**“Where are you from?” Navigating Oppression, Power and Privilege in Music Therapy Spaces: A Critical Autoethnography Exploring Intersectional Identities**

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### Review

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# Abstract

This research explored a second-generation, New Zealand born Filipino music therapy student’s experience using a critical auto-ethnography to explore their intersectional identities while on placement in aged-care settings. Using a thematic analysis, four themes emerged: 1) Locating the self; 2) connection in and around therapeutic interactions; 3) dissonance in and around therapeutic interactions; 4) restorative practices. The findings revealed insights into the importance of taking accountability for privilege and unchecked bias, while also practising self-compassion for minority identities. Taken together, these ideas can enhance a music therapist’s sense-of-safety as they navigate the complexities found within the therapeutic relationship.

My intersectional identities profoundly shape the ways I exist and interact with the world around me. This research was no exception, so I feel it is important to begin by sharing these parts of me to provide context for my experiences and positionality. I am a second-generation, New Zealand born Filipino. I am a son of two Filipino immigrants and a person of colour (PoC). I am non-disabled, neurotypical, and cis-gendered. I grew up in a secure middle class family home and English is my first and only spoken language. I am in my mid-twenties.

**Emerging Research Context**

My placement took place across eight different aged residential care (ARC) facilities (rest homes, hospitals, palliative units, and dementia care) primarily in the greater Wellington region. I worked across community-settings, rest homes and hospital units, and dementia units, working with residents one-to-one and in group settings. The diversity of environments meant I met many people in a short period of time, and I began to encounter racial microaggressions about my brown skin colour. Microaggressions are defined as “everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalised group membership” (Sue, 2010, p. 3). Despite being born and raised in Aotearoa, I was frequently asked by staff members and residents, “where are you from?”, and “how long have you been in the country?” Residents asked my supervisor, “I want to know where he’s from” rather than addressing me directly. In another case, a staff member introduced me to a group of music therapy participants as a Kiwi despite explicitly introducing myself to them as a second-generation Filipino.

I was initially curious to explore how my identity as a male music therapist might manifest during placement. I was fortunate to have many positive male-role models throughout my formative years who demonstrated gentle, reflective, and kind ways of being. This led me to develop an interest in the idea of masculinity and how young boys may or may not be socialised into caring roles. The notion of ‘caring masculinities’ is emerging within feminist and critical-studies literature (Elliott, 2016), although regarding music therapy, male-identifying music therapists are a minority within the profession (American Music Therapy Association, 2019; Molyneux et al., 2016) and detailed accounts from male music therapists concerning their masculinity are sparse.

My interest in gender was quickly replaced by the need to respond to the attention my brown skin drew and the subsequent racial microaggressions. Before starting placement, I had considered myself equally Filipino and Kiwi; a Kiwi-pino (pino derived from Pinoy, a widely used slang term similar to the way New Zealander’s are called ‘Kiwi’). The racism I experienced challenged this notion; how was I to navigate only being seen as one thing when my lived experience told me otherwise? During this identity fracturing, I also encountered privileges stemming from my identity as a non-disabled and neurotypical person. ARC facilities were a completely new environment for me, and I found myself stumbling into unchecked ableist biases. I was unsure how to navigate the simultaneous experience of racism and holding more power in my positionality. In response, my research shifted away from exclusively exploring masculinity, and towards my intersectional identities as a whole to capture the wide range of experiences I had begun to encounter.

## Research Question and Aims

The research question for my exegesis was: “How do I manage intersectional identities and hidden privileges during therapeutic interactions with aged-care residents?”

My research aimed to:

* Identify experiences of oppression I experience as a PoC and simultaneously perpetuate as a non-disabled, neurotypical, young student music therapist.
* Develop insights around self-care and the navigation of negative experiences in music therapy.
* Develop tools to navigate differences within the therapeutic relationship.

# Literature Review

**Intersectionality in Music Therapy**

Intersectionality (Crenshaw, 1989) suggests that a person’s gender, culture, ethnicity, class or whether they live with a disability shape how people experience the world around them (Bhopal, 2018). It draws attention to how experiences of inequality, such as sexism, racism, eurocentrism, ableism, and classism (and more), do not exist in isolation to one another (Crenshaw, 2016), and their intersections position people within a nexus of privilege and oppression (McKinzie & Richards, 2019). Intersectionality has become increasingly relevant in music therapy, as the people we work with may hold multiple minority identities which may make them more vulnerable to social injustice (Seabrook, 2019).

## Privilege and Oppression

Viewing identity with an intersectional lens allows us to see how people can exist in multiple social situations; an identity may afford privileges in one environment, while being the cause for subjugation in another (McFerran, 2021). Privilege, in this sense, refers to a special advantage, benefit, or entitlement that stems from a particular identity marker, such as ethnicity, skin colour, gender or sexuality (Black & Stone, 2005). There has been growing recognition for less visible privileges like immigration status, the ability to speak and read English, or differentiation between working class and middle or upper class (Turner, 2021). Oppression can be considered both an action and a state-of-being (Whitehead-Pleaux, 2018), and concerns interactions between majority and minority groups. According to Baines (2021), these interactions concern differences in class, race, gender, ableism and colonialism. This research takes a similar stance. Oppression was encountered during moments of injustice or inequality, and often concerned the minority identities of myself and music therapy participants. Microaggressions or unintentional harm brought on by unchecked biases are forms of oppression mentioned thus far.

## Intersectionality-Informed View on the Therapeutic Relationship

Intersectionality (Crenshaw, 1989) brings to attention the ways an individual can exist across multiple contexts and how they may experience privilege or oppression. This line of thinking can also be extended to our identities as practitioners, clinicians, and/or therapists. These labels can inadvertently position us as appearing more knowledgeable than our participants (McFerran, 2021) and assumes that we are immune from bias, or excused from perpetuating systems of inequality because we have undergone studies, training, or registered with a governing body (Hahna, 2017). There exists a power imbalance between therapist and participant as the former is present as a professional, whilst the latter is present to address aspects of their health and wellbeing (Seabrook, 2019). This dichotomous view positions the therapist as an expert, while relegating the participant as “needing to be fixed” (Davies, 2022, p. 21).

Intersectionality allows us to see how music therapists and clients can occupy and move between spaces of privilege and subjugation by way of their identities, and further supports the notion that a therapeutic relationship is a political entity that is not immune to broader societal injustice and oppression (Hadley, 2013). Drawing from my own experience, microaggressions subjugated me as a PoC relative to the residents, yet I simultaneously held power over them as a result working in a professional capacity as a student music therapist.

## Music Therapy in Aged Residential Care

The discourse above considers how language can shape perceptions of music therapists and participants alike. In this section, I describe some ways music therapy is used practically across residential care spaces to provide context for the musical interactions detailed later in the findings. Music therapy can be active or receptive (Edwards, 2015). Within aged-care, active forms can encompass instrument playing, improvisation, movement, and singing, while receptive forms can encompass listening and discussion-based practices. This can all be underpinned by Small's (1998) concept of “musicking”, which “covers all participation in a musical [activity], whether it takes place actively or passively” (p. 9). Music therapy offers a flexible and relational approach to support the well-being of older adults, such as supporting their identities, providing opportunities to access and build community, and bolster quality of life for those (but not limited to) living with degenerative disease like dementia. These various areas will be discussed below.

### Identity

Hays and Minichiello (2005) reported that music is a “symbol for defining their own sense of self and identity” (p. 4), and it was connected to life-experience and memories. Song-based reminiscence is a method that captures these sentiments (Grocke & Wigram, 2006). Reminiscence includes verbal discussion of memories which can be prompted using objects and artefacts (like photographs), or through music (Istvandity, 2017). Listening to personally significant music that is tied strongly to key life events can be a deeply impactful experience that prompts memories of important relationships or developmental milestones (Ridder & Wheeler, 2015). These experiences have been noted to positively influence well-being among older adults (Istvandity, 2017).

**Supporting Connection and Mental Health**

Music can be a “social glue” (Hays & Minichiello, 2005, p. 6) that can safely and non-confrontationally bring isolated residents together. In group settings, residents can interact with one another directly during group singing, instrument playing, and song requests (Ridder & Wheeler, 2015), or through receptive-based reminiscence activities (Grocke, 2015). Additionally, music can facilitate communication in other modalities when spoken language is inaccessible (Hays & Minichiello, 2005).

Werner et al., (2017) notes how music therapy is more effective in alleviating depressive symptoms in older adults compared to non-therapist facilitated musical activities. This is attributed to the person-centred and relational nature of music therapy. Receptive music therapy methods are described as having similar positive impacts on mental health as they can evoke reminiscence, affectively stimulate and relax when necessary, and connect listeners socially (Grocke, 2015). Moreover, receptive methods can help residents express difficult emotions like frustration, irritation, and sadness (Jang & Kunde, 2021).

**Dementia Care**

The music therapy principles outlined above are also relevant when working with residents living with dementia. McDermott et al., (2014) explain that music therapy can provide residents a safe and comforting environment to engage in reminiscence in ways that avoid disorienting them from their present moment. Music is seen as an accessible resource for those living with dementia to remain connected to their identity and sense of personhood by connecting with significant songs (Elliott & Gardner, 2018). Alongside the music therapist’s ability to shape music to relax residents when they are agitated, or energise when apathetic, music therapy provides a space where are not required to be “in the moment” and can be validated wherever they may be in their memories (Dowlen et al., 2018).

# Methodology

A critical autoethnography was used in this research. Autoethnography is defined as “an approach to research and writing that seeks to describe and systematically analyse (graphy) personal experiences (auto) in order to understand cultural experiences (ethno)” (Ellis et al., 2011, p. 1). The critical element is added when the research(er) seeks to understand the lived experiences of socially marginalised folk in order to highlight systematic injustice and inequity (Adams, 2017; Boylorn & Orbe, 2016). This method allowed me to examine how I exist and acted within ARC facilities, and in music therapy spaces.

Data consisted of personal reflexive and reflective journals, session notes, and supervision discussions (practice and academic). These sources were collected over a six-month period. A thematic analysis was used to analyse the data. This is the “process of making sense of the data and abstracting broader ideas than the explicit words on the paper” (Fugard & Potts, 2019, p. 3). I took guidance from Braun and Clarke's (2022) six phases of thematic analysis, which included 1) data familiarisation, 2) developing initial codes, 3) sorting codes into candidate themes, 4) reviewing themes, 5) refining, re-defining, or re-coding where necessary, 6) establishing themes and writing. NVivo 12 was used to code the data and sort them into themes. For clarity, I have used italics in this article when quoting directly from my journals, session notes and supervision discussions.

Māori music therapy participants were not explicitly involved in the research, yet this research occurred in Aotearoa. It felt important to consider several principles held by the Te Tiriti o Waitangi statute held by Te Herenga Waka, Victoria University of Wellington (2022).[[1]](#footnote-1) Principles of Rangatiratanga (self-determination), Mahi Tahi (partnership and mutually beneficial outcomes), and Kōwhiringa (“about ensuring that Māori can be Māori, in whatever form that takes”) were particularly relevant and seemed to parallel the person-centred and critical approaches used in my practice.

# Findings

Four themes emerged across all data sources:

1. Locating the Self
2. Enhancing Connection in and around Therapeutic Interactions
   1. Musical Interactions
   2. Ethnicity and Culture
   3. Age and Gender
3. Dissonance in and around Therapeutic Interactions
   1. Therapists’ Experience with Subjugation
   2. Confronting Privileges and Participant Subjugation
4. Restorative Practices
   1. Supervision
   2. Reflection
   3. Boundaries

Data extracts are provided alongside personal commentary of the findings. While these extracts are presented linearly and categorically below, the themes are interrelated, and can be organised in a non-linear and interconnected way (see figure 1).

**Figure 1: Themes in Action**

A diagram showing the non-linear relationship between the four themes

Description automatically generated

Image description: This figure shows a non-linear and interconnected relationship between the four themes. Each theme is positioned in a speech bubble and the movements between them are represented with arrows. The theme “locating the self” is positioned at the top, “dissonance in and around therapeutic interactions” and “enhancing connection in and around therapeutic interactions” are placed side by side in the middle, and “restorative practice” at the bottom. The arrows flow through the themes, showing the way that they flow to and from one another and ultimately the arrows converge on the theme of “locating the self” to suggest that our experiences feed back into our identities. Dotted arrows between the “dissonance” and “connection” themes in the middle indicate the way that these themes can coexist in a non-binary way as a given therapeutic interaction can be considered both positive and negative depending on which of our identities is foregrounded.

In the exegesis submitted to the university, I included voices of other music therapists from published journal articles or reflexive commentaries written by Akash Bhatia (2021), Natasha Thomas (2021), Dennis Kahui (2013), and Hilary Davies (2022). My research supervisor recommended including these voices alongside mine to further support generalisability outside my own experience as a Filipino. Each therapist held unique intersectional identities, including (but not limited to) identifying as neurodivergent, disabled, Black, Māori, or cis-gendered. Due to constraints on space, I have chosen to focus on my experiences and identities, although I wish to pay tribute to these music therapists for their part in my learning journey.

## Theme 1: Locating the Self

Unexpected racial microaggressions required me to shift my initial focus on masculinity to cultural identity. Throughout my placement, I was asked “where are you from?” with an alarming frequency and in attempts to process my confusion, I wrote:

*I’m finding these occur a bit more frequently now that I’m meeting lots more people […] Still not sure how to deal with these questions.*

Despite being born and raised in Aotearoa the frequency of this question was confronting. Early in my learning I was not cognitively aware that I was being triggered. The sense of security surrounding my “Kiwi-ness” began to erode, and so did my mental health. Grappling with this, I wrote:

*I feel wholly unprepared to answer this question. On a cognitive level, I know the answer. I am a 1st generation Filipino. To be 1st generation is to be born in New Zealand. I am a citizen by birth. The answer to this question on an emotional level is vastly different. To ask where I am from is to ask me where I started. It implies my upbringing, and every major milestone. Where do I start? All the way at the beginning? Do I start with [street I grew up on], or the legacy of colonisation? Do I start with the cycle of generational trauma? Assimilation? I cannot speak my mother tongue. Yet my skin is brown. I am wholly unprepared and unready to answer such a question. I am, I AM from “here”. Earth. I am human just like you. But I am also so different than you.*

The intense feelings of otherness made it very challenging to connect with the residents during music therapy. In attempts to address these feelings, I unknowingly copied my Pākehā supervisor’s mannerisms and idiosyncrasies, down to the tone and cadence of their voice, whilst running group sessions (which consisted largely of white-presenting residents, typically of European ancestry). Realising that I had not been acting authentically made me uncomfortable. Discussing this with my supervisor, I was reminded that my job as student music therapist was to learn, and to:

*Figure out who I am in [ARC] contexts, [and] how to be genuine and authentic while being young, brown, and male.*

Data revealed that perfectionism was another source of my anxiety and apprehension. The nature of my placement meant I typically had another experienced music therapist onsite with me, co-facilitating sessions. Subconsciously, I expected myself to work at their level. Supervision was important in untangling these thoughts, to which I later wrote:

*… know that I am a student and I CANNOT TRY TO BE PERFECT*

## Theme 2: Enhancing Connection in and around Therapeutic Interactions

Connection enhancing moments (CEMs) appeared widely throughout the data. These interactions occurred before, during, and after sessions and ultimately enriched the therapeutic relationship. CEMs included musical and non-musical interactions with participants, and tangential figures like caregivers, ARC staff, or whānau.

### Musical Interactions

CEMs often related to positive moments where residents broke into smile or song and became more animated. Conversations facilitated by song-lyric discussion and reminiscence were particularly important for deepening connection. For example, lyrics from “Edelweiss” and “Home on the Range” invited residents to reminisce around their childhood homes. Residents were often quick to express their appreciation when I sang these songs, and comment on my “lovely voice*”,* or told me to *“*come back soon.”There was even one instance where a resident suggested that me visiting them was like“[having] one of the family members around…”

Keeping in mind the feelings of otherness and isolation that followed racial microaggressions, I found these comments very encouraging. Songs provided a way to discuss non-musical topics, like family or life-adventures, which aided in rapport building and learning about each other more deeply. Musical interactions provided opportunities to the residents and I to connect reciprocally regardless of how different our intersectional identities appeared. It was pleasing to discover the things we had in common with one another.

***Ethnicity and Culture***

Shared ethnicity and culture also facilitated CEMs and enriched relationships. For example, other Filipino care staff were quick to notice my presence despite not engaging closely with one another. A Filipino caregiver (with whom I had no prior interaction) greeted me in Tagalog, saying “Kamusta” (hello). I wrote about this interaction later, saying it “*made me feel at home…*”

Unprompted comments around my cultural appearance often left me feeling uncomfortable, however, the data suggest that music made talking about race less confronting. Considering my Kiwi identity for example:

*I noticed I was using Kiwi imagery/music. I don’t recall feeling weird about it in the moment…*

*I noticed a “kiwi” moment that I would say was genuine. Having been talking about the ocean, I mentioned that “we’re” quite lucky in New Zealand to never be too far away from the ocean.*

Music also facilitated the discussion of grief and loss. During an interaction with a resident who was grieving the gradual loss of their family, we found mutual comfort in talking about our families and using music to keep the memories of them alive. I reflected:

*It didn’t feel strange to talk about my Filipino background when I talked about my dad’s family, and my Lola. In this moment, there was a sharing of grief and remembrance. It felt extremely genuine.*

***Age and Gender***

Discussion of age and gender were less present in the data but remained important when considering intersectional identities. I was typically the youngest person at an ARC facility. I noted that the residents expressed:

…*Enjoyment that a ‘young person’ like me is learning these old songs…*

I was also one of the few men on site, as the caregiving staff largely consisted of women. Navigating my masculinity here was not challenging for me, although when working with a group of male residents, I reflected that:

*My low bass voice helps miles and makes me feel ‘in place.’*

The findings indicate that our intersectional identities influence how we create CEMs with music therapy participants. Our multiple identities open various avenues of connection and can create positive feelings of appreciation, security, and closeness. When identities differed, music allowed for more reciprocal and non-confrontational ways to learn about one another.

## Theme 3: Dissonance in and around Therapeutic Interactions

There were moments where differences in intersectional identities created feelings of dissonance between me and the residents. Dissonance is a gut feeling that refers to discomfort and internal tension in response to challenging interactions or conflict. Experiencing dissonance often made it harder to stay present within enriching and connecting interactions.

### Therapists’ Experience with Subjugation and Dissonance

Racial microaggressions are particularly relevant here. My cultural appearance invited curious comments, and I received unprompted statements like:

*You’ve got an accent on you…*

*You must have some Spanish ancestry in you…*

Such comments were received while ethnicity or culture were not explicitly being discussed. I felt irritated and defensive as a PoC. As a music therapy student, I was more concerned with trying to remain responsive to the residents. In these early stages I believed that this meant putting the residents’ needs above my own. This caused me to suppress the pain I felt due to my cultural self being exposed. Despite my best efforts, my attention kept returning to the racial microaggressions.

*I have a limited capacity of attention at the moment [...] Being so absorbed by the challenging things prevents me from noticing the residents who are engaging and having a good time.*

Other interactions were more ambiguous. For example, a group session ended on the theme of classic Kiwi foods. After closing the session, a resident approached me and started a conversation. They eventually commented:

*… on Sundays, New Zealanders have Sunday roast…*

Some assumptions can be made as to whether the resident’s referral to New Zealanders included me. Perhaps they assumed that because of my appearance, that I must not be Kiwi and thus, not aware of Sunday roasts. These ambiguous interactions occurred frequently. They were initially uncomfortable, but eventually became irritating to engage with. I reflected on this:

*… I wonder how different this interaction would have gone if I had willingly shared that information about myself, rather than having it coaxed out of me…*

It became extremely laborious to respond and remain vigilant to these forms of microaggressions. I found that I was reserving energy in anticipation, and this negatively impacted my ability to feel present and remain responsive to the residents.

### Confronting Privileges and Participant Subjugation

This sub-theme draws attention to ways music therapists might unknowingly harm our participants. Such moments are characterised by low-experience levels and nervousness and relate to my privileged non-disabled and neurotypical identities. Earlier in my learning I would speak without thinking and unchecked biases would reveal themselves. For example, some ableist biases were revealed when I asked a music therapy participant, living with neurological impairments, to introduce themselves. Unbeknownst to me, this resident was non-speaking, and it wasn’t until a caregiver introduced them on their behalf, I realised my misstep. I reflected on this, saying:

*… I will definitely learn from this, but regardless, this mistake was due to my unconscious ableist beliefs. In the moment, I assumed that everyone was ABLE to verbally introduce themselves.*

Subjugation can be less direct. For example, I typically had access to residents’ case files and medical history, and this created massive feelings of dissonance. To me, it felt as if:

*… I was violating [their] privacy. The act of flicking through a profile really makes me feel too powerful…*

These subtle acts of subjugation were especially relevant in secure dementia units. On multiple occasions I had to sneak out behind the password protected doors after some residents/participants followed me to the exit after a session. Being able to return home at the end of the day also made me feel too powerful, and the March to April 2022 COVID-19/Omicron outbreak only exacerbated these feelings. This occurred approximately a month into full-time placement, and I was beginning to feel the early stages of burnout:

*I was feeling incredibly drained last night, so much so that I almost didn’t come to placement today. The looming cloud that is covid, is starting to get to me.*

*I’m going to take placement off as I’m really unsure how I’ll cope. I can hear myself trying to tell myself/ convince myself to go to placement as I’m ‘not really that sick… right now…’. I believe that this is due to some form of guilt or that I’m trying to justify my level of sickness; to quantify my well-being.*

I felt relieved being able to stay home during the outbreak while ARC facilities were in lockdown as it provided me a moment to catch my breath, however, these feelings were often overshadowed by how privileged I felt:

*I’m still feeling so anxious and drained. I really can’t comprehend what the residents must be experiencing. Things move too fast. [The residents] don’t have a choice. I have so much choice.*

At this stage, I did not have the tools or insight to navigate the power I felt in relation to the residents. The experience of having to simultaneously confront such privileges and navigate racial microaggressions brought me to a standstill. I became avoidant and apprehensive of placement, and after returning to ARC once lockdowns were lifted, I ruminated heavily. I questioned whether:

… *I was suited for this work…*

## Theme 4: Restorative Practices

This final theme illustrates the restorative practices I discovered in response to CEMs and dissonances. Restorative practices included reflection, implementing boundaries, and supervision. These made dissonant experiences more manageable, and reinforced CEMs.

### Supervision

Supervision was key in navigating dissonance in and around therapeutic interactions. With guidance from my supervisor, I was able to think out loud in a safer space which allowed me to reach my own conclusions. This was important in developing my reflexivity and learning to solve problems my way. Having supervision at a regular frequency also gave me a checkpoint to aim for which was particularly helpful when I was struggling. It was comforting to know that support was just around the corner.

One challenge supervision supported me in navigating concerned resident-preferred music, and the generational gap between the residents and myself. The music was not difficult to play, however, I found it difficult to relate to. My supervisor observed that I appeared distant while singing, and affirming this, I expressed it felt like I was filling space rather than contributing meaningfully to the residents’ well-being. My supervisor encouraged me to:

*… find something that I personally enjoy in the music [and to] be involved in it…*

I slowly became more attuned to the melodies, rhythms, lyrics, or harmonic structures of these songs which allowed me to breathe life into the music and stay more present. Supervision helped me move from simply making noise to using music as a health tool while running sessions.

### Reflection

I kept a small reflection notebook on hand throughout the duration of my placement. I used this to externalise anxious thoughts or to capture dissonant interactions, and I discovered that this practice helped me avoid rumination. For example, I checked in with myself throughout the day:

*9.30am: I’m feeling particularly anxious this morning. I can’t ‘hear’ the anxiety so much as I can feel it buzzing around in me…*

*10.30am: Anxiety isn’t as palpable, but I could still feel its effects in the session with [resident]. It was hard to focus…*

This practice did not prevent anxiety. Instead, externalising these thoughts helped me hold these feelings and validate my emotions. I also used reflection to explore how I conceptualised music therapy. My supervisor offered novel ways of thinking about my role as a student music therapist, suggesting that being a music therapist is:

*… a career rather than a job. Something you do your entire professional life/ passion…*

This prompted me to reflect on how I’d previous thought about the profession. Seeing music therapy this way implied a long-lasting and continual process of development rather than a job we simply show up for. This re-framing helped me relax the unrealistic “I should be able to” standards I had for myself.

### Boundaries

Earlier in my learning, I avoided using the word ‘client’ after learning about the connotations such language can have in creating power divisions within the therapeutic relationship (McFerran, 2021). Unexpectedly, this opened me up for dissonant experiences. For example, I experienced a very distressing countertransference following a one-to-one session due to a lack of therapeutic distance between the participant and myself. My mental health plummeted, and I found myself dissociating frequently in my personal life. The duration of this challenging episode encouraged me to reflect deeply around my boundaries. I realised that a level of distance in the therapeutic relationship is needed, and that ultimatums are not helpful. I began to understand the contextual nature of boundaries, and the nuance within them. I reflected:

*… “client” helps provide some needed distance as I continue to learn how to manage boundaries effectively. Is McFerran’s (2021) argument too black and white?*

As placement continued, I naturally gravitated to the words “residents” or “participants,” feeling they provided a comfortable level of distance, without forgoing warmth within the therapeutic relationship. Reflections around distance also prompted me to consider how I might detach from music therapy at the end of the day. I learned that it is possible to unintentionally take aspects of our work home with us. My practice supervisor encouraged me to think broadly, and suggested I think:

*… about my* [name] *badge as a ‘uniform’/ I’m on duty/ working/ therapist hat on*

# Discussion

## Towards Accountability

Power and oppression manifest in different ways in and around music therapy. It can appear in the language we use to describe and conceptualise the people we work with, which can be a product of unchecked biases. For example, language plays a role in how we think about the world around us and create meaning and beliefs (Drewery & Monk, 1994). Thompson (2022) suggests that music therapists are responsible for shaping the narratives of our participants' experiences of music therapy and this inherently affords us a great deal of power. Thompson (2022) notes further that pathological/ deficit-based language (i.e. suffering from, burdens, issues) are still present in the literature, and adherence to such language acts as a “mechanism through which clinicians assert their perceived expertise” (Low et al., 2022, p. 482).

Music therapists are not immune to personal bias (Hahna, 2017), nor are we “automatically given the title of ‘ally’ [or] display ally behaviours and actions unless we have taken considerable time working on self-awareness, education/ training…” (p. 259) around our positions in systems of power and oppression (Oswanski & Donnenwerth, 2018). In this sense, accountability in music therapy spaces is the act of critical reflexivity. Being reflexive about how our various identities position us throughout different environments provides pathways for music therapists to develop self-awareness surrounding their privileges or unchecked biases. This asks us to own up to parts of ourselves we’d much prefer to keep hidden. The intention behind this is not to diminish ourselves or engage in negative self-talk, but rather critical reflexivity allows us to think about the difficult aspects of our work in generative ways “… so that an inclusive and respectful agenda for music therapy [can] evolve (Pickard et al., 2020, p.11).

## Our Minority-Selves and Self-Compassion

Music therapists can experience subjugation through microaggressions directed at their minority identities. Reflecting on how we may be triggered by these experiences is confronting. However, engaging reflexively may lead to rich insights and ultimately deepen the therapeutic relationship (Goedert, 2020). In addressing our triggers, ideas around self-compassion are important.

Musical holding and attunement are associated with how we as music therapists relate to our participants. Bunt and Hoskyns (2002) suggest the image of a parental figure holding a young child in ways that are “non-invasive and finely balanced” (p. 40). When directed at ourselves, holding can provide a steady foundation upon which we can build compassion for ourselves. ‘Self-attunement’ is described as the action of tuning in with our internal thoughts and emotions (Koloroutis, 2014), and shares similarities with mindfulness practices which advocate for non-judgmental, patient, and kind attitudes towards ourselves (Robertson, 2012,). Being able to tune into ourselves is perhaps the first step towards self-compassion, however, some elements of mindfulness may not fully translate to minoritized experiences.

Considering microaggressions, there is a fine line between being non-judgmental and downplaying their impact. With the growing acknowledgement of accountability, it is important to remind ourselves not to overcompensate for our privileges at the expense of own well-being. A non-judgmental attitude towards microaggressions asks that we separate our triggers from our personal history, which invalidates our subjective experiences of harm. Germer and Neff (2013) capture this beautifully, urging us that we “can’t ignore or deny your pain and feel compassion for it at the same time” (p. 2).

Self-compassion differs from therapist self-care, which usually refers to specific actions or practices that manage occupation stressors. Unfortunately, actions of self-care can be perceived as conditional, that it is earned and can only be practiced guilt free when we have worked hard (Hersh, 2022a). As described by Germer and Neff (2013) self-compassion is “simply compassion directed inward” (p. 856) and includes taking “the stance of a compassionate ‘other’” (p. 857). This gives us the impetus to hold ourselves with the same level of empathy as we would our participants. Self-compassion is not conditional. It allows us to handle ourselves, and all our intersectional identities “with as much care and tenderness as possible” (Hersh, 2022, p. 32).

## Towards an Intersectional-Informed Practice

Intersectionality can inform how we can navigate contradictions that arise in and around therapeutic interactions. This includes the experience of holding our privileged and minoritised identities simultaneously, as well as engaging with connecting and dissonant moments. For example, I had discussed my attempts to rationalise the racial microaggressions I received from residents as their way of making connections and overcoming barriers to socialisation in ARC contexts (Bogati & Pirret, 2021; Boyd et al., 2021). In this context, I was asked to acknowledge the residents’ experiences with isolation and loneliness while simultaneously attempting to navigate my own oppression. For a long time, I was unable to articulate these contradicting experiences, however, intersectionality provided useful ways to frame these experiences, as it “exposes the complexity of social life, including simultaneity of oppression and privilege for *all* social actors” (Grzanka, 2020, p. 249). Thus, intersectionality allows us to live within complexities and acknowledge that they can co-exist. It is possible to take accountability for our privilege and practice self-compassion at the same time. Transformative justice and disabilities advocate, Mia Mingus (2019) captures this eloquently:

What if accountability wasn’t rooted in punishment, revenge or superficiality, but rooted in our values, growth, transformation, healing, freedom, and liberation? What if the work of accountability was held as so supremely sacred, that people who got to practice it – truly practice it – were considered lucky. (Mingus, 2019, paragraph 8)

Herein lies the usefulness of self-compassion, such that it permits us to practice accountability without guilt. It suggests that being accountable can be something beautiful, rather than punishing.

# Limitations

Autoethnographies draw from the researchers subjective experiences, and for some, this raises concerns surrounding generalisability and how the findings can be applied to other contexts (Méndez, 2013). Ellis et al. (2010) identify concerns around informed consent and how others can be unknowingly implied in the research. To ensure confidentiality of those implicated, the researcher needs to remove any identifying information pertaining to the individual or interaction, however, this can compromise the essence of the cultural phenomena in question. Concerns of self-disclosure are also worth discussing. I shared experiences of racism and generational traumas; I acknowledge that this may be triggering for some and cannot predict how reading these experiences might impact the reader. It is important to balance oversharing while not censoring lived minority experiences.

# Conclusion

This research presents the importance of critically and reflexively engaging with our intersectional identities. The findings illustrate that our identities appear in every action we take during music therapy and in every interaction with our participants. Awareness of the way in which they position us within systems of power and oppression is essential. Music therapy is not a neutral space, void of systemic pressures and oppression. Acting as such erases and invalidates our participants’ lived experiences with subjugation. The same can be said for our minority identities as music therapists, where denying our pain or overcompensating for our privileges does more harm than good. As music therapists, it is necessary that we practise critical reflexivity to reveal how we occupy systems of oppression. It is important that this act is not punitive, and that we show compassion to ourselves.

This research is my declaration “I am here” and was done “in the spirit of centering the margins” (Davies, 2022, p. 17). By bringing attention to underrepresented voices, a space is created where minority realities can be validated. Witnessing others with shared or similar life experiences can be empowering and show us that we’re not alone in our struggles. This “can nourish you on occasions when you need something other than food to keep you going” (Bochner & Ellis, 2013, p. 3).

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1. It is important to acknowledge that I did not directly reference Te Tiriti O Waitangi and have instead referenced a document written by Te Herenga Waka, Victoria University of Wellington. At this point in my learning journey as a music therapy student conducting research within an academic context, this document felt sufficient. As I continue my learning, I recognise the colonial nature of this reference and would choose to refer to Te Tiriti directly. [↑](#footnote-ref-1)