefore come into prominence and some disability community members, advocates, and scholars have argued powerfully for owning the language, requiring professionals to be culturally sensitive and not to assume that there is a singular, preferred way that all people in the disability community wish to have used (Dunn & Andrews, 2015). The convenience of language for professionals is no longer considered to be the main priority when selecting our words.

What Would We Call Ourselves?

Another complex question related to terminology is in regard to us as practitioners. Are we comfortable with a universalizing discourse about our own name(s), given that many new graduates report being challenged by the question of whether they should introduce themselves as a music therapist or something else to avoid the connotations of therapy or to legitimize themselves by attaching to a higher level categorization such as allied health or psychotherapist? The challenge seems related to our professional label being a description of what we do professionally, rather than focusing on what is addressed, such as speech or occupational skills, although a music-centred discourse does resolve that problem if accepted (Aigen, 2005). The idea of being called "health musickers" has been trialed in Norway, embracing Christopher Small's notion of musicking as the most appropriate verb for describing the actions of doing music with others (Small, 1998). However, this does not escape the problem of medical alignment, which is only relevant when working in medical settings.

I suggest that we should embrace creative approaches that respond to the needs in each place, rather than being concerned about betraying our professional body by using diverse terminology at different times. It is not our individual obligation to protect the profession. Our obligation is to the people with whom we work and the places in which we work. It is entirely feasible that we can move beyond a positivistic need for a universalizing language that satisfies the philosophical beliefs of those who believe in singular truths. The profession is music therapy, but what we do in each place can vary significantly.

The Music Worker

I enjoy the idea of being a Music Worker for a range of reasons. By admitting this is about work with music, it is clear that we are being paid to spend this creative and spontaneous time with others. As part of that work, we negotiate what music to engage in, how to music, and towards what shared purpose we might agree to work. I also tend to align professionally with the kinds of work that social workers and youth workers do. This is less about being the "expert" that fixes and more about contributing to a team which aims to support individuals, families, and groups. It is less about special sessions with clients in closed rooms where they reveal their private selves, but then have no further opportunity to do so until we meet again. I have come to believe that music therapists would benefit from being more embedded and responsible in teams, contributing to case management and all the other administrative duties that most team members have to do. This also supports the idea of being a worker. Some music therapists prefer to be employed solely for the purposes of running sessions and doing the associated documentation, but that can also foster professional jealousy and resentment within teams, as well as positioning ourselves as outside of responsibilities and therefore being much more vulnerable to funding cuts.

I would personally rather be more like a social worker than a clinician, more like a youth worker than a psychologist, and more like a transformational coach than a psychotherapist. This comes from my experience of working in teams that serve adolescents where being a therapist is not a useful point of reference for the young people in schools and services. Most only have a vague sense of what a therapist does, and they assume that my being a therapist means they are "crazy." Whereas I might refer to myself as a therapist when I am working in my private practice and people have come to me specifically for therapy, that is not a useful frame for me in community-based, education, and health programs. It does not adequately convey the work I do.

What Theories Might Inform Our Practices?

If we were to start now, theories such as behaviouralism, psychoanalysis, and even humanism would not be the theoretical influences that I would privilege. If they were not already embedded in my practice and thinking, I would view them as historical words supported by colonial, binary, heteronormative assumptions about wellness and responsibility. There have been wonderful learnings from these traditions, but that does not justify a continued adherence to them. They have been deconstructed and critiqued by contemporary proponents and, in many cases, they have been found to have significant flaws. They have been transcended by new theoretical perspectives (Combs, 2013), which include the knowledge gained from previous approaches, but extend and rise above the limits of them, particularly to triumph over the negative and restrictive aspects. This requires moving beyond binaries like good and bad or old and new, and focusing more on evolution and growth. It becomes possible to pay respect to all that has landed us here, without being trapped by it. It is not disrespectful to evolve. It is a necessary and unavoidable human action. And some would argue it is what the world needs right now (Wilber, 2000).

Intersectionality

Intersectional theory provides a useful way of understanding how power interlocks and intersects in people's lives, creating a multitude of barriers for those outside the straight, white, heteronormative, male norm. Kimberlé Crenshaw's (1991) seminal work has slowly infiltrated the thinking and theorizing about most fields of practice from law to health to education and beyond. Crenshaw's work is increasingly referenced in doctoral dissertations and is beginning to be centralized in refereed journals (Boggan et al., 2017; Hadley & Thomas, 2018; Seabrook, 2019). Intersectionality is particularly relevant for music therapists who work with people who usually encounter more than one barrier in their lives (e.g., individuals who are excluded or marginalized). It provides a framework for explaining why we might not adopt a psychodynamic framework when working with people who have experienced violence and abuse, for example. It articulates a powerful rationale for why we do not focus only on their historical experiences and the resolution of them, because the meanings that have been constructed as a way of surviving are shaped by other aspects of their identity, such as gender and financial possibilities, and the resources afforded them for coping, etc. It can also be used to explain why, when we work with people in prisons, we do not focus primarily on their crime but rather on their reconstruction of identity, or perhaps even the intersection of their life experience and the biases that pervade our society. In this way, intersectionality provides a useful way of understanding the people we work with as well as explaining why we might not focus on their individual problems within the therapeutic encounter.

Post-humanism

As an extension of the influence of humanistic thinking in music therapy, post-humanism would be integral to the development of a profession launched in today's world. Gary Ansdell and Brynjulf Stige (2018) have provided an important introduction to conceptualizing a post-humanist approach and have identified a focus on individualism, internalism, and exclusivism as the key problems that might bear further critique. They highlight Carolyn Kenny's (1982) early contributions to the inclusion of humanism; however her later work (Kenny, 2015) also began to move towards post-humanism in the increasing recognition of the anthropocentrism in music therapy. For Kenny, this was largely about indigenous understandings that naturally privilege spirituality and nature, whereas Carolyn Shaw (2019) also embraces and acknowledges the non-human aspects of therapy that are the built environment, and animals and creatures, as well as nature and spirituality. Given that music is often positioned as an object for consumption, it seems feasible that music-based practitioners might be better served by a contemporary discourse like post-humanism. In addition, it might be useful to distance ourselves from the suggestion of human superiority, given that it suggests a narrow conception of an "ideal" human (Ansdell & Stige, 2018, p.179), where some types of humans are more valued than others (Shaw, 2019, p.142).

Post-ableism

The notion of ableism is linked to the challenges of humanism but focuses specifically on the body and mind. Shaw's (2019) doctoral dissertation has centralized the importance of a post-ableist music therapy, grounded in her own experiences of illness and disability. Zoë Kalenderidis (2020) has similarly examined her own experiences of disability through an arts-based project that led her to call for music therapists to more actively challenge ableist assumptions in our workplaces. Compared to the calls for post-humanism, the recognition of ableism has been

much more grounded in lived experience and music therapy practice. For example, Hiroko Miyake (2014) calls music therapy professionals to action by saying, "Simply encouraging the social participation of people with disabilities will not change the boundaries that divide people across ability/disability, health/disease, normal/abnormal, majority/minority binaries." For Miyake, the recognition of ableism is seen as a call for social justice that focuses on disabled people but includes others who are marginalized by dominant perspectives and actions, perhaps similarly to feminism. Daphne Rickson (2014) reminds us that not all people in the disability community have the same views, and highlights how some of the young people she worked with were uncomfortable with this activist approach. This is a timely reminder that our attempts to embrace diversity need to be carefully moderated by the human tendency to classify and categorize with fresh boundaries.

Our professional practices may be out of step with the social movements that are gaining increasing prominence and power in the various places we inhabit. The time has come for reflexive examination of our field.

What Could Our Practices Look Like?

My answer to the question of what our practices could look like is that they might look very similar. However, the way we describe how and why we do what we do is the area that requires careful, curious, optimistic reconsideration. Consider a young man I worked with in individual and small group music therapy, collaborating with a beat-making colleague who wanted to experiment with technology and improvisation, and supported by a youth worker who travelled to the sessions with the young man each week (Crooke & McFerran, 2019). I would describe our work as follows:

We entered into a mutually agreed process of musicking together, which mostly involved me listening when he played instruments and generated song lyrics and told stories about his journey to sessions. I could say that I was witness to his tales of suffering and marginalization and that I made space for that by adjusting my session plans and disregarding my own intentions about what might happen in any given session. As professionals supporting this young man, we also discarded our assumed goal that we would make a recording of him rapping his own story by the end of our time together. Instead, I allowed him to determine what happened in our time together, how long we played drums, how long we stood by the white board writing his story down and then rubbing it off and then writing again. When the sessions came to an end and he expressed a desire to continue, I advocated for him, negotiating with the school principal, writing reports and having meetings so that we could work together for another five weeks. When he returned for these additional sessions, he was clearer about how much time we had and this time he was ready for the end. He knew he had taught me as much as I had witnessed him and that I would benefit from his participation in my research as much as he would benefit from being in therapy with me.

Another way of writing this story would have been to focus on how my client did not make it to school every day and that his life is chaotic because of a combination of historical poverty, the reliance on his ageing grandparents because of the deaths of his parents, and the fact that he was expelled from schools when he was younger because he had "anger issues." He was encouraged to attend music therapy by his youth worker, who accompanied him to the venue each week. I developed goals to address issues related to grief and loss and to empower him to express his authentic self, which would lead to increased self-confidence. I created session plans that allowed him to have freedom and control through choosing between different activities I presented and supplemented each week based on his preferences. Through music therapy, he developed the ability to regulate his emotions in sessions and to express his feelings through songwriting. He described having greater insight into his own history and optimism for the future, and wished that he, and others, could have access to ongoing music therapy services.

The second description highlights my professional skills and, importantly, how my expertise in session construction, goal-setting, and musicianship created the context for this young man to reach his full potential. Both descriptions are accurate, but only the first one captures how this young man had decided that he was willing to try this "music therapy grief and loss thing" because he had known suffering and he wanted to do anything that might help him deal with it. The first description shows that many of the professionals' expert ideas about how we would proceed needed to be abandoned, because this young man had his own aspirations for how he could appropriate the affordances of music therapy. It is possible that the second description could lead to ongoing funding of a music therapy position in his school, but the first description feels more accurate to me. I am not sure whether anything I did helped improve his confidence and emotion regulation, but I would usually take his statements about enjoying the sessions and feeling proud of his achievements as affirming.

In the following table I have attempted to capture how different dimensions of our music work might be described from different perspectives (Table 1). This allowed me to consider how starkly different they are —the traditional language represents the tradition of our field, the lived experience language is taken directly from my interview with him, and the contemporary language is my proposal for how we might reframe in a less problematic way.

Table 1

Traditional Compared to Contemporary Ways of Describing Music Therapy

	Traditional Language	**Lived Experience**	**Contemporary Language**
Person	Client	I / Me / My	Young Person (they/he/him)
Their reason for being in therapy	Extensive childhood trauma, school refusal and expulsion, violence, criminal activity	I've been through some extremely hard shit that no-one should go through, and why not get help for that shit if it's going to help me feel better. I'm always going to be open to something that helps me.	Making Space Listening / Being Heard
Outcomes	Improved social skills, Increased self-insight, Greater clarity about connection between childhood and current state, Self-confidence, Authentic self-expression	I've been seeing whether that could make me happy and shit. I've been looking forward to it. It made me really happy It gave me opportunities for taking photos and stuff, and I never used to go into the city at all.	Advocating

What helped	Beat-based improvisations, Song and lyric writing, Structured drumming games	I just like the variety and stuff It helped to think about stuff while we were doing it (writing song lyrics). I've always known it, but a little bit more I guess It was sort of an escape from thinking about stuff too.	Allowing Witnessing
Connection	Established rapport, Sensitivity to group dynamics	One of us made the bass beat and everyone else just climbed on board. I thought it was really good. I got to make them (youth workers) more of my friends and see them not just in class.	Musicking Solidarity / Allyship
Commitment	Attendance: Failed to attend 1 session of 15, Travelled from outer suburbs on public transport with youth worker each week	I did everything I possibly could to be there. I enjoyed the sessions. I was always really proud that I could make it there.	Acknowledging

Conclusion

Where would we choose to go if we started now? Shirley Riley's (2009) question has been remarkably freeing in allowing me to move beyond my critiques of the outdated theories on which we rely and towards the future. I believe that 2020 has shown us how responding to critical perspectives is the challenge of the next decade. It is a challenge that we need to embrace without being defensive, a challenge which will enable us to evolve in ways that incorporate the strengths of the theories that informed our practices over the past decades but move beyond outdated assumptions.

Our ways of doing music therapy might remain reasonably consistent but our ways of describing what we do needs to change. I have proposed that critical theories such as intersectionality, post-ableism, and post-humanist theories seem immediately relevant as points of departure but have tried to face the challenge of describing what that means in action. Pragmatism has always been a strong influence on my teaching and theorizing, and I am constantly drawn back from my armchair philosophizing by music therapists in training who still want to learn what to do, and for whom being critical of a profession they have not yet practised is too much conjecture and not enough substance.

I believe that there will be many ways forward for those of us who train as music therapists. Some will identify as therapists who have clients, others as workers who support service users, others as musicians who facilitate well-being experiences, and more. Embracing diversity seems critical and being curious about one another's approaches will be necessary, rather than aligning with a particular school of thought. For myself, I will embrace being a professional who is a contextually sensitive, arts-based negotiator, with a change orientation and a deep respect for social justice. What about you?

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