



# Paths of Professional Development in Music Therapy: Training, Professional Identity and Practice

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## ABSTRACT

Music therapy is listed as a profession in the EU Regulated Professions Database. This has assisted the next steps towards recognition in relevant countries and regions. The author's experience as an academic leader in music therapy training over more than two decades is used to reflect on the profession of music therapy within Europe through interrogation of concepts underpinning professional identity, training, and professional practice. Potential tensions between recognition and regulation of healthcare professions are presented and discussed. As all practice takes place in context, balancing training needs between techniques and skills, systemic national and regional policy, and institutional knowledge is crucial. Achieving this balance is not easy but is key to successful growth of practitioner knowledge, seeding student's curiosity about context and systems from the dawn of training.

## KEYWORDS

music therapy training; university contexts; music therapy trainers; music therapy students; professional regulation

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## INTRODUCTION

Music experiences are a human right. Article 27 of the Universal Declaration of Human Rights states that "Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits". For many of the people music therapists meet every week, music is not so much a right as something that either pounds in the background

through their care routine, or is provided to them through headphones by a carer who means well but may not have any idea of the benefits or disadvantages of what they are doing. To introduce music therapy is to provide an evidence based service which acknowledges the client's humanity and their capacity for musical engagement along with their right to share in the cultural life of their society. To maintain and develop music therapy disciplinary expertise, statutory recognition of the

profession across Europe and in each country where music therapy credentials are available is a worthy ambition.

This paper examines some of the ways in which becoming a good enough practitioner in music therapy occurs at multiple levels. This *becoming* occurs at an individual level with the student's process and learning, at an interpersonal level with the dynamic between students as a group and in collaboration with their trainers, and at a wider meta-systemic level that includes the training provider institution – usually a university – the management and department in which the music therapy training programme is housed, and the external regulating procedures of the state structures and the professional body. Narrative reflections on these aspects of training, professional identity and practice are provided from the author's experience of full-time academic appointments since 1993, participating as course leader, guest professor or research scholar in music therapy training programmes in Ireland, Germany (Berlin), Scotland and Australia, and in various roles including as an invited guest lecturer in other German music therapy trainings and for programmes in Austria, Norway, England, Australia and the USA. Additionally she has extensive university leadership and management experience in a range of roles at the University of Limerick including as Associate Dean for Research, Director of Psychology, Director of the Clinical Therapies Development Unit, and as an elected professorial member of the Board of Governance.

## PROFESSIONAL IDENTITY IN MUSIC THERAPY

In Cameron's (2014) reading of multiple accounts of music therapy he described encountering rampant social status anxiety. He presented this anxiety as belonging to the ubiquitous reporting by music therapy authors of being *undervalued* and *under-recognised*. Ledger's research about music therapy development in healthcare contexts also revealed similar experiences of professional music therapists in healthcare, and published accounts of the experiences of other allied health practitioners and nurses reviewed for the research also reflected this theme (Ledger 2015). The author has had experience in evaluating allied health students' final project work in which concerns about other professionals' perceptions of their lack of credibility appeared.

Cameron's commentary is reflected on throughout this essay. He wrote,

“Speaking openly, I would suggest that the issue with music therapy from a disability studies perspective relates precisely to its concern for recognition as a credible clinical practice. In other words, the things that music therapy aspires to in order to be recognised as a serious clinical profession are the very things that make it (from a disability studies perspective) a questionable enterprise. It is not that I believe music therapists are not good or well-intentioned people but that, in supporting a medicalising, individualising, normalising ideology, I believe they are complicit in the oppression of the very people they intend to help” (Cameron 2014: conclusion, para. 2).

In the profession of music therapy credibility is a credo. This is revealed in the frequent mention of *recognition* in music therapy and related writing (for example, Krout & Tischler 1986; Reschke-Hernández 2011; Waller & Guthrie 2013), with many authors making reference to the immense efforts made by music therapists in attaining professional recognition (for example, Register 2013; Waller & Guthrie 2013). The search for mainstream acceptance in music therapy could be perceived through a critical feminist lens as belonging to middle class preoccupations of security and personal wealth. Writing about healthcare professionals, Finlay noted,

“New groups strive to professionalise as part of a dynamic process of advancing claims to expertise, political power and/or formal status” (Finlay 2000: 73).

Occupational specialism, or professionalism, serves the needs of a class oriented society in which all work has the function to promote the attainment of profit and the maintenance of inequality between social groups (Finlay 2000).

The need for credibility in the healthcare services belongs, in Kuhlmann's (2006: 617) words, to “a male body...serv[ing], most of the time, the interests of white, male actors from the upper and middle classes”, particularly in the profession of medicine. Professional groups with high numbers of females, such as music therapy and nursing, and in groups which are aligned with medicine but not sharing diagnostic and pharmacological treatment responsibility, continue to seek to attain credibility through similar processes and means as the medical profession.

Keeping some people *in* and some people *out* of an inner circle can sound as if one is referring to behaviour within a school playground, but the maintenance of professionalism is upheld by this principle. Finlay (2000) used Weber's idea of *social*

*closure* to describe how professional healthcare groups form and create impermeable borders by regulating, credentialing and creating organisations which oversee and legalise accreditation, registration and training. Waller and Guthrie (2013) questioned the inherent requirement of commitment to homogeneity of practice which can be hidden within the process of regulation;

“[...] to ask a group aspiring to statutory regulation to demonstrate that it is homogenous, has reached maturity and seeks social closure is to infer a hierarchical, fossilised structure, out of keeping with the individualist, diverse and sometimes radical traditions of the psychological therapies” (Waller & Guthrie 2013: 11).

The narratives that guide the impetus towards regulation and recognition are commonly framed in terms of protection of the patient from unruly, unregulated and, supposedly therefore, *dangerous* practices.

If professional work must be reliable, well paid and provide social status, or at least protect from status anxiety, then achieving the goal of professionalism can potentially be confining, creating a position from which there is too much at stake for music therapists to be able to negotiate, bargain, or build capacity. Reflection on the power dynamics of the context in which our services are provided necessarily becomes limited as anxiety provoking questions can arise as to the viability of our contract with the state – the source of our financial security. In order to have pensionable and secure work as music therapists we need patients, service users and clients; people who want and need music therapy, and have access to the services we provide. In turn music therapists are required to dutifully reiterate tropes about the beneficence and appropriateness of services, with the goals of the state often unwittingly embedded in these rationales (Edwards 2011).

If music therapists strive to be credentialled and recognised then this endeavour must take place within a critical sensibility of how the wider healthcare system functions as an arm of state control. Finlay described this function of healthcare professionals from a Marxist perspective;

“[...] professionals are seen to act on behalf of the capitalist state by individualising social problems, and suggesting that individuals are essentially responsible for the plight in which they find themselves [...] [which] shifts attention away from the structural inequalities” (Finlay 2000: 83).

Within professional supervision, peer support and team meetings, ways can be found to critique the healthcare system as well to consider issues arising in *the case*. It is only by this critique and reflection, as well as the inclusion of service user perspectives, that changes by which all stakeholders benefit can be promulgated.

Training courses can also demonstrate for students how to engage in this dialogue and to become part of the conversation with the caveat that care must be taken that students are prepared for feelings of discomfort and perhaps even stress that unfamiliar dialogues can evoke. Being explicit with students about the reasons to encourage group discussion and the need to be heard and to share within the group context, includes explaining that such conversations are a preparation for testing ideas in future professional contexts such as team meetings and also with service user groups and carer support contexts.

## PROFESSIONAL PRACTICE

The author has sometimes asked students to think about Crow's observations of the provision of *therapy* to people who are disabled.

“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” (Crow 1992: 4).

In meeting with the client, we are available to listen to their story, acknowledge and enjoy their capacities, and appreciate with them a space in which musical sharing can occur. But we also meet them within a system that needs to be navigated, and where necessary its maintenance of inequality challenged and critiqued. As the author has remarked elsewhere

“It is increasingly clear that the therapist is not the benign *helper*, but rather an active being who is undertaking a social and political work. First, this occurs because the helper believes that by belonging to a particular professional occupation and orientation, s/he is capable of prompting and supporting change in others. Second, by believing that such interventions are necessary, required, and helpful the helper is obliged to take particular actions. When the authors write about these interactions and experiences in music therapy we are not separate from them, but

rather are actively engaged in their construction, interpretation, and consequently their meaning” (Edwards & Hadley 2007: 202).

A disability studies perspective to music therapy, such as that shared by Cameron (2014), is welcomed with the caution his commentary must be received critically, not as some remote observer’s truth. However, his commentary lacks reference to the fact that music therapy practitioners navigate a system, and music therapists may find it difficult to experience agency themselves in trying to change the system for the better, especially when hourly sessional or part-time services are the only opportunities available to them. As Verloo has argued in relation to the development of European policies that seek to mitigate discrimination,

“Inequalities are found in both the public and private spheres. They are reproduced through identities, behaviours, interactions, norms and symbols, organizations and institutions, including states and state-like institutions” (Verloo 2006: 224).

If we are not prepared to challenge inequities in the systems that provide services, we run the risk of fulfilling Cameron’s observations of our complicity with the perpetuation of inequality. If the provision of music making opportunities for people who are disabled needs to be justified in terms of beneficence only in relation to individual symptoms or functional limitations rather than human rights and capacity building, then music therapy risks conforming to oppressive and silencing practices that align with state control of the non-conforming body. In order to avoid the continued reproduction of inequalities, music therapists might not be able to have it both ways – to achieve *recognition*, along with its conjoined twin of being regulated by the state – and to protest the inequality forced upon many people by the state’s policies and practices whether overt or covert.

A potentially hidden aspect of music therapy work, which may not be immediately obvious to other allied health professionals or others commenting on music therapy’s role and efficacy, is that music therapy work is often provided to clients experiencing multiple vulnerabilities across various domains of functioning (such as social, psychological and communication), while they may also be coping with the additional challenges of their illness or diagnosis. Some of our published case material reveals that music therapists are referred people who have complex histories and needs (Drake 2011; Edwards & Kennelly 2011),

and who additionally are sometimes experienced as *difficult* by members of the team. Comparator case referrals against those made to other members of the team are not available, but would be a useful process by which to test this observation. In the author’s experience the referral to music therapy might be made because the client or patient evokes anxiety in the referring practitioner who is unable to help. To soothe this anxiety music therapy is recommended, perhaps because it is better to be able to do *something* than to leave the patient with nothing, which would additionally leave the practitioner’s anxieties unattended.

The processes by which professional regulation is managed by the state would benefit from further critical reflection as more music therapy associations achieve recognition across Europe. For example, the UK’s Health and Care Professions Council (HCPC) is the regulating body for arts therapists. The webpage publishes allegations of misconduct claims in advance of hearings. If the complaint is not upheld nonetheless the person, whether a paramedic, an occupational therapist, or an arts therapist, has the ignominy of their name and notice of allegation being publicly available for four weeks. If any result is recorded, the entire allegation remains in full view even if some parts were not upheld.

One response to reading many of the HCPC allegations of misconduct is that it seems odd that a professional practice tribunal is used for such a wide range of behaviours including interpersonal issues between colleagues and students’ issues with lecturers. There must be workplace structures that exist for managing workplace bullying in a hospital, or dealing effectively with student concerns within a university. To be able to bring such issues to the fitness to practice context seems a long reach for the arm of the state into evaluating and disciplining the behaviour of individual healthcare professionals. While regulation should provide processes by which inappropriate professional behaviour can be disciplined, in general it is usual that this disciplining occurs where a client’s rights or needs have been compromised in some way, or the professional has broken professional boundaries in a way that is confusing for, or harmful to, the client.

The desire that some people are kept out by framing music therapy as a profession might have doubtful value if music therapists work within organisations that abdicate responsibility for providing solutions to certain situations. For example: when problems occur between a course



leader and students in a course accredited by a regulating body, or between professional colleagues in a healthcare site where supervisory oversight must have been lacking in order for such behaviours to be perpetuated. If the regulatory body is given responsibility for all work place behaviours of the professional, not just those that relate to their work with clients as a therapy professional, it seems possible that eventually non workplace behaviours might be presented as evidence to inform tribunal decisions.

## THE TRAINING CONTEXT

Music therapy training takes place in a context which has social, cultural, geographical and chronological/historical dimensions which benefit from acknowledgement. Course materials must be reflected upon and regularly updated. The university context provides a supportive environment for these aspirations. The library resources are usually rich, and colleagues are keen to share with and support each other. However, many changes have occurred in recent times and potentially not all of these developments will advantage small courses, such as music therapy, in the longer term.

The dynamic within student groups, and between students and faculty in a therapy training, requires attention and maintenance to ensure that parallel processes which might disrupt student's learning can be detected (Edwards & Daveson 2004), and that course learning and personal development are integrated within the trainee's experience across the course (Edwards 2013). However, the maintenance of an environment where psychological thinking can be developed and where students have the opportunity for personal development can potentially be compromised by the increasing service ethos of the European university project (Kwiek 2012).

Descriptions of the current higher education context include that it "abounds with a sense of crisis of funding, purpose and fears for its future" (Morley 2012: 354). Commentators have noted the increasing repositioning of higher education away from its functions as a social institution towards an industry (for example, Kwiek 2012; Morley 2001). Lynch (2010: 54) stated that "Over the last two decades universities have been transformed increasingly into powerful consumer-oriented corporate networks, whose public interest values have been seriously challenged". The shift within many parts of Europe from the sector valuing the university as a public institution contributing to

public good, towards a more commercialised and competitive entity, impacts healthcare trainings offered in universities in several ways but none more so than the shift in ethos towards the student as customer.

## THE MUSIC THERAPY STUDENT

While new courses of music therapy, or the revamping of existing courses, may help music therapy's revitalisation, it could be that we also need to imagine new student roles and identities, new institutional frameworks, and to expand the types of academic practitioners that are employed to teach. This can potentially bring some aspects of European music therapy training into a more vital self-reflective criticality, in order to provoke and engage a new phase of development.

Rizq stated in relation to psychotherapy training that, "the teaching of therapeutic skills demands extremely close attention to the student's personal experience and how his or her subjectivity translates into clinical work" (Rizq 2007: 290-291). The curiosity of students and their capacity for self-reflection needs to be encouraged within a context that can support them should they be overwhelmed by what they find when they examine anew their past history, their current psychological state and their original impulse for undergoing a music therapy training.

In a study of 12 counselling psychology trainees over a three year period (Rizq 2011), it was found that only half of these candidates had secure attachment as recorded by the Adult Attachment Interview (Main, Goldwyn & Hesse 2002). Rizq concluded that if the field of counselling psychology attracts the same proportion of insecurely attached adults as are found in the general population, it is necessary for professional bodies to determine how trainings can ensure processes by which "trainees can harness these experiences and [...] transform them into effective work with clients" (Rizq 2011: 365). However, it has been noted that where professional bodies require engagement with personal growth opportunities; such as that provided through individual psychotherapy, it is not always possible for universities to mandate these activities (Edwards 2013). Rizq's results must be interpreted with caution because of the small number of participants. Nonetheless it is important to consider whether adults who have poor working models of attachment are able to be effective in providing relational therapy services to others. There is much more to be considered in relation to this topic. However, in essence, course teams

cannot ignore some student behaviour that is associated with insecure attachment, yet, in the contemporary educator role, feedback can only be provided through reflections on work submitted for assessment.

The focus on supporting the student's exploration and growth can be compromised in a service oriented university culture where the student is considered a client to whom the university provides a service. If a student becomes convinced that either the course team as a whole or an individual faculty member is responsible for their feelings of distress or vulnerability that arise in their self-development process, it can be difficult to address if management do not support the course team's view that the issue lies with the student's difficulties, rather than the student's unhappiness about aspects of the course requirements and teaching. Even if a course has no contemporary experience of this, there is always the risk as the service ethos continues to pervade that if a student is struggling and manages to create a coherent explanation of the demands of the course being at the heart of their distress, it is possible that course leaders will experience pressure from management to make course changes. Regular course reviews with outside experts not known to the music therapy team are helpful to ensure that the course frame is able to withstand the challenges of a student who is having such difficulties.

Although the situation with student upset described above is rare – the author can only think of a very few times when it has happened in more than two decades as music therapy course leader – if it does happen that students are upset and management do not support the course team's perspective, it can be highly disruptive and require a great deal of emotional labour to resolve from the course team and especially the course director. In psychodynamic terms, it can be useful to try to locate or hypothesise the source of tension between the course team and a student. For example, perhaps an unrealistic expectation of selfless mothering from the course director was not met and this then evoked for one or more of the students their previous experiences of the inadequacy of parental care or loss. It is not appropriate for the team to share this perspective with the student, but this way of thinking can help to be empathetic when a student is struggling or lashes out in some way. Where students can do the difficult work of reflecting on their current and past circumstances, and use the course team as a source of support for their own process of emancipation, it can be inspiring for all.

When students have the opportunity to experience themselves as more than a selfless deliverer of services to future clients, their exponential growth pathway can be valuable and exciting. Note this reflection by the educational philosopher Gerrard:

“[...] my teaching degree seemed to focus almost entirely on the micropedagogical dynamics of classroom interaction. It wasn't until my final year in 2002, when I embarked on a philosophical honors thesis, that with guidance from my supervisor I stumbled into what seemed to be a secret garden of educational literature. Finding critical and feminist pedagogy, I finally felt like my own interest in, and dedication to, education was reflected back at me [...] Starting with Peter McLaren, Henry Giroux, bell hooks, and Maxine Greene, I was thrust on a backward trajectory in an attempt to trace the genealogy of radical educational philosophy: from Paulo Freire to Antonio Gramsci, the social reconstructivists, and John Dewey. This treasure trove of education scholarship felt like a genuine discovery, and although aspects of this literature sparked in me many questions, some ambivalence, and even discontent, it felt as though I had found my 'kinfolk'” (Gerrard 2013: 183).<sup>1</sup>

As a music therapy educator, it is a source of profound joy to be able to facilitate students' learning so that they can have experiences of exploring theoretical and philosophical resonances that are personally meaningful and can lead to engaging metacognitive processes. By comparison a student who is not ready or able to do more than re-iterate their existing world view, or who experiences course requirements as distressing because they involve some form of inconvenience or discomfort can be challenging for the course team. More importantly, they can be considered at risk of not attaining or demonstrating the skills needed to be a future practitioner. Providing feedback to students about their thinking and behaviour is important. Gentle encouragement as to how they might recalibrate either their expectations, reflections, or understandings about

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<sup>1</sup> Although this description of discovery is charming and heart-warming, it is surprising that the supervisor is anonymous. If done unconsciously by the author, it raises questions about what might be frightening or anxiety inducing in acknowledging that one's work follows on from the support and inspiration of others. To anonymise these *others* is a type of silencing that should not go unremarked.

course requirements is necessary, and educators need to align these with future workplace expectations. Unfortunately sometimes student dissent as to the value of this feedback can have traction in the contemporary university in which responding to student needs and wishes is increasingly a central principle. Rizq (2007: 286) has suggested this is evidence of the *privileging of cognition over emotion* within the contemporary university culture. In her view, it can mean that

“[...] a psychotherapeutic team’s interest in and focus on emotional contact represents the institution’s ‘shadow side’, the feeling or relational aspect of its [the university’s] task that has been lost, disowned and located in a psychotherapeutic team. If this is so, I think we must expect universities to be highly ambivalent towards all such teams” (Rizq 2007: 291).

Rizq has described how this ambivalence leads to the risk that the team will be envied, denigrated, and/or marginalised, resulting in a position where team members are “unconsciously attempting to placate what is felt as an unreasonably demanding institution” (Rizq 2007: 293).

Developing a helpful and profession-ready collaborative approach between course team and students can, and should, extend past the period of the course. Graduates become practitioners, and the interpersonal dynamics of the course can unwittingly be brought forward into the professional terrain. In smaller countries, where music therapy is developing the processes of recognition, it is essential that the community of music therapists, including course trainers, is able to collaborate and move forward, ambitiously sharing and celebrating ideas as to how music therapy can flourish.

## THE MUSIC THERAPY COURSE LEADER

Small countries with small courses, or a sole small course, often have distinctive needs and circumstances that can differ widely between regions across Europe. However, music therapy training (whether large or small) shares with other healthcare trainings the requirement to understand and anticipate issues that can arise between all stakeholders; the professional body, students, management and other academic peers who do not have knowledge of therapy training. This work of reflection – a kind of emotional labour (Hochschild 2012) – is often the responsibility of one person holding the role of course leader who, in the author’s experience and observations, can find that

multiple sources of pressure are experienced including frequent requests for information and support from management, the student body, and the part-time or contract based staff appointments. All have needs that can be difficult to meet from one person’s resources.

Shaw (2006), a psychoanalytic trainer, considered that tensions that can arise between students and trainers are usually *power games* resulting from:

“1) the temptation to exhibit our superior expertise and power so as to invite idealization and defend against our own anxieties about inadequacy; 2) envy, competitiveness and the fear of being surpassed; 3) the need to be admired and to feel indispensable, along with the fear that we will be rejected; and 4) concerns about our reputation, especially in institutional situations” (Shaw 2006: 66).

Perhaps there is never only one source for the anxiety that can create tensions between course teams and students. However, in the experience and observations of the author, there is often an expectation that the individual course leader will take responsibility to hold and resolve any tensions that arise, especially if experiences of bringing in a perspective from management in the past proved to preclude a rapid or effective resolution. As the author has reflected elsewhere about a complicated situation at a university where a therapy training programme was eventually closed,

“[...] if management become involved sometimes it can be challenging to find a way through if the operational paradigm within the higher education institution is that the student, as consumer, has needs that must be heard but also be satiated. Also, if student concerns are perceived by management as *evidence* of problems with a training programme, or as a reflection of faculty member’s performance, then the possibility of being able to consider whether there are underlying issues for the student, or the potential for the student in their own personal therapy work being able to discover additional meaning of their dissatisfaction, can be almost impossible” (Edwards 2013: 117).

Student loyalty is considered a driver of student satisfaction and is influenced by students’ perception of the quality of services they receive (Helgesen & Nettet 2007), rather than by their evaluation of teaching quality or the perceived quality of the wider institution. In small courses, these services are required to be provided by one

or two people who are also the teaching academics and perhaps not particularly suited to or available for service support tasks. It would be interesting to study whether there are any notable differences regarding student experiences between European music therapy courses which have support for student queries provided from a range of sources, compared to those where all student support is provided from the academic team.

In all levels of the European university system, in spite of the frequent reiteration that academics compete with each other for positions or promotions on merit, there is a large body of research that disrupts these claims. For example, in “twenty-seven countries of the European Union, women occupy only 15 per cent of full professorship and/or tenured positions” (Fotaki 2013: 1251). A number of studies have pointed to the ways in which men are advantaged in European university appointment and promotion structures (Fotaki 2013; Özbilgin 2009; van den Brink & Benschop 2012). There is ample evidence that the supposed science of the university’s meritocracy serves to exclude and ignore women’s contributions and success (van den Brink & Benschop 2012). Avoiding collusion with this for both women and men can be challenging (Fotaki 2013) but learning about the structural inequalities embedded in the system is a useful starting point.

## THE MUSIC THERAPY COURSE

When opportunities for change, growth, or development are proposed, the ensuing anxiety can be potentially debilitating within a university system that is often conflicted as to its purpose and mission (Edwards 2014; Kwiek 2012). In such circumstances of *mission drift* easy metrics, such as student numbers, can be used as the bluntest of instruments to evaluate effectiveness and quality of courses. Music therapy courses have been described as *self-contained* in comparison to larger courses in which students have multiple subject options, or electives, and in which larger units or modules have multiple lecturers and tutors (Edwards & Gilbertson 2015). When searching for ways to make cuts, removing a self-contained programme can be attractive to management as it potentially involves the least impact on the wider school or department.

A small music therapy course can exist precariously in the contemporary university context. Management’s anxiety about whether the course is big enough to fund the positions needed to teach can be contagious. It can be a struggle to show that

music therapy is relevant enough, or unique enough, to support and maintain when wider economic issues within the institution are pressing, and where it is considered essential that courses are attractive enough to large enough groups of students/consumers in accounting for their worth. Smaller music therapy courses need supporters from outside and inside the university, and the course team to survive a threat of closure in economically bleak times. This effort to find and retain course champions can be somewhat hidden in the workload of the course leader. However, when downsizing of courses or course closure occurs, it is rare for this action to be perceived in terms of the university system but rather what the course team did or did not do, with special blame attributed to the course leader.<sup>2</sup>

As stressful as it can be to try to understand management’s anxiety, it also behoves the course team to reflect on the dynamics of the university context and to share, where appropriate, reflections on the functions of gender, power, marginalisation and values of the institution with students so that they can understand ways in which to consider broader social and political contexts for their profession and their work. The parallel processes of professional life, where one might be a sole music therapy practitioner in a large institution, can also be considered.

## CONCLUSION

The author has used the writing of this paper as an opportunity to reflect on the profession of music therapy and the contemporary movement within the field towards attaining increasing professionalism and state regulation. This paper also provides an opportunity to propose a European music therapy Heads of training meeting at least bi-annually if not every year. The group could develop working and position papers on a range of relevant topics, and provide peer support and sharing opportunities which are especially important for people new to this role. Themes relevant to multiple trainings could be scoped for working discussions in advance of the event.

As the European state increasingly becomes a regulator of healthcare services, rather than a

<sup>2</sup> It is not possible or appropriate to comment on music therapy course closures across Europe. Additionally, it is noted that some of this commentary is based on observations and experiences of small courses similar to music therapy that have been closed.



provider (Finlay 2000), music therapy groups seeking national recognition need to be aware of recognition's symbiotic twin: regulation. Music therapists may unwittingly see regulation as delivering only benefits and offering some final *full stop* in the process of being recognised. A more balanced view holds that the freedom of lack of formal recognition needs to be balanced against the potential confinement of regulation. As Waller and Guthrie (2013: 10) have suggested, it can be useful to view "[...] regulation as a potential (developmental) milestone, rather than as the only or end goal". To remain vital, interesting and relevant to service user needs, music therapy needs to constantly revise its parameters and intent, become renewed and elaborate further pathways of practice. The need for reinvention has never been greater, the ability to reinvent never more difficult to attain as we become more professionalised. If recognition is desired by professional associations of music therapy, it is important to ensure that the accompanying regulation can honour the dynamic and creative client-based practice and profession that we can be, rather than a conformist, or perhaps at worst *boring*, music based healthcare enterprise.

## REFERENCES

- Cameron, C. (2014). Does disability studies have anything to say to music therapy? And would music therapy listen if it did? *Voices: A World Forum for Music Therapy*, 14(3). Retrieved from <https://voices.no/index.php/voices/article/view/794>
- Crow, L. (1992). On our terms. *Women's Art Magazine*, 47, 4-6.
- Drake, T. (2011). Becoming in Tune: The Use of Music Therapy to Assist the Developing Bond Between Traumatized Children and Their New Adoptive Parents. In J. Edwards (Ed.), *Music Therapy and Parent-Infant Bonding* (pp. 22-41). Oxford: Oxford University Press.
- Edwards, J. (2011). A music and health perspective on music's perceived "goodness". *Nordic Journal of Music Therapy*, 20(1), 90-101.
- Edwards, J. (2013). Examining the role and functions of self-development in healthcare therapy trainings: A review of the literature with a modest proposal for the use of learning agreements. *European Journal of Psychotherapy & Counselling*, 15(3), 214-232.
- Edwards, J. (2014). Facilitating the highly bonded cohort: Should more be done to anticipate and reduce the potential for hyper-cohesiveness and deindividuation in therapy training cohorts in universities? *European Journal of Psychotherapy & Counselling*, 16, 114-126.
- Edwards, J., & Daveson, B. (2004). Music therapy student supervision: Considering aspects of resistance and parallel process in the supervisory relationship with students in final clinical placement. *The Arts in Psychotherapy*, 31, 67-73.
- Edwards, J., & Gilbertson, S. (2015). Exploring Resistance and Change in Music Therapy Learning. In K. Goodman (Ed.), *International Perspectives in Music Therapy Education and Training: Adapting to a Changing World* (pp. 219-241). Springfield: Charles C Thomas.
- Edwards, J., & Hadley, S. (2007). Expanding music therapy practice: Incorporating the feminist frame. *The Arts in Psychotherapy*, 34, 199-207.
- Edwards, J., & Kennelly, J. (2011). Music Therapy for Children in Hospital Care: A Stress and Coping Framework for Practice. In A. Meadows (Ed.), *Developments in Music Therapy Practice: Case Study Perspectives* (pp. 150-165). Gilsum, NH: Barcelona Publishers.
- Finlay, L. (2000). The Challenge of Professionalism. In A. Brechin, H. Brown & M. A. Eby (Eds.), *Critical Practice in Health and Social Care* (pp. 73-95). London: SAGE
- Fotaki, M. (2013). No woman is like a man (in academia): The masculine symbolic order and the unwanted female body. *Organization Studies*, 34(9), 1251-1275.
- Gerrard, J. (2013). Class analysis and the emancipatory potential of education. *Educational Theory*, 63(2), 185-202.
- Helgesen, Ø., & Nettet, E. (2007). Images, satisfaction and antecedents: Drivers of student loyalty? A case study of a Norwegian university college. *Corporate Reputation Review*, 10(1), 38-59.
- Hochschild, A. R. (2012). *The Managed Heart: Commercialization of Human Feeling*. CA: University of California Press.
- Krout, R., & Tischler, B. (1986). Hands across the water: Impressions of music therapy in England. *The Arts in Psychotherapy*, 13(2), 143-146.
- Kuhlmann, E. (2006). Traces of doubt and sources of trust: Health professions in an uncertain society. *Current Sociology*, 54(4), 607-620.
- Kwiek, M. (2012). The growing complexity of the academic enterprise in Europe: A panoramic view. *European Journal of Higher Education*, 2(2-3), 112-131.
- Ledger, A. (2015). Developing New Posts in Music Therapy. In J. Edwards (Ed.), *Oxford Handbook of Music Therapy*. Oxford: Oxford University Press.
- Main, M., Goldwyn, R., & Hesse, E. (2002). *Adult attachment scoring and classification system*. Unpublished manuscript, University of California, Berkeley.
- Morley, L. (2001). Producing new workers: Quality, equality and employability in higher education. *Quality in Higher Education*, 7, 131-138
- Morley, L. (2012). Researching absences and silences in higher education: Data for democratisation. *Higher Education Research & Development*, 31(3), 353-368.
- Özbilgin, M. (2009). From journal rankings to making sense of the world. *Academy of Management Learning and Education* 8(1), 113-121.
- Register, D. (2013). Professional recognition of music therapy: Past, present, and future. *Music Therapy Perspectives*, 31(2), 159-165.
- Reschke-Hernández, A. E. (2011). History of music therapy treatment interventions for children with autism. *Journal of Music Therapy*, 48(2), 169-207.

- Rizq, R. (2007). On the margins: A psychoanalytic perspective on the location of counselling, psychotherapy and counselling psychology training programmes within universities. *British Journal of Guidance & Counselling*, 35(3), 283-297.
- Rizq, R. (2011). Personal therapy in psychotherapeutic training: Current research and future directions. *Journal of Contemporary Psychotherapy*, 41, 175-185.
- Shaw, D. (2006). Narcissistic Authoritarianism in Psychoanalysis. R. Raubolt (Ed.), *Power Games: Influence, Persuasion, and Indoctrination in Psychotherapy Training* (pp. 65-82). New York: Other Press.
- UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III). Retrieved from [www.refworld.org/docid/3ae6b3712c.html](http://www.refworld.org/docid/3ae6b3712c.html)
- van den Brink, M., & Benschop, Y. (2012). Gender practices in the construction of academic excellence: Sheep with five legs. *Organization*, 19(4), 507-524.
- Verloo, M. (2006). Multiple inequalities, intersectionality and the European Union. *European Journal of Women's Studies*, 13(3), 211-228.
- Waller, D., & Guthrie, M. (2013). The sociology of regulation: The case of psychotherapy and counselling and the experience of the arts therapies. *British Journal of Guidance & Counselling*, 41(1), 4-13.

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