ISSN 2515-981X

This special issue follows the *Music, Well-being and Mental Health* Conference at York St John University in May 2018. The event was supported by the RMA, BFE, and NAHME

Music, Mental Health, & Wellbeing

Volume 1

James Williams
Caroline Waddington-Jones
Sarah Mawby
Emma Sharpe

Musicology Research Journal
Issue 6
Spring 2019

MusicologyResearch
The New Generation of Research in Music

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MusicologyResearch
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Acknowledgements

This volume is the first of a series of publications on the topic of music, mental health, and wellbeing. The papers in this Spring 2019 volume stem from a Call for Papers following the Music, Wellbeing, and Mental Health Study Day at York St John University in May 2018, supported by the RMA, BFE, and NAHME.

As principal editor, I would first like to thank Núria Bonet for arranging the study day event (across two days), of which there were many thought-provoking presentations and workshops. This volume of articles explores many of the themes and topics covered from the event, including perspectives on music and/in education, wellbeing, healthcare, and cross-cultural contexts. Secondly, I would like thank my Co-editors, Dr Caroline Waddington-Jones (University of Hull), Dr Emma Sharpe (University of Derby), and Dr Sarah Mawby (University of Leeds) for their time and effort towards putting this volume together. Thirdly, I would like to thank the seven contributing authors to this specific volume for their fascinating papers, without which this volume could not have happened. I also offer my thanks to all of the external reviewers who helped provide feedback as part of the double-blind peer review process – your expertise help to insure and uphold the academic rigour of our publications. My final thanks (last but not least) go to our newly-appointed Assistant Editor Asma Mohseni, who has helped incredibly with the copy-editing, proofreading, and typesetting of this volume. Your assistance on this volume has offered extraordinary support

to us as a team – thank you for such dedicated and committed time and effort.

Thank you all.

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Abstracts

Deligianni — Pregnant Women in Prenatal Music Settings: Moving from Research to Implementation Through a Literature Review

Various endeavors of sound and music stimuli provision during the prenatal and postnatal period seem to increasingly be under discussion among the academic world. However, the interventions that take into consideration the nature of the provided music stimuli and go beyond the typical transmission of the sound appear significantly scarce. In the paper below, the integration of music into organized prenatal experiences of communication and stimulation is under discussion. The development of antenatal music programmes consisted of qualitative and interactive music experiences are able to enhance the forming of a unique channel of binary interaction between the pregnant woman and fetus during the gestation period. The present paper places the pregnant woman in prenatal music settings and demonstrates, through a literature review, the need for further music interventional studies and implementations during the antenatal period. The presented data indicate a significant lack of related applications, while the limited

organized programmes report essential outcomes. Lastly, the proposal to create a prenatal music programme defines the principal objectives of providing rich music stimuli and experiences for the embryo and the pregnant women, while the utilized mediums are conducive to achieving an active and interactive structure.

Douglas — Music, Language and Mental Health: Music as Epistemic Necessity

Since Cooke (1959) defined music as a language of the emotions, the idea that music is a 'universal language' has become firmly established on a global vernacular level. And since the turn of the century, the importance of music to mental wellbeing (including 'recovery') has found increasing favour. In addition to qualified music therapists, more and more music-makers without formal clinical training are involved in clinical care settings as the 'Arts and Health' movement gains momentum. However, it remains the case that music-makers of all descriptions continue to conceptualise music in relation to language – to the extent that music remains a handmaiden of language even by those advocating for its importance (not least in the context of mental health). More recent research in music therapy has endeavoured to position music on its own terms, but for the most part what has been produced are not arguments for the singular importance of music vis-à-vis language, but sequences of often-unsubstantiated statements.

This paper is an introduction to a new phenomenology of music and mental health that argues for music as an 'epistemic

necessity'. Because of the inherent structural limitations of language, not all forms of human capacity 'to know' can be effectively brokered and circumscribed by language. In drawing upon a wide range of disciplinary areas and being grounded in non-abstract realities, it paves the way for a new way of understanding of the importance of music to self-realisation (and thus cognition beyond emotion).

Hachmeyer — The Uncontrolled Equivocation of Music Therapy: Health, Illness and Musical Healing Among the Kallawaya in the Northern Bolivian Andes

Kallawaya are Indigenous healers from the Northern Bolivian Andes, internationally well-known for their herbalist medical tradition and ritual healing practices. Kallawaya music, especially their signature genre *qantu*[1], has lately been evoked as music therapy in different national and international contexts. Drawing on recent debates about ontological perspectives in anthropology, the article discusses Kallawaya music therapy as an 'uncontrolled equivocation' in the sense of Viveiros de Castro (2004), which is defined as a 'communicative disjuncture where interlocutors are not talking about the same thing'. The article proposes a place-based understanding of music, chant and sound in Kallawaya healing grounded in animism as ontology or 'mode of identification' (Descola, 2013). It is argued that healing practices are always embedded in ontological realities, in which they make

[1] I use the grammatical form used by my host in Niñocorin, the *yachaj* Feliciano Patty. Other forms are *Khantu*, *Kantu*, *Qhantu*, *K'antu*, etc. He relates the word *qantu* to a local flower with the same name (*Cantua boxifolia*).

sense. The focus on the body in Kallawaya healing has to be related to the prevalence of animist/perspectivist ontological premises, where the body is the central locus of perspective, difference and relationality. This differs, to certain degree, to modern (naturalist) notions of clinical music therapy where the mind is the centre and mental health the ultimate goal of music interventions.

Haddon — University Music Students: Mental Health and the Academic Supervisor

This study explores music students' perceptions of the role of the academic supervisor in supporting students' mental health. Data from students at a UK university indicates complexities relating to the supervisory role including quality and boundaries, students' expectations and awareness of effects on supervisors of providing support, and views on responsibility for mental health. Issues of communication, roles, agency and departmental culture are identified as concerns worthy of further investigation and institutional support.

Hawley, Humphreys, & Ramachandran

'Making music in the wards felt like lifting off a grey cloud and letting in a ray of sunlight': Emerging Findings from Medical and Music Student Experiences of Train with Hospital Musicians

Learning alongside professional musicians as they work on hospital wards offers medical and music students opportunities to explore new approaches to communication where music making is central to learning and reflection. It is not uncommon for these students to experience performance anxiety pressure during study, as emphasis on technical competence becomes heightened. Musicking during visits to wards encourages a reconnection with self, as focus shifts away from perceived pressures of institutionalized training towards a musically responsive and personalized approach to interaction and communication, embedded in acts of sound creation and shared listening. Through experiencing music making in hospital wards, music students make discoveries about musicianship, as they learn to find new ways of sound making on their instruments, and use body, voice, and percussion to improvise and interact with patients and fellow musicians. Medical students, familiar to some extent with the clinical environment, discover new approaches to bedside communication, developing skills in nonverbal interaction with child patients, and building an awareness of the value of a holistic approach to patient care. In being exposed to patients, family, and staff *through* music, these students are not only learning techniques of music making specific to the hospital environment; music 'in the moment' becomes key to increasing confidence in performance and communication, supporting increased wellbeing and resilience. Using feedback we have gained during Lime Music for Health training programmes delivered in partnership with The University of Manchester Medical School and the Royal Northern

College of Music we will examine the benefits of these experiences and discuss why such opportunities are an important component in supporting student wellbeing.

Lansley — The Inclusive Classroom: Mental Health and the HE Musician

This wellbeing-based study explores the use of next generation technology in developing more inclusive learning environments for students who struggle to engage with curricula due to mental health and well-being issues. This investigation took place as part of an action research project that challenged music and non-musical specialists in a creative context to co-create adapted lecture materials.

The development of teaching materials with six autistic students made use of both the dynamic environment of a learning management system as well as the role mobile devices play in allowing students to access materials in a virtual environment. This was done with the aim to remove or reduce some of the obstructions that were identified that could be faced by learners who found accessibility, comprehension, collaboration or socialisation difficult when approaching creative work. The findings critically comment and evaluate the practical merits in response to a review of current literature, module evaluations and qualitative commentary on the experiences of students.

This study has been inspired from my own experience as an autistic learner and the barriers I have faced in engaging with group work and through travelling the world performing music in challenging and ever-changing environments. It is hoped that this research is able to offer a meaningful perspective to the

current conversations around wellbeing of the creative learner and associated educational strategies, acknowledging the primary goal of this project was to directly benefit those students who had participated in it. As last years' 'Fit to Perform' paper concludes 'music educators, administrators and policy makers must play an active role in providing supportive environments where health and wellbeing is considered integral to expert music training.'

Shihabi

Depression in Higher Education: Shame, 'Courage' and Making the Political Personal

After experiencing anxiety, panic attacks, and bouts of depression throughout my Higher Education career, I began conducting research on the topic of mental health and wellbeing. With YouGov UK revealing in 2016 that 'one in four students in the UK suffer from mental health problems' and the IPPR (Institute for Public Policy Research) reporting that the number of student suicides increased by 79 percent between 2007 and 2015, it is apparent that mental health and wellbeing issues in Higher Education are on the rise. This paper includes an autoethnographic sketch of certain themes relating to depression and mental health that emerged during my PhD journey thus far. Informed by a social constructivist theoretical framework, I have applied an autoethnographic methodology and analysis, which provides an interpretation of the self-narrative within and outside the context of socio-cultural surroundings of two cultures. A concomitant critical discussion on the concept of 'shame', how society defines 'courage', and the potential of making the political personal is also included.

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1

Music, Mental Health, and Wellbeing in Context

Caroline Waddington-Jones and James Williams

1. Overview

This volume of papers is the first in a *Musicology Research Journal* series on the topic of music, mental health, and wellbeing. The call for papers for the issue stemmed from a study day and workshop day held at York St John University in May 2018, supported by the Royal Musical Association (RMA), the British Forum for Ethnomusicology (BFE), and the National Associate for Music in Higher Education (NAHME). With the issue of mental health propagating through the media, and growing reports of increasing mental health concerns, it seems important to consider the role of the creative and performing arts, (and in

this case specifically music) in this context. Discussions on the topic of wellbeing are equally important; that is, to consider how music can function as a tool to support and improve peoples' day-to-day stability as a preventative measure against mental health difficulties. Finally, it is vital to consider the mental health and wellbeing circumstances of individuals engaging with music both at student and professional levels: many of the studies cited in the volume refer to the rising number of poor mental health and wellbeing cases in music schools, conservatoires, and other Higher Education Institutions (HEIs). These three considerations sat at the crux of the call for papers for the RMA, BFE, and NAHME event in York:

> Individuals and communities' wellbeing and mental health can benefit from musical audition and performance. Conversely, we are becoming increasingly aware of the physical and mental challenges that music professionals from all areas face. These can be further accentuated when considered in a high-pressure environment such as academia. This event proposes to bring together researchers and practitioners to share their research on positive and negative effects of music and music making. It also aims to offer a space to discuss related issues affecting these communities. […] Workshop[s] will be an opportunity to share and establish strategies to protect and improve their wellbeing and mental health.

The initial topics offered included music and silence for wellbeing, music and silence for mental health, negative effects

of music and silence on physical and mental health, music and citizenship, Music and communities, wellbeing for musicians, mental health issues in music, wellbeing in HE, and mental health issues in HE. The study day involved a number of discussions mainly pertaining to music and mental health in two contexts: firstly, applied/practical uses in a range of settings, including language, therapy, and healthcare (including phenomenological approaches in medical anthropology such as healing and cross-cultural perspectives); and secondly, in education settings (including topics on University music students [and staff], autoethnographic and reflective studies of student musicians, and technology). Both in response to this these topics of conversation and to the subsequent *MRJ* Call for Papers, this special issue aims to extend and expand the discourse on these two contexts.

2. Introduction

Since ancient times, humans have been fascinated with how to live a good life, with prominent thinkers such as Aristotle arguing that wellbeing is the overarching purpose of all human actions (Aristotle, 2004). In recent years, there has been a renewed research interest in wellbeing, as people seek to learn how they might lead healthier and happier lives. Alongside this growing interest there has been much debate over how to define

wellbeing, with researchers broadly conceptualizing two dimensions: subjective wellbeing and psychological wellbeing (e.g., Deci and Ryan, 2008; Diener et al., 1999; Proctor et al., 2009).

Our modern conceptualization of subjective wellbeing is rooted in the utilitarian hedonist philosophies of John Stuart Mill and Jeremy Bentham who both argued that pleasure is central to wellbeing. This dimension of wellbeing primarily concerns our subjective judgments of how satisfied we are with life (Diener, 1984) and emphasizes high positive affect and low negative affect (Bradburn, 1969; Kahneman et al., 1999). Subjective wellbeing involves the pursuit of happiness and is based on the principle that the more positive emotion we experience, the happier we will be (Seligman, 2002). By contrast, psychological wellbeing has emerged from Aristotle's concept of *eudaimonia* and accentuates positive psychological functioning and human development (e.g., Rogers, 1961; Waterman, 1993). Various dimensions of positive psychological functioning have been proposed, including how we relate to other people, how independent we are, how we engage in various experiences, and how we find meaning in our lives (e.g., Ryan et al., 2008; Seligman et al., 2005). More recently, positive psychologists have suggested that in order for humans to flourish fully, a balance of the elements of both subjective and psychological dimensions of wellbeing is

required (Peterson et al., 2005; Seligman, 2010; Sirgy and Wu, 2009).

With regard to definitions and use of terminology in this volume, it should be noted that authors provide complementary and sometimes competing understandings of central terms and concepts, including 'wellbeing'. There are two spellings for this concept: 'wellbeing' and 'well-being'. Whilst both terms may be used to describe the kind of flourishing described in the previous paragraphs and some disciplines, notably philosophy, still commonly use the latter form of the word, the editors have encouraged the use of 'wellbeing' within this volume. This is primarily to avoid confusion between wellbeing as human flourishing, and well-being as the opposite of ill-being. As the term garners more and more interest in academia and beyond we expect that the use of the hyphen may disappear entirely with reference to wellbeing as human flourishing.

With the current emphasis on health promotion, there is heightened interest in the therapeutic benefits of musical engagement (see e.g., Coulter and Gordon-Nesbitt, 2016). In the UK, for example, there has been a movement toward social prescribing, which advocates for participation in arts-based activities to enhance wellbeing. Several studies have highlighted

the positive relationship between musical engagement and both subjective and psychological dimensions of wellbeing. Researchers have considered how musical engagement may increase positive affect (e.g., Juslin, 2013; Van Goethem and Sloboda, 2011), offer opportunities for deep engagement (e.g., Dietrich, 2004; de Manzano et al., 2010), connect us with other people (e.g., Ballantyne et al., 2014; Koelsch, 2013; Rabinowitch et al., 2013), bring a sense of meaning or purpose to people's lives (Frith, 1996; Hays and Minichiello, 2005), and result in a sense of accomplishment (e.g., Hiscock et al., 2013; Waddington-Jones et al., 2019). Musical engagement, therefore, has great potential to contribute positively to multiple dimensions of wellbeing.

The seven papers of this volume are organized into two main areas of enquiry. Part One (Music, Mental Health, and Wellbeing in Practice), focuses on music applications in three diverse settings: firstly in language; secondly in ritualistic and place-based healing; and thirdly in prenatal settings. Part Two ('Music, Mental Health, and Wellbeing in Education') considers how higher education institutions and teachers can support music student wellbeing through a variety of means, including interdisciplinary collaboration, strengthening support structures, developing and promoting inclusive practice, challenging

attitudes, and placing the student voice at the centre of higher education practice.

3. Part One: Music, Mental Health, and Wellbeing: Practical Considerations

Following this introductory chapter, the second chapter of this volume, written by Alexander Douglas, argues for new phenomenological readings of music and mental health, making the case for music to be viewed as an 'epistemic necessity). In doing so, Douglas draws attention to 'unregulated assumptions' about language and music (especially in the context of clinical care settings), rejecting Pinker's (1997) reading of music as 'pleasure technology' and 'auditory cheesecake', and Kivy's (2008) argument for 'absolute music' lacking any 'epistemic moral force'. In his argument, Douglas states that mental health 'is about more than emotional stability', and that music 'deserves better than a technically-conceptually-underpowered verbal identity as a phenomenon of nothing more than the emotions'.

In the third chapter of the volume, Sebastian Hachmeyer moves the narrative on from epistemic considerations to more ontological perspectives. Specifically, Hachmeyer's text explores music and ontology in the context of the Kallawaya people in the Northern Bolivian Andes. Through discussing and recognising

their indigenous healing qualities, argument is made for their herbalist medical traditions and ritualistic practices in the contexts of applied music therapy. Hachmeyer offers a 'place-based' understanding of healing, and argues that a focus on the body 'has to be related to the prevalence of animist/perspectivist ontological premises, where the body is the central locus of perspective, difference and relationality'.

In Chapter 4, Sofia Deligianni reviews current research on the role of applied music in prenatal and postnatal contexts. Deligianni states that there is a lack of implementation of music intervention during prenatal phases, arguing for the integration of music into prenatal care. Further music-based interventions and research on the implementation of music in antenatal contexts is also advised. By reviewing the existing recent literature, Deligianni proposes a prenatal music programme in applied health care support.

4. Part Two: Music, Mental Health, and Wellbeing in Education Settings

Bridging the two parts of this volume, Chapter 5 ('Emerging Findings from Medical and Music Student Experiences of Training with Hospital Musicians') explores the perceived impact of an innovative module that brings together

conservatoire students, medical students, and professional hospital musicians on students' mental health and wellbeing. The authors, Rosalind Hawley, Julia Humphreys, and Shanath Ramachandran, outline the unique challenges to wellbeing faced by music conservatoire students, who may experience Music Performance Anxiety, and the physiological, cognitive, and behavioural impacts that these may have on their training (Matei and Ginsborg, 2017). Medical students too experience high levels of stress that can impact their studies and future career negatively (Dyrbye, et al., 2010). The authors explore music and medical students experiences of a new module that places music-making at the centre of learning and reflection. For music students, music-making during visits to wards encourages a reconnection with self, as focus shifts away from perceived pressures of institutionalized training towards a musically responsive and personalized approach to interaction and communication, embedded in acts of sound creation and shared listening. Meanwhile, medical students, familiar to some extent with the clinical environment, discover new approaches to bedside communication, developing skills in nonverbal interaction with child patients and building an awareness of the value of a holistic approach to patient care. In being exposed to patients, family, and staff *through* music, these students not only learn music making techniques specific to the hospital

environment; music 'in the moment' becomes key to increasing confidence in performance and communication, supporting increased wellbeing and resilience.

In Chapter 6 ('Depression in Higher Education: Shame, 'Courage', and Making the Political Personal'), Zaina Shihabi presents an auto-ethnographic sketch of themes relating to mental health and depression that emerged during her experiences as a doctoral student. This account provides an interpretation of the author's self-narrative within and outside the context of socio-cultural surroundings of two cultures: a somewhat 'Westernized' version of the author's experience in the Middle East, and one 'outsider's' experience of being an international postgraduate student in England against the backdrop of recent research surrounding international students and mental health. The chapter highlights current research around the experiences of both UK and international students in higher education and considers the barriers to accessing mental health support. The notion of 'shame' in particular is explored in depth, both socio-culturally and in relation to mental health support. Society's definition of 'courage' is also evaluated, with Shihabi arguing that the term can be problematic when used to characterise individuals who share their experiences of mental health difficulties due to its potential for creating division and

further barriers. Finally, the paper considers some of the growing evidence around staff experiences of mental health in higher education, ending with a call to change current attitudes towards mental health and support within the sector as a whole.

Continuing the theme of students' mental health and support, Chapter 7 ('University Music Students: Mental Health and the Academic Supervisor') by Elizabeth Haddon explores the perceptions of a sample of students from a UK university music department in relation to the role of the academic supervisor in supporting their mental health. The questionnaire data reveal complex perceptions of the supervisory role concerning quality and boundaries, students' expectations and awareness of the effects on supervisors of providing support, and views on responsibility for mental health. The findings indicate tensions between support provision and demand, supervisory capacity and ability to meet students' needs, boundaries, staff training, student awareness of the effects on their supervisors when providing support, and departmental and institutional developmental needs. Also highlighted is the importance of the student voice, which deserves greater representation in the ongoing discussions of mental health and wellbeing. Issues of communication, roles, agency, and departmental culture are

identified as concerns worthy of further investigation and institutional support.

The final chapter of this collection ('The Inclusive Classroom: Wellbeing and the HE Musician') focusses on the use of technology in addressing teaching and learning challenges faced by students diagnosed with autism spectrum disorder (ASD) in creative musical contexts within higher education. In this study, Andrew Lansley aims to develop more inclusive environments by removing barriers to accessing learning materials and engaging with group work. As Haddon highlights in Chapter 7, Lansley also emphasises the centrality of student voice here for the development of an inclusive learning environment. He outlines the process of development and the collaboration between teacher and learners in designing, integrating, and ensuring accessibility of content. This study offers interesting practical findings around layout and accessibility of VLE content, and colouration of learning resources in particular. The author provides some useful reflections around the implications for learner autonomy, engagement, and motivation. The insights into and reflection on the process of development provided here may prove particularly valuable as further advances in technology to enhance learning are made and greater emphasis is placed on inclusive practice in higher education.

As a whole, this volume is securely bound together by its overall theme of music, mental health, and wellbeing, yet clear overlaps and links exist across the two parts and between chapters. The diversity of perspective and methodology evident throughout the volume reflects the cross-disciplinarity of contemporary thinking about the subject. There is representation here from scholars working in the fields of music education, philosophy, ecomusicology, ethnomusicology, arts and health, and medicine. Much of the research presented in this volume offers exciting ways forward for shaping future practice and policy in the fields of music therapy, community music, and higher education, whilst also emphasizing the need for further exploration of topics around music, mental health, and wellbeing. It is hoped that this volume will inspire such research as well as encourage fruitful discussion among and between researchers, music practitioners, students, and professionals.

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Musicology Research
Issue 6: pp. 17-50

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Music, Language and Mental Health: Music as Epistemic Necessity

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This paper constitutes an exercise in 'generative reasoning' (Engle, Sedek, von Hecker and McIntosh, 2005). Inspired in part by Rosen (1977), it seeks to develop a new hermeneutic lens for understanding the (collective) phenomenology of music and mental health that is undergirded by a critical anthropology as opposed to philosophy .[1] Following Rabinow (1986), it is also an

[1] 'Inspired in part by' Victor Rosen (1977). It would seem that previous uses of 'critical anthropology' are specifically connected to political questions and constructs (Ulin, 1991; Hage, 2012; etc). What I intend by using this lexeme is to identify a way of thinking that leverages the observations made by both L. Rosen (1977) and P. Rosen (1972) about the nature of the privileges afforded to certain social sciences with the insights found in James and Marcus (1986). Anthropology makes for powerful hermeneutic frameworks, but care is needed in (amongst other things) accepting its limitations.

experiment in dialogical enquiry between anthropology and epistemology. To achieve this, it has been necessary to return to the subject of a little-known dialectic found in Kierkegaard's *Either/Or* (1843): the question of the precise roles played in human knowledge and experience by music and language. Having submitted this paper to peer review, it was extremely exciting to discover that Adorno and Kierkegaard have much more to say about music and language than I had previously understood (especially Kierkegaard, whose interpreters have tended to draw attention to his remarks on Mozart without really engaging with the music/language/epistemology questions he raises; e.g. Tetjen 2013, Croxall 1945). I have resisted the temptation to restructure this narrative for two reasons: a) the positions here espoused are neither undermined by nor dependent on Adorno and/or Kierkegaard; b) this proposed phenomenology of music and mental health is undergirded by anthropology as opposed to philosophy. Given that a comprehensive argument is impossible in this context, I simply hope to begin the process of arguing that music is as epistemically necessary as language – thus changing (some of) the way/s in which we think about music in relation to a) mind and brain; b) cognition and emotion; c) selfhood/personhood and society.[2]

[2] 'Epistemic necessity' is an original formulation.

> Humboldt derived his well-known axiom: "All understanding is at the same time a misunderstanding, all agreement in thought and feeling is also a parting of the ways." Or as Fritz Mauthner put it, it was via language, with its common surface and private base, that men had "made it impossible to get to know each other" (George Steiner 1975: 6, cited by Mahony, 1987: 6).

Here in the English-speaking West, it is only very recently that attention has been paid to the role of language in clinical care settings. [3] The seventh chapter of Lewis Carroll's *Alice in Wonderland* contains a scene in which the March Hare tells Alice off for saying that to 'say what you mean and mean what you say' are one and the same thing – because they are not![4] Mahony (1987) connects this idea to George Steiner's above-cited observation about the 'phenomenology of speech' before noting Freud's observation that for mental health patients striving towards recovery, every single word and action is not 'pure expression' but a 'compromise between the forces that are striving towards recovery and the opposing forces' (S. E. 12: 103, cited in Mahony, 1987: 6).[5]

[3] A plethora of scholarly and vernacular sources are easily found in a basic search online. Unfortunately, very important questions herewith remain largely unaddressed. Part of my future research agenda is to investigate some of the work that has taken place in the philosophy of psychiatry in this regard.

[4] Strictly speaking, in Carroll's actual narrative the March Hare's argument is a logical fallacy because he attacks the structure ('validity') of Alice's statement as opposed to the statement itself. Notwithstanding this technicality, as an individual chiasmus the Hare's assertion is absolutely correct.

[5] 'Standard Edition' of the psychological works of Sigmund Freud.

It is relatively straightforward to imagine the problems involved in receiving appropriate medical care if one requires assistance from a translator. However, I hereby argue (following Szasz, 1960) that clinical judgment in mental health does not really take place based on extrinsic behaviour but on the basis of the prospective patient's language use.[6] Mental health diagnosis is impossible without language-judgment on the part of a given 'expert-observer' and language realities cannot be experienced outside of a cultural context. This in part accounts for the rise of 'cultural psychiatry' and the concept of 'cultural formulation' in psychiatric diagnostic practice. Within medical anthropology, questions have been raised regarding the concept/s of 'culture' employed in the *Diagnostic and Statistical Manual of Mental Disorders* (fifth edition, more commonly known as DSM V) – and right across the healthcare spectrum members of D/deaf communities face some uniquely profound challenges that, taken cumulatively, strongly suggest that language is rather more limited than clinical practitioners have traditionally been willing to acknowledge – despite the claims made for the importance of professional reflexivity in professional healthcare environments.[7]

[6] The role of language in clinical judgment within mental health is (another) huge and under-researched area. A suitable defense for this claim will have to wait for a future publication opportunity.

[7] 'D/deaf' is now the technically correct way to refer to members of deaf communities. The use of both upper and lower-case first letters is linked to the self-understandings and cultural assignations derived from within these communities.

These unregulated assumptions about the nature of the importance of language in clinical care settings have contributed to equally unregulated assumptions about music latent in both the burgeoning 'arts for health' movement/s and 'music therapy.' In linguistics, Pinker (1997) reduces music to the status of 'pleasure technology' (1997: 524) in the form of 'auditory cheesecake' (1997: 534). In the philosophy of music, Kivy (2008) denies that 'absolute music' has any capacity to possess 'epistemic moral force.' In both cases, language - by virtue of its capacity to express verbal propositions – is assumed to be intrinsically superior to music. However, Lidov (2005) asked, 'Is Language a Music?' As such, I hereby contend that:

1. cognitive functionality is about much more than language;
2. music is important to cognitive functionality in certain ways that cannot be accessed by language.

One research team working in music perception under the aegis of the *Neurosciences Institute* opened a paper entitled *An empirical comparison of rhythm in language and music* with the following sentence: 'Speech and music are universal among human cultures' (Patel and Daniele, 2002), thus betraying an unfortunate assumption about the capacity for 'language' to serve as a

synonym for 'speech' (which is what they were actually investigating). Speech is impossible without language, but language does exist without speech (i.e. the neurocognitive functionality required for 'language' is in no way dependent on 'speech' or 'hearing' – as attested to by thinkers as diverse as Jean Piaget, Steven Pinker and Oliver Sacks). One of the core tenets of ethnomusicology is that not every language (representing a specific cultural community) has a specific word that directly translates as 'music'.[8] As such, a significant part of this paper is given to a serious discussion of the inherent structural limitations of language in both the expression and understanding of thought itself. More creativity within both artistic praxis (including music-making) and mental healthcare is needed than ever before and if the way/s in which we think about music can gradually become less and less dependent on frames of reference from language, then with respect to Freud and Steiner (cited above), music might just offer scope for a type of resolution to the conflict involved in self-realisation that cannot be found in language.

There are three particularly popular concepts/formulations deployed in advocacy for the importance of music to mental

[8] Lewis (2013) cites several examples (including with relation to dance) from South America, the South Pacific, East Asia and Africa. Additionally, Adorno and Horkheimer's (1946) disavowal of the 'universal' as an unfortunate Enlightenment ideological construction comes to mind (see also Walton, 2017).

health (as in well-being) that I hereby characterise as propositions:

a) music as effectively synonymous with 'performance' (*P*)
b) music as existing solely for the expression of emotion (*E*)
c) music as a language (including 'universal') (*L*)

With a small number of notable exceptions (e.g. 'historical performance' of 'early music'), professional performers in multiple Western and non-Western genres of music generally do not regard the reading of specialist academic texts on 'performance studies' (e.g. Rink, 2002; Nettl, 1998) as indispensable to preparation for 'public performance' – a concept that continues to be rethought in occasionally surprising ways (an example being the 2018 *Connections and Communication in Instrumental and Vocal Teaching*[9] conference for which prospective presenters were advised that the pedagogic approach would prioritise strategies for teaching students who actively did not wish to 'perform'). And in semantic terms, the 'performance' of a car engine is very different to that being employed when referring to the 'performance' of a renowned Shakespearean

[9] Conference website: https://musiceducationconferenceyork2018.wordpress.com

actor (we might even understand speech as the 'performance' of language). According to Aldridge (1996), 'becoming healthy is itself a creative performance' (1996: 20).[10] Ledger and McCaffrey (2015) explore recent developments in 'arts-based' research (ABR) in music therapy, one example of which was designated as a 'Performing Social Science' (2015: 4). However, despite certain inevitable connections made by musicians and non-musicians between music and performance and the acceptance of these connections in music therapy and beyond, my argument for the importance of music to mental health will apply to the process of music being 'made' as opposed to (necessarily) 'performed.'

A reasonably basic ontological concept of 'music-making' would not distinguish between:

a) a free improvisation onstage at a music festival;
b) a doxological gathering of a group of Sufis in the North African desert;
c) a group of music undergraduates getting together with a postgraduate conductor to simply rehearse and play through a Mahler symphony 'just because';

and

[10] An important author in music therapy, David Aldridge is cited more than once herein.

d) a rendition of a favoured song in a shower.

A is an organic, spontaneous act of collective musical creation; B is actually a religious occasion, so 'performance' in the Western sense cannot apply;' C has no audience; D is the epitome of a private matter; all four are instances of 'music-making.' Were one to now insist that all four can equally be understood as 'performances' the questions raised would be extremely difficult to answer.

'Performance' is entirely temporal (words such as 'episodic' and 'transient' could also be used), but personhood is a process the temporality of which extends beyond specific episodes with which we calibrate the chronologies of our lives. There is no scope herein for an adequate explication of the complex associations between, jazz, drugs, creativity and society; suffice it to say that more than one contemporary source attests to the fact that musicians like Charlie 'Bird' Parker were especially vulnerable when they were not able to play (i.e. in both the 'private' and 'public' senses of 'performance'). Russell (1973) tells us that heroin was not the facilitator of Bird's phenomenal creativity – but once he became dependent on it, he could not function normally without it (Parker himself confirmed this in spoken interviews conducted towards the end of his life) – and

that included being able to 'perform'. Russell tells the story of the young white, talented and highly impressionable trumpeter Red Rodney who joins what history records as Parker's last proper band and through what he perceives as the evidence of his own eyes, Rodney concludes that 'junk' and Bird-style improvisational creativity go hand-in-hand. Rodney graduates from 'scoring for the boss' to becoming a fully-fledged heroin addict. Two generations of jazz musicians will live under the shadow of Rodney's misconception.

It is easy to say that life is not one continuous 'gig' (i.e. 'performance' in the public sense). But for creative, instinctual individuals (more than a few of whom come from less-than-stable family environments/upbringings; see Wills 2003), both private and public modes of 'music-making' often offer the most important opportunities (and sometimes the only opportunities) for self-realisation. But the cognitive-emotive apparatus these individuals possess may not suffice for life outside music-making. And while some creative geniuses are driven by a desire to play and create for its own sake, legendary British entertainer Bruce Forsyth describes applause as a 'drug' that 'gives you a high' (Brown, 2011). As such, a simple (non-comprehensive) binary formulation:

- Performer: someone intrinsically motivated to be onstage before an audience who succeeds in realising this desire by whatever means.
- Artist: someone intrinsically motivated by a creative concept and who pursues a level of technical mastery of it that becomes part of their self-realisation of personhood.

For some, a 'performance' inheres a set of holistic values. For others, the opposite would arguably be more accurate. A large part of what causes many 'professional' and 'amateur' musicians [11] to walk away from music-making is the stress involved in public performance – not least because it is society that determines 'success' in 'performance' or otherwise.[12] If we accept Wittgenstein's (1953) 'meaning is use' formulation, then 'performance' as a 'word-concept' [13] has a much more complicated role in mental health (including 'performance anxiety;' see Kenny, 2011) than is currently acknowledged.

[11] These are loaded and ultimately unsatisfactory terms, but they serve an important purpose in the context of this specific argument.
[12] 'Society' and 'audience' will – at any given moment – comprise both those technically knowledgeable about the performance parameters and those for whom the same could not be said. This makes the process of ascertaining 'success' and 'failure' in performance even more contentious.
[13] See Hospers 1967.

The title of the 2016 Help Musicians UK research project *Can Music Make You Sick?* should have denoted some sort of empirical investigation into the aetiological capacity of 'music.' *Can Working in the Music Industry Make You Sick?* would not only have been a more accurate reflection of the study, it might have facilitated a much more enlightening debate than the one that transpired. The fact that a) 71 percent of the research participants have suffered from / do suffer with (clinical) anxiety; and b) 69 percent have suffered from / do suffer with (clinical) depression tells us that process of making a professional living from music – which can only include 'public performance' for a very significant number – can be highly deleterious to mental health.

As a phenomenon, music is more easily experienced than it is understood. This partially explains why pro-music arguments often default to the relationship between music and the emotions – an area of human experience, which in linguistic terms is notorious for its consistent evasion of easy circumscriptions brokered by language (multifarious disciplines agree – see Goldie, 2000; Kashima, Foddy and Platow, 2002; Strongman, 2003; van Goozen, van de Poll and Sergeant, 1994). We can and do explicate language in language, but we have no such corresponding possibility in music. This does not mean that music cannot be a means of communication about extra-musical

matters, nor is it to say that actually 'thinking in music' is impossible (in jazz/improvisation, see McAdams and Bigand, 1993 and Berliner, 1994; in classical music, see Kramer, 2016). It is to say that (for example) a C major chord played on either the piano or guitar cannot be specifically interpreted as meaning something like "I feel happy today!" A rigorous account of music's capacity to possess truth-content (a matter on which Adorno had much to say) will form the subject of future research endeavours.[14]

Bill Evans (1929-1980) and Kenny Kirkland (1955-1998) are two of the greatest jazz pianists in the history of the music. Respectively white and black, both were open heroin users until towards the end of their lives when both switched to cocaine. Both were noted for their formidable theoretical and technical accomplishments and spectacular levels of creativity. Both had professors for brothers (music for Evans, philosophy for Kirkland) with whom in childhood there was a genuine bond. Somehow, both were also very broken people and despite the written material available about their lives it is still very difficult to understand how the enormity of their musical accomplishments was not fulfilling enough to lead them away from drugs. We must therefore accept that there are certain

[14] Owen Hulatt (2013) offers a very important reading of Adorno in this regard that is appropriately philosophical (as opposed to musicological or music-sociological).

things in human experience that music cannot heal. I have personally spoken with Branford Marsalis about Kenny Kirkland's situation as I was present at the Panasonic Village Jazz Festival gig in August 1998 that Branford later described as the Doctone's 'send-off.' For me personally, playing jazz piano did more than any other activity to keep me from becoming a fully-fledged mental health service user. Improvisatory creativity sparked a new level of hope within me that gave me the strength to continue to battle with life. But for both Bill Evans and Kenny Kirkland, music – even at that exalted level – was not enough.[15]

Notwithstanding, I believe that both men (and others such as Bird and Roy Hargrove) were only really and truly free when making music – whether in 'performance' or not – and exercising their highest levels of creativity in 'the music'.[16] Jazz itself is no more an aetiological driver for mental illness than anything else that either a) destabilises personhood and agency (loss of a job, bereavement, betrayal, unfulfillment, toxic religiosity, etc) to the extent of chronic breakdown of brain biochemistry; or b) triggers some form of (sometimes genetically predisposed) organic mental illness. On the contrary, the type of creativity required for

[15] As both men also preferred to express themselves in music rather than words, this cannot be understood as an example of the limitations of music and the necessity of language. Once again, more research beckons.

[16] 'The music' was a way in which the early jazz pioneers spoke about what they played and how they lived.

jazz to exist spans such a broad area of cognition that one simply cannot not play anything resembling jazz without a genuinely high level of cognitive functionality (and concomitant motor coordination). Where things become more complicated (and words like 'transcendental' start to be employed) is in the interaction between cognition and emotion where the highest levels of improvisation leave conscious music-theoretical and technical-instrumental thought behind in flights of the imagination that are 'metaphysical' by definition. If one's life outside that sort of space is not sufficiently balanced, the return to more 'mundane' realities may in some cases contain realities of life that cannot easily be borne, potentially rendering a person vulnerable in ways that include the propensity for self-destructive behaviour.

On this account, 'performance' functions as a coping strategy (Ogden, 2004) – but this is a consequence of the exercise of volition on the part of the musician and not a causal consequence of music performance itself. And as life is more than performance, the potential for destructive coping mechanisms increases in the absence of more positive coping strategies (as earlier stated). What we have here is a paradox: 'the music' cannot be 'made' (much less 'performed') without a certain amount of mental coherence. However, in the case of a person

whose mental health issues are profound but insufficiently visible to others, it is possible for the coherence manifested in 'musicking' (Small, 1998) to be taken as being emblematic of wider mental stability and coherence – a recurring theme in so many of the instances where a mental health service user has been incorrectly assessed by both clinical and non-clinical practitioners with tangibly negative consequences.[17]

Given the foregoing, I see no justification whatsoever in using the word-concept 'performance' to describe any/every instance of 'musicking.' 'Performance' in the context of music can only function as a stable and coherent concept if it serves unambiguously as a referent for some kind of public performance. Some musical performers cannot be content with private music-making (as one Viennese concert pianist recent told me, 'I need the inspiration of a concert'!); for them, there *must* be an outlet in a public forum. As a consequence, *P* must be jettisoned because it frames the relationship between music and mental health specifically as a socially-situated process with socially-situated actors – and important as interacting with others is, one must become a self on one's own terms or 'self-realisation' is impossible. 'Performance' will of course be

[17] Again, there is now no shortage of literature dealing with the challenges of visual assessment of a MH service user and presuppositions concerning their welfare; more for a future research agenda.

applicable to certain social metaphors, but music has a role to play in self-identity without depending on other minds and bodies. Mental health (and well-being in general) cannot afford to emphasise conceptual frameworks that fit into societal structures/values of thought that facilitate the ever-increasing fragmentation of cognition – not least through ongoing sequential temporal episodes by which we calibrate the chronologies of our lives. This means that 'performance' cannot serve as a logically consistent metaphor for 'recovery'. This does not correspond with Aldridge (2010) whose thinking about music in the context of recovery from addiction places a very particular emphasis on 'performance' of 'self' and 'culture' in direct correlation to the performance of music where the 'essential element' in the necessary 'coherence' that one needs within oneself is 'timing.'

Aldridge also suggests that the body might well possess 'its own consciousness not always immediately available to interpretation' and then immediately advances his metaphysical position: '… we can say the same of music… [which is] direct and *the* bridge to other consciousnesses' (2010: 16, emphasis mine). Whether or not one finds this sort of idea attractive, there is nothing here that qualifies as an argument. Moreover, these sorts of disembodied abstractions purporting to be coherent

statements of fact fail to account for the fact that '… words don't refer to anything. People refer' (Yule, 1996: 17). [18] 'Body', 'consciousness', 'music', 'bridge' – the ways in which Aldridge uses these words are based on what appears to be a solipsistic view of both language and music and do very little for the cause of promoting music as being of fundamental importance to mental health.

The conspicuous ongoing failure to distinguish between 'mental illness' and 'mental health' represents an example of socially-accepted-yet-functionally-irrational language use that does not require the kind of insight/s associated with Wittgenstein (1953), Searle (1969) and Derrida (1967) to be recognised as being wholly problematic. Because there are more public references than ever before to facts such as a) one in four people will suffer some sort of mental health problem in their lifetime (World Health Report 2001, still very influential); and b) the World Health Organisation (WHO) has stated that by 2020 depression will be the number one global health problem – as a cause of death, as the second biggest cause of world disability, etc (World Mental Health

[18] Yule (1995) explains the difference between **syntax** (relationships between linguistic forms and how they are internally structured and then externally sequenced), **semantics** (how linguistic forms – words and groups of words – actually connect to external entities "in the world" and whether the relationships/associations made between "verbal descriptions" and "states of affairs" are reasonable and cogent) and his own discipline, **pragmatics** which is "the study of the relationships between linguistic forms and the users of those forms."

Federation 2012), mental illness is no longer absent in mainstream public conversations. In the UK, the National Health Service (NHS) has rolled out several initiatives based around 'mindfulness' and arts-based 'interventions' such as the 'Singing for the Brain' project. [It is worth the time it takes to point out that 'dementia' is in fact an umbrella term for the hundred or so disorders (of which Alzheimer's Disease is but one) that fall into a category of 'neurological' disorder as opposed to 'psychological' disorder – and the fact that some NHS trusts actually conflate the clinical care for dementia under 'mental health' makes it very difficult to point out that disorders of the mind are ontologically and conceptually distinct from disorders of the brain.] As philosopher of health David Seedhouse has observed, 'The predominant image which overshadows medicine and the [NHS] is that health is a commodity' (1986: 34). Health can be supplied, but it can also be lost. Perhaps a shade of nuance is needed: one can indeed infer that the NHS is a 'service' providing 'health' – but one might equally infer that the NHS is in the service of health itself. Arguably, there is something of both to be found in the ethos of the NHS, but in asking the question of this assertion, we see more clearly that this way of thinking has significant consequences for mental health in particular – treatment for organic schizo-affective mental disorder is less easily supplied than treatment for a broken leg.

However, despite the above-mentioned enterprises and the proliferation of 'positive psychology' (see Seligman and Csikszentmihalyi, 2000) and various derivatives, the stigmas that surround mental health continue (George, 2001). Our language concerning mental health and social inclusivity has changed (for the better) – but our actual feelings about mental health as a society have not changed in any real qualitative way.[19] And it is the mental health service users who are most affected by this discrepancy (as Peter Beresford – himself a mental health service user – outline in a 2015 *Guardian* piece). What is needed at this point is an approach in which we:

a) ruthlessly interrogate our verbal concepts of both health and mental health in order to find the *lacunae;*
b) carefully consider our understanding of the 'mental' – and the ways in which language does and does not work within that;
c) reconsider our current thinking about the role/s that non-linguistic forms of intersubjective communication and exchange – such as music –

[19] Morsanyi, Devine, Nobes & Szücs (2013) report on a critical 'special needs' issue that remains largely unrecognised involving the link between logic, mathematics and imagination in child development that is particularly relevant to mental health. Campaigns to raise awareness about these sorts of challenges are still not having the impact that is needed.

> might be able to play in supporting and facilitating mental health.

A crucial consequence of a more rigorous understanding of the continuum between 'sickness' and 'health' (Ogden, 2004) will mean than when a performing musician becomes a mental health service user, all parties involved in caring for such patients can draw upon a much deeper well of understanding. The contention at hand is not that there should be no connection whatsoever made between music, performance and mental health (i.e. it is not the whole concept/reality of performance that has been jettisoned; it is the easy concept *P*); nor that there should be no metaphysical claims about the relationship between our understanding of music and our understanding of consciousness. Notwithstanding, '…the problems arising through a misinterpretation of our forms of language…are deep disquietudes; their roots are as deep in us as the forms of our language' (Wittgenstein, 1953: §111). The claims being advanced by Aldridge regarding the importance of music for mental health – including the cognate claims about the capacity of music to reference time within conscious process – work very well in a conceptual environment which is in some way predisposed to accepting the importance of music for more than aesthetic processing. However, developing more substantive arguments

for the importance of music to mental health vis-à-vis language will require a very different set of language games than many of those currently in vogue. In 1956, the US philosopher John Hospers published *An Introduction to Philosophical Analysis.* In the first chapter ('Language and Reality') of the second edition (1967), Hospers argued that words were 'tokens of meaning' in that meaning was not 'natural' but 'ascribed.' In that same chapter of the fourth edition (1997) words have become 'signs' and the distinction he makes is between 'natural signs' and 'conventional signs:'

> But words, like the notes on a musical staff, are conventional signs: this word stands for this class of things, this note on the staff stands for this class of sound pitches. In natural signs, A signifies B regardless of what human beings believe or decide; in conventional signs, human beings decide which A's will be used to stand for which B's (*sic*). (1997: 12)[20]

I take this account to be emblematic of the structural-conceptual problems involved in explicating language in language and argue for a 'hermeneutic of suspicion' towards all accounts of musical verities in language; not least this association between musical notes and words (Hospers does not appear to understand how staff notation functions). The bifurcation

[20] The use of the apostrophe is very interesting; the idea is clearly not to designate 'possession' but if that was deemed the best solution to avoid "As" and "Bs" then it is merely another reminder of the fickle arbitrariness and instability that inheres within language – even at the level of grammar.

between 'natural' and 'conventional' signs is not illogical but it is still problematic. Future work will require a proper explication of Adorno's ontology of music, but all of the foregoing points towards the fact that music is not a language. Music is a music, by which I mean that it is not a subsidiary of language – it is equal and complementary to language.[21] And so we must jettison *L.* Both music and language are mechanisms that facilitate intersubjective communication and exchange between human beings, and an appropriate understanding of both contributes to the prospect and reality of good mental health.[22] Given that music is increasingly understood to possess the capacity to support (and be supported within) a much wider framework of brain (separate to mind) functionality (Levitin 2006; Sacks 2007), 'music as a language' emasculates the potential of music to operate in cognitive domains beyond those occupied by language.

[21] Although I had originally intended to include a more detailed and forceful explication of certain specific challenges involved in comparing music and language (Deryck Cooke from musicology and Aniruddh Patel from cognitive neuroscience as applied to music perception being two examples of scholars whose work I would have drawn upon), I have had to set that aside for a future piece of writing.

[22] The collection of essays in *Rethinking Music* (Cook and Everist, 1999) – beginning with Philip Bohlman's mischievous-yet-serious essay on the ontology of music (manifesting, in my opinion, a rather more 'musically-informed' explication on the actual nature of the phenomenon of music than that found in several prototypical works from the philosophy of music canon) is a very important recent effort within 'musicology proper' to rethink some of the cardinal assumptions regarding what music is and is not in English. Another contributor to that volume, Kevin Korsyn (ch. 3) was working on *Decentering Music* (published 2003) at the time. *Decentering Music* was extremely helpful to me as a graduate student and is part of the foundation for that which you now read; it deserves much more recognition than it appears to receive at present.

In a penetrating review of the now seminal *How Musical is Man?* (Blacking, 1973), Feld (1975) argues that it is *not* a 'scholarly study of human musicality' but an assemblage of some important ideas about how the study of the anthropology of music is advanced. [23] Being influenced by the 'theoretical linguistics' of the time, Blacking chooses to invoke the concepts of 'deep' and 'surface' structures as being applicable to music (we might make an association with the Chomsky-led search that had started in linguistics for a 'universal grammar') – but emphatically states that he 'is not suggesting that ethnomusicology use the methods of linguistics' and that there 'is no reason to assume that music is a kind of language' (1973: 21). However, 'Blacking does not formally define his own terms, nor does he really make it clear what motivates him to borrow them' (Feld, 1975: 159). I find this observation to be valid, but an important question that now arises concerns the definition of a 'scholarly study of human musicality' – precisely what should such a study look like? How would one argue for any given criteria that would obtain? If our knowledge of music were restricted to verbal-linguistic propositions, we would need to ask if knowledge about solely instrumental music is even possible.

[23] Derrida's (1967) ruthless deconstruction of several particularities within the theories of language espoused by anthropologists from Lévi-Strauss onwards need not necessarily be accepted for one to recognise various problems that inhere in this canon of ideas.

But in jettisoning *L* a new discursive plane opens, enabling us to consider music and language as ontologically separate-yet-equal.

Let us now take a moment to consider a specific condition that affects hearing as well as thought, language, music, speech, categories of health and categories of the 'mental' – deafness.

The UK has 11 million deaf people. Of those, 2 million own hearing aids, but 1.4 million refuse to wear them nearly all the time due to high levels of discomfort. Cochlear implants are increasingly common, but they do not work for everyone. Although British Sign Language (BSL) was finally established as a language in 2003, only 156,000 people in Britain's D/deaf community speak it as a 'first language.' In addition to the question concerning quite how the other 10,844,000 communicate[24] is the question of how the deaf communicated in the past. D/deafness has been taken by a number of researchers in recent years as a means of interrogating our presuppositions about language (Chomsky 1965, 1968, 2002, etc; Jackendoff 1994; Lashley, 1948[25]; Sacks 1989; Skinner, 1957). For several decades,

[24] Leaving for the moment those whose ethnicity is not Anglo-European and for whom English is not the language in which they conduct their daily lives, the answer to this question is 'sign-supported English' (SSE). However, trying to ascertain the differences between SSE and BSL is genuinely unstraightforward.

[25] Found in Chomsky 1968: 3. It seems that what Chomsky regarded as ground-breaking work on the part of Lashley does not appear to have been formally published at the time.

researchers have been concerned with the question of how very young children are able to assimilate language structures that are technically complex without being taught formal grammar. Since 1957, Chomsky has applied himself to research questions in this area, becoming strongly associated with the concepts of 'transformational grammar' and 'generative grammar' (both 1968) and then the later 'universal grammar' (also 1968).[26]

It is often asserted that Chomsky claimed that language itself is 'innate' rather than 'learned' or 'acquired.' Without serving as a Chomsky apologist, this is not accurate. Chomsky's position – simply put – was and is that human beings possess an innate capacity for *grammar* – they do not have to be 'taught' the 'correct' way/s to apply vocabulary. This was the ineluctable conclusion given the consistency of the ways in which the youngest of minds acquire the ability to understand and be understood in language – a state of affairs described as 'the paradox of language acquisition' (Jackendoff, 1994: 82).

[26] All three lexemes are associated with Chomsky, but as he makes clear in the introduction of the 50th anniversary edition of *Aspects* (1965), research into generative grammar dates back to the 1940s. The notions of both transformational grammar (TG) and universal grammar (UG) later evolved into different 'modern' forms which have not done much to shed light on an already contested area. So, references to 'TG' and 'UG' in more modern scholarship are not necessarily references to Chomsky's specific-and-evolving ideas.

L and *E* come together in Cooke (1959), who makes a case for understanding music as 'an explicit language system of emotional symbols' (Feld, 1975: 159); a thesis comprehensively dismantled by Blacking (1973) on the grounds of being 'insufficiently context-sensitive' (Feld, 1975) and therefore unable to fulfil its own stated ambitions as an analytic framework for understanding Western art music from 1400-1953. However, Cooke's thesis has endured and together with Chomsky's 'generative grammar' may be understood as part of the foundation for what Cespedes-Guevara and Eerola (2018) have described as the 'Basic Emotions' theory in music psychology in which music is understood as having the intrinsic capacity to express 'basic' emotions. They note that the advocates of this position have not only failed to agree a confirmed list of emotions that qualify under this hypothesis, but that 'asking listeners which emotions they think music expresses, inform us about people's ideas about what emotions music expresses, not about their *actual experiences* of perceiving those emotions in music' (*sic*) (2018: 5).

As such, *E* has no place in this phenomenology for two reasons: a) 'mental health' is about more than emotional stability; b) music deserves better than a technically-conceptually-

underpowered verbal identity as a phenomenon of nothing more than the emotions.

Anti-psychiatry (Cooper, 1967; Foucault, 1961; Laing, 1969; Szasz, 2009)[27] has come and gone – but 'postpsychiatry' (Bracken and Thomas, 2005) is here to stay – and understanding the role of music in both 'mental illness' and 'mental health' has never been more important. Given that it is increasingly accepted that music can actively contribute to the 'healing of the mind' (which of course presupposes that the mind is an actual ontological entity as opposed to a convenient fiction), I would like to extend that plane of thought and reiterate that music is in fact a necessity to cognitive functionality in ways that extend far beyond emotions – indeed, in ways that comprehensively extend into territories that have traditionally been considered the sole domain of language.

[27] Two important points: a) 'anti-psychiatry' began long before David Cooper first used that exact lexeme in print; b) more than one writer has taken Thomas Szasz to have been a proponent of 'anti-psychiatry' – but in fact he was equally antagonistic towards both 'psychiatry' and the formal 'anti-psychiatry' movement, which he regarded as psychiatry in disguise. Szasz's *Antipsychiatry* (2009) specifically addresses this issue and the decline of antipsychiatry in the English-speaking world.

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Musicology Research
Issue 6: pp. 51-82

3

The Uncontrolled Equivocation of Music Therapy: Health, Illness and Musical Healing Among the Kallawaya in the Northern Bolivian Andes

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Figure 1. The community of Niñocorin. Photo: Sebastian Hachmeyer, 18 November 2014.

1. Introduction

The Kallawaya are Indigenous healers from the Northern Bolivian Andes, internationally well-known for their herbalist medical tradition and ritual healing practices. According to Bastien (1978), the word "Kallawaya" derives from *qulla* meaning medicine, and *waya* meaning place or land in Quechua. In former times itinerant, many Kallawaya are sedentary nowadays, live in Bolivian main cities and have adapted their specialist medical practice and discourse to modern clinical contexts (hospital, consulting room, etc.). The Kallawaya medical tradition is divided into two specialities: herbalists specialized in herbal healing, so called *qulla kapachuyuq* ('masters of the medicine bag'), and ritualists or diviners called *yachaj* ('wiseman') or *watapurichiq* ('the one who makes the year walk'), specialized in curative and collective ritual practices (Rösing, 2010; Bastien, 1978, 1985). This division is more of an analytical kind, as Kallawaya healers might be working with both specialties.

Kallawaya healers received an increasing international interest after the studies of anthropologist turned North American Maryknoll priest Joseph Bastien and German psychologist and anthropologist Ina Rösing. Rösing's (1990a, 1990b, 1991, 1992a, 1992b, 1993, 1995, 1996, 2003, 2008a, 2008b, 2008c, 2010) studies contributed to a deeper understanding of Kallawaya ritual

healing practices, while Bastien's (1978, 1981, 1983, 1985, 1987) classical Andean anthropological works offered fundamental insights into rural Indigenous Andean life in relation to place and territory. However, most of these former studies in the Kallawaya region, including those about *qantu* music (Baumann, 1985; Langevin, 1992, 1990; Whitney Templeman, 1994), did not discuss the role of sound, chant and music in Kallawaya healing, although these elements directly relate to broader understandings of life, death, health, and illness.

In 2003, the UNESCO proclaimed the 'Andean Cosmovision of the Kallawaya' Intangible Cultural Heritage of Humanity. In the 2002 application of the Bolivian Viceministry of Culture, it is written that Kallawaya, apparently more in the sense of herbalists, 'do not only apply plants, animals or minerals to heal, but also music therapy (called in their language Kantus)' (Viceministry of Culture, 2002: 42 [my translation]). [1] This formulation is highly problematic and ambiguous. *Qantu* is the name of a famous panpipe style[2], which has originated in the Kallawaya region (nowadays the province of Bautista Saavedra

[1] For more information about the background of the UNESCO application, see Alderman (2016), Llanos and Speeding (2009) and Loza (2004).

[2] The typical *qantu* panpipe style is played in large consorts (25 musicians) playing panpipes (*qantuphukuna*), drums and a metal percussion triangle called *ch'inisku*. The panpipes are organized in six registers tuned in parallel fourths, fifths and octaves, where panpipe players use hocketing between two complementary pairs of panpipes (Baumann, 1985).

in La Paz department) at the beginning of the twentieth century (Hachmeyer, 2018). It does not at all possess the same meaning as 'music therapy', as if the latter was a literal translation of the former. *Qantu* music has also been described as music therapy in recent anthropological works (Blanco Huaqui, 2018; Kuljis, 2016; Sigl and Mendoza, 2012). However, none of these has presented an ontological understanding of what 'music therapy' actually means for Kallawaya healers.

I will argue in this article that Kallawaya healers understand health as a process by which matter and energy are constantly interchanged between living members of the cosmos, including humans and all kinds of non-humans. When health is understood in such relational terms, illness is a condition of disruption of healthy correspondences between these living beings in shared, cohabitated and interrelated worlds (*pacha*). In the context of a rural community in Northern Potosí, Stobart (2000: 28) argues that illness is a 'symptom of deterioration or imbalance in a much broader series of relationships'. He shows parallels between the use of sound in the transformation of the landscape through music and of the body through healing. These circumstances make musical healing a place-based and mutually beneficial undertaking. With this article, I intend to understand the use of music, chant, and sound in Kallawaya healing

practices, drawing on recent anthropological debates about the importance of ontological perspectives in the Andes (Allen, 2015; Arnold, 2017; Cavalcanti-Schiel, 2014, 2007; De la Cadena, 2015). I argue that the concept of music therapy in the Kallawaya context is an 'uncontrolled equivocation' in the sense of Viveiros de Castro (2004: 9), which is 'a type of communicative disjuncture where the interlocutors are not talking about the same thing, and do not know this'. I will describe the conflict between modern notions of music therapy in the Kallawaya context and prepare for its resolving.

2. Music Therapy: An uncontrolled equivocation?

The World Federation of Music Therapy (2011) defines music therapy as 'the professional use of music and its elements as an intervention in medical, educational, and everyday environments with individuals, groups, families, or communities who seek to optimize their quality of life and improve their physical, social, communicative, emotional, intellectual, and spiritual health and wellbeing'. Music therapy as an established health profession and medical discipline has struggled to gain scientific legitimacy in the past (Davis, Gfeller, and Thaut, 2008). Many national music therapy associations, like the British Association of Music

Therapy[3] or the American Music Therapy Association[4], highlight nowadays that music therapy is the scientific evidence-based and clinical use of music interventions, as opposed to informal usages of music in private spheres and everyday life. This can be either done in a receptive type through guided listening to music, or in a more active type through making music and using a variety of musical instruments. Generally speaking, therapeutic relationships between an (officially recognized) music therapist and his/her patient is central and very important to understand modern approaches to clinical music therapy. For example, Gfeller and Davis (2008: 5f) argue that

> Music is used as a therapeutic tool, but its optimal benefit in therapy depends on the appropriate use by the therapist. […] The effectiveness of music as a therapeutic tool applied for particular use depends on the skill and knowledge of the therapist. (Gfeller and Davis, 2008: 5f)

If we were to translate this modern notion of clinical music therapy to the Kallawaya context, it is highly misleading, as it

[3] 'Central to how music therapy works is the therapeutic relationship that is established and developed, through engagement in live musical interaction and play between a therapist and client. […] Music therapy is an established psychological clinical intervention, which is delivered by HCPC registered music therapists to help people whose lives have been affected by injury, illness or disability through supporting their psychological, emotional, cognitive, physical, communicative and social needs'. (https://www.bamt.org/)

[4] 'Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music Therapy is an established health profession in which music is used within a therapeutic relationship to address physical, emotional, cognitive, and social needs of individuals'. (https://www.musictherapy.org/)

suggests an image of a traditional healer, herbalist or ritualist, 'applying' a collective music, such as the *qantu* panpipe style, as a medical treatment, in the sense of the Greek meaning of *therapeia*. Hypothetically, it would be possible that Kallawaya healers use recordings of *qantu* music nowadays, but the problem is the image of guided therapy itself. In the contemporary Kallawaya context, I have never seen myself nor have I heard about a situation, where music is clinically used in this modern sense of music therapy.[5] A variety of collective flute music, including the *qantu* panpipe style, is nowadays played in Indigenous communities in the Kallawaya region not because a traditional healer prescribes it as a particular therapeutic intervention for his or her clients.

Yet, certain terminology of modern medicine has been adopted by Kallawaya healers, who have inserted themselves into modern clinical contexts recently. In another article, I argue that this has happened in order to justify demands of being properly recognised as 'professional doctors', compared to their modern homologs, and to facilitate intercultural communication and understandings with a new clientele in the cities, as the majority of Kallawaya healers, mainly herbalists, nowadays work in

[5] Similarly, Stobart (2000) argues, in the context of a rural community in Northern Potosí, that although sound is a very important dimension of ritual healing, music itself is not directly used in clinical contexts.

urban environments with both Indigenous and non-Indigenous clients (Hachmeyer, 2018).[6] The Cochabamba-based Kallawaya herbal specialist from Curva, Luis Walter Quispe, acknowledged in an interview that 'today, we, the professionals in the cities, recently started to talk about Kallawaya music therapy'.

In the article (Hachmeyer, 2018), I describe another interview I had in his consulting room with the El Alto-based Kallawaya herbal specialist Walter Álvarez, the president of the 'Bolivian Institute of Traditional Kallawaya Medicine' (INBOMETRAKA), who explained to me the healing properties of *qantu* music. He said that:

> music and dance, such as *qantu*, are curative. If you are very weak, a smooth/gentle (*suave*) rhythm is needed, but if you have high blood pressure, with polyglobulia, the rhythms need to be lively and energetic. You move and begin to sweat, and your joints don't hurt [anymore]. Your breathing speeds up when you blow [panpipes] and dance; this all helps to prevent heart diseases (*cardiopatías*).

I would argue in the context of modern music therapy, also influenced by biomusicological studies, that this can be considered a type of musical entrainment. According to DeNora

[6] In the same article, I also discuss how the Intangible Cultural Heritage by UNESCO impacted on the social reproduction of *qantu* music in the Kallawaya region. I argue that the UNESCO declaration contributed to the decontextualization of *qantu* music from its former social, participatory and spiritual milieu while transforming it into a) a representative music with more presentational performances and b) a discourse of music therapy drawn upon by urban Kallawaya herbalists in the cities.

(2004), the musically entrained body and its processes unfold in relation to musical elements, aligning and regulating themselves in relation to music. Bodies might thus be said to organize and compose themselves musically. Musical entrainment can involve the regulation and/or modification of physical states, behaviours, temporal parameters like mood and emotion, as well as social roles (DeNora, 2004; Clayton et al., 2004). But how can we understand Álvarez's affirmation against the background of Kallawaya understandings of illness, health and cure?

I would like to suggest here that the translation of Kallawaya understandings of sound, chant, and music in healing into the modern concept of music therapy can be understood as an 'uncontrolled equivocation' in the sense of Viveiros de Castro (2004). It concerns the process involved with the translation of the 'native's' practical and discursive concepts in terms of the conceptual apparatus of modern medicine. Although the *qantu* panpipe style is not a clinical music therapy in its modern sense, it does not simultaneously suggest that music, as well as chant and sound, are not important parts of healing among the Kallawaya. Health and illness, as well as sound and music, can be very different things for different people.[7] Drawing on

[7] This is strongly supported by pertinent literature about healing sounds and music in different historical and - as they are called - cultural contexts (Davis, Gfeller and Thaut, 2008; Horden, 2000; Gouk, 2000).

Burman (2016), I would argue that musical healing as a concrete situated place-based practice corresponds with a certain reality, in which it makes sense. In order to understand the meaning of musical healing among the Kallawaya, I would like to introduce a short testimony of a Kallawaya healing story, which exemplifies Kallawaya animist and perspectivist understandings of illness and health well, before unfolding some implications for musical healing among the Kallawaya.

3. Animism and Perspectivism in Kallawaya healing

A young Bolivian lady suffers from a common long-term inflammatory disease of the pulmonary airways called asthma in modern clinical terms. A specialist physician of lung diseases prescribed nebulizations and inhalers with glucocorticoids. She was told that asthma cannot be cured, making an appropriate management indispensable to secure life quality. She continued suffering attacks of breathlessness and wheezing while drawing on symptomatic treatments in such cases. The physician explained to her that the fundamental causes of asthma are not completely understood, but would most probably relate to genetic predisposition. She found such a diagnosis unsatisfactory and called upon a Kallawaya. In his etiological and pathogenetic analysis, the Kallawaya argued that many lung diseases are family evils which are carried around from one generation to the

next. The Kallawaya initiated a series of healing rituals, before starting therapy with medicinal herbs. He explained that it would be important to understand that medicinal herbs are not mere medicinal 'objects', but rather other living beings. Therefore, it would be necessary to understand the nature of these living beings and whether both patient and medicinal herb 'understand and know each other'. After a while, she did not notice any improvement in her symptoms. She consulted the Kallawaya again, who argued she would lack knowledge about certain medicinal herbs. This lack of knowledge, but also of trans-specific communication (among different species, human and non-human), would constrain her to receive any cure. The Kallawaya invited her to his origin community in the Northern Bolivian Andes, in order to not only show her some wild-growing medicinal herbs, but to introduce her to them, just as he would do in the case of two humans. They directed themselves towards the higher parts of the Kallawaya region, where he showed her the mountainous habitat of some medicinal herbs. He thoughtfully asked her what she would see. She did not immediately understand what he meant and hesitated to answer. He continued explaining that after knowing some medicinal herbs and the places where they grow, she could know now why they can help her to breathe. In his logic, they would help her to breathe, because they live in a difficult environment and are able

to breathe themselves in the highest parts of the region (over 3500m above sea level).

This anecdote is descriptive of how the Kallawaya think about disease and cure. Firstly, it is not a 'belief' in the healing powers of the plant, which causes a mental predisposition of physical healing, as the Kallawaya explicitly mention *knowledge* and *communication*, thus trans-specific relationships. One might contest from a modern biological point of view that humans and plants are not comparable, as plants do not breathe oxygen, but rather expulse it as the final product of photosynthesis. But this is not how the Kallawaya think about respiration. Bastien (1978) shows that his Kallawaya interlocutors argued that the wind (*wayra*) is the world's (*pacha*) breathing, which comes out of a cavity-like mouth called *wayra wisqani*. Respiration happens everywhere, in all living beings, whether humans, animals, plants, mountains, stars, or as the whole earth itself (understood as a mother – *pacha tayka*). It has to be like this, as it is a primary life-sustaining process related to an all-encompassing spirit (*ajayu*)[8] that every living being partakes. If there is no *ajayu*, there is no life, thus no respiration, no feeling and knowledge, no

[8] *Ajayu* is an Aymara word, which is also used in the Kallawaya region, where also some Aymara communities, for instance Upinhuaya, in the North of Niñocorin, exist. Some of my interlocutors also used the Quechua word *qamas*. According to Burman (2016), *qamasa* is only one part of *ajayu* indicating courage and strength. Langevin (1990) shows how the nomenclature of musical instruments mixes together the Quechua and Aymara languages. I would argue that the same also happens concerning ritual terminology.

speech, and so on. Hence, we could say that there is a 'discontinuous physicality' between living beings in form of corporal envelopes, a 'clothing' as Viveiros de Castro (2012) would argue, but a 'continuous interiority' of spirit, i.e. intentionality and subjectivity, identical in every species (Descola, 2013). Descola (2013) calls this particular 'mode of identification' animism, which opens up the possibility for Viveiros de Castro's (2012) cosmological perspectivism[9].

Recently, anthropologists like Allen (2015) and Cavalcanti-Schiel (2014, 2007) have put forward arguments for understanding Andean life in the light of new perspectives in animism and perspectivism. What caught my attention was Allen's (2015) idea of point of hearing in the Andes, the aural equivalent of visual perspective, which Lewy (2017) in his Indigenous sonorism coined 'the audible stance'. Lewy (2017) argues that if species with identical spirits see different worlds because of their varying bodily forms (blood for humans is chicha for jaguar) (the main argument of cosmological perspectivism), they need a particular form of trans-specific communication happening in the same world, which is organized by music, sound, chant and the use of particular sound ornaments. These are sonorous agents

[9] 'The conception, […] according to which the world is inhabited by different sorts of subjects or persons, human and non-human, which apprehend reality from distinct points of view' (Viveiros de Castro, 2012: 45).

interacting with all subjective inhabitants in every layer of the multiverse, as they transcend these layers to make trans-specific communication possible. According to Allen (2015), sometimes, for instance, during divination sessions at night, speech and hearing are the salient modes of communication in the Andes. Her conclusions suggest that non-humans, including places, speak to each other in species-specific modes not intelligible to human beings. Thus, different species have also different points of hearing. 'That what human beings hear as distant thunder', Allen (2015: 35) argues, 'places may hear as intelligible speech'. Both visual perspective and audible stance are grounded in multinaturalism[10], as species perceive the same way, but the things they perceive vary according to their dissimilarity of their bodies. I would like to follow up on this idea of audible stance in the Andes and unfold some implications for the use of chant, sound, and music in Kallawaya healing.

[10] According to Viveiros de Castro (2012: 46), multinaturalism is a concept 'to designate one of the contrastive features of Amerindian thought in relation to modern "multiculturalist" cosmologies. Where the latter are founded on the mutual implication of the unity of nature and the multiplicity of cultures – the first guaranteed by the objective universality of body and substance, the second generated by the subjective particularity of spirit and meaning – the Amerindian conception would suppose a spiritual unity and a corporeal diversity. Here, culture or the subject would be the form of the universal, whilst nature or the object would be the form of the particular'.

4. Chant-like healing words in healing rituals in the family realm

Kallawaya rituals in the realm of the family is divided into two major types (Rösing, 2010): White healing (*yuraq mesa*) has the objective in favour of something, positive circumstances (like reciprocal payments, health, well-being, good harvest), while black healing (*yana mesa*) has the objective against something. Its spectrum covers the apotropaic rejection of misfortune, bad thoughts or evil intentions of others, sending it back to the source (*kuti kuti, kutichina*), or causing intentional harm to enemies. Despite these two proper Kallawaya ritual types, Rösing (2010) introduces her own concept of grey healing, in order to conceptually distinguish it from the others. She defines grey healing as rituals for defence, cleaning, and purification. Under grey healing, she subsumes rituals for sending away sadness, pain, and sorrow (*llaki wijch'uña*), but also purifications and cleanings against *yana mesa*. Many *yuraq mesa* practices are directed towards the prevention of harm, the maintenance of physical and mental integrity or well-being, as well as the balancing of forces and energy in a series of broader relationships with 'earth beings' (De la Cadena, 2015), who actively participate in the constitution of human health. Grey healing, instead, is the restitution of health after imbalances. One common Andean pathology is the 'susto' (*manchrisqa*), which is

the temporal dispersal of *ajayu* from the body to the land, causing symptoms like diarrhoea, low fever, lack of appetite, but also depression, melancholy and nervous ticks (Bastien, 1985; Rösing, 1993). In many cases, Kallawaya ritualists identify the place, where the *ajayu* has been trapped, in order to call it back with (sometimes murmuring) healing words (*jampiy rimaykuna*) by paying a sacrificial offering in return for the "owner of the place" (*lugarniyuq*) (see also Rösing 2010).

In modern clinical music therapy, music is said to contribute to healing mental conditions such as depressions and anxieties (Wang and Agius, 2018; Erkkilä et al., 2011; Maratos et al., 2011; Maratos et al., 2008). Although these conditions would probably be attributed to the dispersal of fluids (fat, air, blood, spirit) from the body (Bastien, 1985), and not particularly to what 'Westerners' call mind, it is quite common in the Kallawaya region to identify the sound of *qantu* panpipes as being an alleviative of depression, melancholy, sadness and sorrow, although there is a stereotype among 'Western' listeners that the particular multiphonic sound structure of the whole consort is 'melancholic' in nature (Stobart, 2017; Hachmeyer, 2018). That *qantu* music is an alleviative of depression is related to a tuning ritual, that has been done with new *qantu* panpipes *(qantuphukuna)* in former times. Newly crafted *qantuphukuna*

were bathed in rosemary water, as rosemary is a medicinal herb against depression and melancholy (Langevin, 1990). During the ritual bath, the properties of rosemary are incorporated into the new *qantuphukuna*, which posteriorly have the same healing powers as the medicinal herb. In Rösing's (2010, 1992, 1991) very detailed ethnographic descriptions of *llaki wijch'uña*, nothing is written about the involvement of collective music such as *qantu*. During every individual and family healing sessions of ritual and spiritual character, collective music is rather not involved (Rösing, 2010), although the *jampiy rimaykuna* of the ritualist sometimes assume melodic and rhythmic forms of spiritual chants, which travel along the layers of the multiverse to make trans-specific communication possible. As Allen (2015) argues, if 'normal' human beings want to participate in the unintelligible speech of places, houses, meteorological phenomena or mountains, earth beings in all of their complexities, they have to call upon an 'extra-ordinary individual', who is capable of trans-specific communication. This is fundamental for many healing practices and rituals as earth beings play a crucial role in maintaining or (re)establishing human health.

5. Collective music and rituality in the context of agricultural production

Collective rituals are more related to particular climatic seasons during the year, which is divided into the dry season (*ch'aki pacha*) and the rainy season (*paray pacha*). Although much of these collective rituals have been lost lately (Rösing, 2008a), some local communities, like Niñocorin, still continue practicing social and spiritual gatherings, where collective music, performed with distinct dry and rainy season flutes, is an essential part of anticipating and initiating seasonal climatic shifts (*pachakuti*) within the agrarian calendar (Hachmeyer, 2015). 'Good' climate conditions are 'adequate' climate conditions for particular agricultural tasks (ploughing, sowing, hilling/ridging, weeding, harvesting), and as many rural Kallawaya communities still depend on rain-fed subsistence agriculture, adequate climate is fundamental for their well-being and the continuation of life, both from an emotional and biophysical point of view. Van den Berg (1989) once argued that the earth requires reciprocal forces, energy and feeding in order to produce agricultural crops in turn. 'Playing music in the context of agricultural activities and rites', Van den Berg (1989: 84 [my translation]) writes, 'is not

simply an act of amusement […]. Rather, it is one effort more for guarantying a good harvest and that life continues'.[11]

One important gathering is the rain-related ritual called *qallay* in November, shortly after the feast of the dead (All Saints). Maize sowing *(sara tapuy)* already happened, and new seedlings require rain to start growing properly. Growing agricultural fruits is the reciprocal act *per excellence*, as you closely get in touch with the earth, work it, ask for its nutrients. After a long and dry *ch'aki pacha*, where the earth and soil turn bare and yellow (Stobart, 2006), and the whole world presents a moment of lifelessness, *qallay*, literally meaning 'beginning' in Quechua, is the re-initiation of cyclic life. In the early morning, so-called messengers *(kachapuriq)* take offerings to sacred water-related places, such as springs or mountain lakes, and bring something to the community in return, like flowers, herbs or water. The *kachapuriq* are received with food and recorder-like *pinkillu* duct flute music, and posteriorly, the Kallawaya collective ritualist of the community, 'the one who makes the year walk' *(watapurichiq)*, prepares the ritual offering with the ingredients that the *kachapuriq* brought to the community. Much has been written about collective rain rituals (*parayman purina, wakayli*) in the

[11] The relation between collective music-making in rural Indigenous communities in Bolivia and agricultural production has also been profoundly studied and documented by Stobart (2006).

Kallawaya region, but the animating power of musical sound has often been degraded to merely accompanying these collective ritual practices (cf. Rösing, 1996, 1995). Interestingly, Rösing (1995) argues that sacrificial *mesa* of rain rituals cannot be visually distinguished from the *mesa* prepared in other collective rituals during the agrarian year. Hence, it is not the ritual performance that reveals the logic of reciprocity, but spoken words, prayers and chants, which invocate Andean spirits of rain (Rösing, 1995). During *wakayli*, children and women cry for rain on the top of a hill. In a multiverse with species-specific intelligible speech and understanding, crying is a trans-specific form of communication of a dependent towards a nurturing guardian who listens (Rösing, 1995; Stobart, 2006). Crying is a moment of communication necessity, temporarily disrupting the overall equilibrium of forces and energy, in order to perpetuate the ontological tension between dependent and guardian, on which life and all existence is founded (Stobart, 2006). Similarly, *qallay pinkillu* flutes are said to cry (*waqay*), if blown strongly with strident sonorities (in their first and second harmonics). Therefore, I have argued elsewhere that musical sound, rather than being the only accompaniment of collective ritual practices, is the cosmic centrality for anticipating and initiating the transformation of *pacha* (*pachakuti*) (Hachmeyer, 2015). This relates to the central and enigmatic Kallawaya wind spirit called

ankari (Rösing, 1990b). There are many versions of *ankari*, his purpose and sphere of action, which indeed renders him ontologically in many ways. Among many Kallawaya ritualists, *ankari* is the servant of the mountain spirits (*apu*), who brings the sacrificial offerings to sacred places. As such, *ankari* is very important for the local climate.

Rösing (1996) shows that many rain rituals in the Kallawaya region have the purpose to 'close the door of the wind' (*wayra punku*), so that *ankari* does not disperse the rainclouds with his breath. Talking about the *qallay* in Niñocorin, my host, the *yachaj* Feliciano Patty, once associated the sound of rainy season *qallay pinkillu* flutes with detaining and banning *ankari*. As the fipple regulates the airstream towards the bevel, the produced sound analogously detains or bans the wind, so that rainclouds are not dispersed. It is a musical sound that initiates the transformation from dry to rainy season, through regulating local wind and rain patterns. Musical practices constitute 'healthy', but sometimes tensional correspondences between different living beings in interrelated and cohabited worlds (*pacha*). They strengthen the sociality between humans and non-humans and prevent harm to the well-being of the whole community, for example, adverse climatic conditions for agricultural production. They are mainly about trans-specific communication.

6. The body of the mountain and Kallawaya humoralism

Yet, unexpected or unprecedented changes in the local climate understood as a 'physical-moral complex' (Rivière, 1997), are manifestations of a weakening of reciprocal relationships (Hachmeyer, 2015; Bold, 2016). As a consequence, the whole 'body of the mountain' (Bastien, 1978) becomes sick, including all beings inhabiting it. This vividly expresses the idea of the mountain as a living body, and how people live in constant material and energetic interchange with the mountain. Bastien (1985) argues that this would explain why Kallawaya ritualists feed earth shrines of the mountain when they are sick.

The human body is called *ukhu* in Quechua, which means 'within' or 'inside'. Sometimes, the suffix *-nti* is added, *ukhunti*, which refers to the idea of emergence or wholeness of its parts (Bastien, 1985). Bastien (1985: 598) argues that the

> wholeness (health) of the body is a process in which centripetal and centrifugal forces pull together and disperse fluids that provide emotions, thought, nutrients, and lubricants for the members of the body. Moreover, this process extends beyond dualistic confines of inner and outer, in that fluids of the body are governed by similar dynamics within the environment. Fluids flow back and forth between the body and the mountain, which has a central axis and

> levels through which air and water flow inward and outward. (Bastien, 1985: 598) [12]

Elsewhere, I argued that the human body and the body of the mountain are ontological equivalents (Hachmeyer, 2018). The fluids of the human body are governed by similar dynamics within the mountain. They flow back and forth between the body of the person and the mountain, as an inseparable unit, in which the person is bound to the mountain, as much as the mountain is bound to the person, *through* their bodies. The integrity of the person-mountain-body, or 'health' in other words, is a process in which centripetal and centrifugal forces unite fluids in order to disperse them to the peripheries. Illness, not only of the person but also of the mountain, the local climate or *pacha* in general, are linked to improper circulation of fluids and the disintegration of internal elements. This corresponds with the way that Kallawaya herbalists primarily treat the circulation of body fluids like air, fat, water, bile, blood, etc. The Kallawaya herbal specialist often

[12] Bastien's (1985) statement can be considered perspectivist in the sense that affects render bodies unique, not physiology. 'A perspective is not a representation because representations are a property of the mind or spirit, whereas the point of view is located in the body. The ability to adopt a point of view is undoubtedly a power of the soul, and non-humans are subjects in so far as they have (or are) spirit; but the differences between viewpoints (and a viewpoint is nothing if not a difference) lies not in the soul. Since the soul is formally identical in all species, it can only see the same things everywhere – the difference is given in the specificity of bodies. […] I am not referring to physiological differences – as far as that is concerned, Amerindians recognize a basic uniformity of bodies – but rather to affects, in the old sense of dispositions or capacities which render the body of every species unique: what it eats, how it moves, how it communicates, where it lives, whether it is gregarious or solitary…'. (Viveiros de Castro 2012: 112f)

diagnosticates illnesses through analyzing the pulse of his or her patient. Depending on the patient's blood quality (hot=fast, cold=slow, wet=thick, dry=thin), the herbal specialist prescribes different medicinal herbs (hot/cold) for regulating circulation processes. *Qallay* music and dance also relate to the person-mountain-body and this idea of integral 'health'. All participants dance in a row like a meandering river, moving upwards and downwards on the main square until the musicians form a circle in the middle of the square and the dancers dance around it in a counterclockwise direction, followed by a clockwise direction (Hachmeyer, 2018, Bastien, 1978). The dance is part of the renewal and regulation of body fluids, in the human body, but also between the human and the mountain.

7. Conclusions

Finally, we can return to Álvarez's statement about the healing properties of *qantu* music introduced above. Interpreting his statement in the light of Kallawaya humoral understandings of the body, we could suggest that *qantu* music's kinaesthetic elements regulate circulation processes of the body, not only of the human body but also of the mountain body. At least as often Álvarez evoked the term 'music therapy', he similarly used the term 'dance therapy' to designate the healing power of *qantu* music. During their typical choreography, the musicians turn

around in a counterclockwise rotation, followed by a clockwise rotation. Similarly, couples dance like a meandering river and spin around in counterclockwise and clockwise movements. Many music and dance choreographies in the Kallawaya region are related to such a place-based humoral and bodily focused healing, which is based on animist/perspectivist ontological premises.

However, it is interesting that emotions and thoughts, but also communicative sound production, i.e. speech, are all related to fluids in the body, especially the air and its transversal link to respiration and the wind. Most emotional states and moods, but also related pathologies, are related to the lungs, rather than to the heart or something similar to what 'Westerners' call mind.[13] They are transported by the wind and enter the body through respiration (Burman, 2016). This obviously makes the relation between *ajayu* and *ukhu* much more complicated. Thus, the mind/body dualism, on which animism and perspectivism are understood as hierarchical inversions of naturalism[14], results to

[13] Against this background, it must sound a little bit pointless for many Kallawaya healers or *originario qantu* musicians from Indigenous Kallawaya communities, that local *mestizo* townspeople in the municipal capital of Charazani often state that *qantu* music as an alleviative of sadness and depression 'fills the heart'.

[14] 'Naturalism, typical of Western cosmologies, which supposes an ontological duality between nature, the domain of necessity, and culture, the domain of spontaneity, areas separated by metonymic discontinuity' (Viveiros de Castro, 2012: 84). Naturalism is the idea that humans differentiate from non-humans by virtue of their interiority, that only humans have immaterial qualities such as reflexive thinking, morality, soul,

be limited, to a certain degree, to understand the complex relationships between spirit and body in the Kallawaya (or probably even Andean) context. On the one hand, *ajayu* itself has some components being more related to the body *(juch'uy ajayu)*. On the other, my host argued that *ajayu* is rather part of *ukhu*, although the main or big spirit *(jatun ajayu)* would always be in contact with the broader web of life, thus going beyond the boundaries of one's own body.[15]

Concluding the article, I would argue that the focus on the body in Kallawaya healing, including music, chant, and sound, has to be related to the prevalence of animist/perspectivist ontological premises, where the body is the central locus of perspective, difference and relationality. This might differ, to a certain degree, to modern (naturalist) approaches of clinical music therapy where the mind is the centre and mental health the ultimate goal of music interventions. Then, it is not surprising that modern science-based clinical music therapy, which has been rooted in social science concepts like 'well-being' from the beginning, lately tends to shift towards more cognitive neuroscientific approaches (Thaut, McIntosh and Hoemberg, 2014). Whether the

language, and that humans and non-humans share the same physicality (Descola, 2013).

[15] Therefore, I would suggest that certain elements of what Halbmeyer (2012) called 'Amerindian mereology' are very central to Kallawaya or other Andean ontologies. I discuss this more in detail elsewhere.

use of the concept of music therapy in the Kallawaya context ultimately helps to facilitate intercultural communication is open for debate. Nowadays, Kallawaya healers sometimes use the same words as their modern homologs but mean different things; a fertile ground for uncontrolled equivocations.

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Musicology Research
Issue 6: pp. 83-101

4

Pregnant Women in Prenatal Music Settings: Moving from Research to Implementation Through A Literature Review

Sofia Deligianni

I used to say we should teach music
to children nine months before they're born.
Now I say we should teach music
nine months before the birth of the baby's mother.
– *Zoltán Kodály*

1. Introduction

The environment of a newborn child is flooded by various sound stimuli from the first moments of their life. Some of the sounds are unknown to them. However, it seems that babies react in a special way to a familiar voice or sound. As a consequence,

neonates' responses to stimuli generate a lot of discussion about the auditory capability of foetuses and their auditory experiences during life in the womb. Together with the transmission of the sound in the womb, researchers show their interest in studying foetuses' responses to music prenatally and postnatally as well as exploring the influence of music exposure to the pregnant woman. As a result, further interest is generated in involving music in prenatal life and taking advantage of its effects on the pregnant woman, the foetus, and their binary relationship.

Nevertheless, before we delve into the importance of music in prenatal life and explore the different ways of using it, we should first consider the capability of the foetus to hear and detect internal and external sounds. For the definition of the foetal auditory capabilities, behavioural and psychological endeavours were implemented, initially with abstract sounds and afterwards with music samples.

The first samples which were produced outside utero – organized in sound and vibroacoustic form – were composed in order to determine the intrauterine sound environment and the foetal auditory competencies. It is essential to mention that until the nineteenth century, the embryo was considered to have no sensory capabilities (Arabin, 2002: 425). Therefore, it is only since

the 1920s and 1930s that obstetricians have begun to systematically investigate antenatal responsiveness to sound stimuli (Lecanuet, 1996: 45). Since then, scientific approaches to the understanding of the foetal audition have been widely extended.

The first published indications for the employment of music stimuli, in contrast to prior pure tone samples, seems to appear at the end of the 1960s (Sontag, Steele and Lewis, 1969: 2). Since then, a new element tends to be considered; the individual maternal reaction to the provided music stimuli and the consequences of it to the foetus. The provision of music experiences generated new pathways to exploration. For example, the foetal habituation and memory, the pre- and postnatal maternal and foetal effects, and the maternal-foetal attachment. Research beyond the 1990s, mainly placed in European countries, but also in the East and in other nations of the world, demonstrate an increasing number of prenatal music practices relating to the utilisation of passive music methods of listening to recorded music. Contemporary studies of the twenty-first century explore the more active practice of singing, with the experiments to be at the early stages of utilisation. Equally, the attributes of music action and interaction, movement, singing,

performing, and improvisation organized in a music programme are significantly scarce.

The present paper will demonstrate, through a literature review, the need for further music interventional studies and implementations during the antenatal period. The presented data indicate a significant lack of related applications, while the limited organized programmes report essential outcomes. Lastly, the proposal to create a prenatal music programme defines the principal objectives of providing rich music stimuli and experiences for the embryo and the pregnant women, while the utilised mediums are conducive to achieving an active and interactive structure. Further related details are categorised and reflected below:

2. Studying the Studies

Moving towards the analysis, it can be easily observed that the music provision during the studies tends to be categorised into recorded and vocal stimuli. As far as the recorded music is concerned, it appears that the auditory stimuli that researchers primarily employ are traditional music, classical music, nature sounds, relaxing instrumental music, and lullabies. Regarding vocal stimuli, the maternal voice is barely used and mainly to sing lullabies. Nevertheless, both kinds of mediums mainly aim,

through a systematic application, to the maternal-foetal attachment, maternal stress limitation, prenatal response to music, and foetal learning measurements. Elements such as the duration, frequency, presence of a facilitator, and setting of a class are associated with the provision of music material and are customized to the research concerned.

To illustrate, in instances that emphasise maternal-foetal attachment, music listening technique does not seem to have been utilised widely. Very limited pieces of evidence are provided, either indicating a significant influence on maternal-foetal bonding (Yang and Kim, 2010: 576) or not (Shin and Kim, 2011: 19). Likewise, gravid women were exposed to recorded music in order to limit anxiety and perceived stress. A systematic review of five individual music-based interventions performed by van Willenswaard et. al. (2017: 78) demonstrated no substantial perceived stress reduction on pregnant women, while the same music interventions signified evidence of anxiety limitation during pregnancy. To elucidate, it appears that the procedure of passive listening, which entails no interactive behaviour, demonstrates no essential outcomes in case of maternal-foetal relationship and maternal perceived stress limitation.

Continuing with the analysis, it seems that despite the big number of publications about the influence of the maternal voice and vibro-acoustic stimuli on the foetus, only a few papers about foetal reactions to music have been reported (Al-Qahtani, 2005: 414). While heart rate accelerations or decelerations in response to sound begin at about 25 weeks (Graven and Browne, 2008: 188), motor and heart rate responses to music are more frequent at 38 weeks (Wilkin, 1995/96: 168). Depending on the elements of the music and the condition of the foetus during the exposure, the embryo tends to display an alteration both in the heart rate moving upwards or downwards to the respective tempo (Gerhardt and Abrams, 1996: 11) and in motor responses (Lecanuet, 1996: 48). In conjunction with the encouraging endeavour of studying this particular subject, crucial limitations need to be taken into account. Corresponding difficulties, which are expressed occasionally by the researchers, refer to the spontaneous variations in foetal behaviour (James, Spencer and Stepsis, 2002: 437) and the case of no foetal reaction to something that it is possible to be perceived (Hepper, 1992: 137).

Consequently, it emerges from the studies that the aforementioned foetal behaviour tends to follow maturational changes. A competent number of researchers have examined the behavioural maturation of the embryo in terms of 'foetal

memory' (Graven and Browne, 2008: 192; Hepper, 1996: 16), 'habituation' (Lecanuet, 1997: 51; Hepper, 1997: 343) and 'prenatal learning' (Moon and Fifer, 2000: 41; Graven and Browne, 2008: 191). Habituation process assumes short-term memory (Kisilecsky and Low, 1998: 15) as the embryo can preserve auditory memory and decrease its response to repeated stimuli (Arabin, 2002: 427). It seems that only early sources are involved with this field using mainly vibro-acoustic stimulation, whereas no use of music seems to arise from the literature. Additionally, in terms of long-term memory, prenatal auditory experience has an impact in various postnatal situations (Lecanuet, 1996: 53). Studies have indicated that prenatal acquired memory of a music stimulus may affect neonatal performance of sleeping (Tabarro et al., 2010: 448) and decrease heart rate and movements (Hepper, 1991: 99) while the effect duration of the prenatal music exposure to neonates varies between the studies.

Contrary to listening to recorded music, which rarely could be described as an active attitude, maternal singing during pregnancy could be expressed as an active music performance spreading emotions. Unfortunately, the utilisation of perinatal maternal singing is lacking in research. Arabin and Jahn in 2012 attempted to evaluate the consumption of recorded music, active

singing, and performing music of 500 pregnant women, demonstrating that only the 26% of them used to sing at least once per week (Arabin and Jahn, 2013: 358). Moreover, the same study presented that multiparous women as well as highly educated women tend to sing significantly more during pregnancy (Arabin and Jahn, 2013: 359). In spite of the low percentage of prenatal singing tendency, some researchers attempted to investigate lullaby singing influence during the period of pregnancy. Essential findings of the *Limerick Lullaby Project* suggest that learning to sing lullabies in a group facilitates the expression of complex emotions, engendering feelings of connection with the unborn baby as well as with other pregnant women (Carolan et al.; 2012: 321). Furthermore, a corresponding study that took place in Italy has demonstrated no significant impact on maternal-foetal attachment, while in terms of maternal stress and postnatal bonding, crucial results were performed. Lastly, Montemurro's findings present the capability of pregnant women to feel their unborn baby participating with spontaneous foetal movements in mother's traditional lullaby singing in Spain (Verny and Weintraub, 2002: 64).

3. Moving from Research to Implementation

The brief aforementioned literature review deduces that a sufficient number of studies have been devised in order to

present information about the prenatal music exposure and the consequences of it postnatally. Nevertheless, a more thorough methodological review indicates that the majority of these studies tend to provide less active mediums as stimuli, such as the recorded material, recorded maternal singing voice and abdominal headphones. The tendency for short-term interferences and the lack of active and interactive process, occasionally, tend to lead to a passive methodological approach instead of fostering a unique experience of interaction between the embryo and the pregnant woman. In contrast, active music interventions and long-term interferences could enhance this binary interaction and lead to a 'music-nurturing' process, significant for the mother and the foetus, as well as for both together. Irrespective of the study purposes, any endeavour that provides music stimuli to the mother and the embryo during the gestation would be advisable to foster their interaction and engender qualitative music experiences.

However, a literature review of active music engagement during pregnancy seems to indicate a limited number of relevant published studies. An encouraging enterprise, which was drawn up by Kaarina Marjanen (2009: 86), studies the possibility of building on prenatal music education practices in comparison to postnatal music methods or none at all. To be more precise,

musical goals associated with the musical components are planned and elements such as improvisation, listening experiences, vocal play as well as physical activities are primarily utilised, while all the sessions are conducted by the music education specialised researcher (Marjanen, 2009: 86). Furthermore, Lorna Zemke working with pregnant women focuses on bringing the embryo in contact with mother's voice through relaxation, tactile and singing activities, building on the foetus's auditory stimulation through instrumental exploration, and fostering the sense of pulse through movement activities (Amtmann, 1997: 70-71). Further reported music programmes planned for pregnant women indicate various activities such as vocal toning, customised words to known melodies, parents talking and singing to the embryo, and singing combined with stomach massage (Young, 2003: 24-25; Charitaki, 2015: 9).

The utilisation of the above methods in a setting of active and interactive communication tends to lead to various advantages for the mother, the foetus, and the relationship with each other prenatally and postnatally. The construction and the implementation of corresponding music programmes entail the early connection of the foetus with the outer environment and the enrichment of his/her auditory experiences, providing in this way an early intrauterine enculturation. The collected data from

the above literature demonstrate a great quantity and variety of acquired musical tools for the parents to be used in the perinatal bonding process and postnatal interaction. Related evidence is presented in Marjannen research (2009: 93), where the active methods of using the voice for singing or saying rhymes and playing an instrument or body percussions comprise the highest percentage. Deep emotional responses are also expressed while the provision of music practices strengthen the connection with the unborn child. Furthermore, related findings express high rates of the mother's relaxation as well as a strong connection with themselves, providing a sentiment of balance in pregnancy and in the upcoming labour (Demecs, Fenwick and Gamble, 2011: 116-118). Particularly noteworthy is the capability of the obtained balance to be imparted to the home environment, spreading pleasant emotions, as it is expressed in Demecs Fenwick and Gamble's research: 'I came home you know feeling happy…if the mother of the house is feeling good then everyone else feels good' (Demecs et al., 2011: 118).

The aforementioned advantageous consequences of a prenatal music programme cultivate a breeding ground for the creation of corresponding implementations. A major aspiration of it, would be the creation of an environment suitable for foetus's familiarisation with diverse music experiences. Nonetheless,

essential is the role of the mother in this process, since she is the caregiver who will allow the transmission of music stimuli to the embryo. Therefore, it is considered prudent to initiate parents into a setting of qualitative and music-nutritional creation in order to develop prenatal and postnatal benefits for the caregiver and the foetus.

Considering all the above-presented information and making allowance for the existing literature, the present paper attempts to demonstrate the basic elements that would constitute a music programme for pregnant women. Structural elements, including the suggested objectives, the methodology, and the music material, are elucidated below in order to create a comprehensible idea of an active prenatal music programme and provide an incentive effect for the person concerned.

In the first place, it would be advisable to refer to the suggested aims of the planned music programme. Taking into consideration the relevant literature data and the already expressed desires and expectations of pregnant women, we could determine the aspirations both for the mother and the foetus. On the one hand, the mother needs to find through the sessions time for relaxation and stress limitation. Particularly significant is the effort of making connections with herself, her

unborn child, and the other members of the group, expressing, with the music as medium, inner thoughts and emotions. Additionally, vital element is the acquirement of useful musical tools in order to be used prenatally and postnatally, in moments of interaction, and in emotional, sensory and physical nourishment. On the other hand, the cultivation of a friendly outer environment is significant for the foetus, constituted of sufficient and various music stimuli. In contrast to the objectives that are set out for the mother, the posed aims for the embryo cannot be assessed for their level of success prenatally. Therefore, new research should be conducted in order to study the effects of prenatal music programmes postnatally.

As far as the methodology is concerned, the suggested music programme should be structured in a manner that allows active participation in terms of performing, singing, and dancing. The programme would be advisable to be organized in long term sessions in order to enhance the group's bonding process and trust. The sessions should be led by a well-trained music facilitator capable of strengthening the emotional expression through music and offer continuous opportunities for participatory music creation. In addition, the facilitator needs to provide the mother with the security and liberty of expression, as well as relieve her from any kind of shame and hesitation.

Particularly important is the creation of a flexible semi-structured session plan, able to be adapted to the needs and suggestions of the pregnant women. Lastly, the preparation of an audible or written piece of work at the end of the sessions could function as a memento and give rise to mothers to continue using the material after birth.

With reference to the music material, the voice is an element that should primarily be used both by pregnant women and the facilitator. Of major importance, the mother's voice that could be described as a dual experience for the embryo, as the sound vibrations are transmitted both via the bones, internally, and through the air, externally (Trehub and Trainor, 1990: 90). Apart from lullabies and rhymes, tools such as tactile stimulation and body percussion performance could be performed through singing or alternatively be combined with recorded music. Recorded material could also be utilised for relaxation and dancing purposes including classical and nature sounds. Furthermore, instrument exploring, improvisation activities, and individual creation are highly recommended, as they could provide a more personalised way of expression. As a final point, equally important is the contribution of the women to the chosen material by sharing with the group ideas that they remember from their childhood. The process of sharing personal material

could be provide evidence of successful familiarisation with the team and willingness for a second way of involvement to the programme.

Admittedly, it is an undeniable fact that there are still many obstacles that need to be overcome. The implementation of corresponding endeavours requires not only the existence of suitable mediums and well-organized objectives by the creator but also a society who will be willing to integrate music into the nurturing process, while at the same time will adopt nurture features to the prenatal parenthood attributes. Modern lifestyle, contemporary ideas, and technological interventions tend to detach natural elements of parental giving from what is ultimately provided. Respectively, in regard to the antenatal period, von Raffler-Engel (1993) states, 'women used to sing to their child in the womb, now pregnant women attach devices to their body that produce soothing noises for the fetus' (1993: 23). Nowadays, this statement is more topical than ever, when commercially available music devices sacrifice maternal music nurture on the altar of more "convenient" methods. As a consequence, foetuses are flooded with doubtful quality music stimuli and ambiguous samples of quality time.

4. Summary

To summarise, it seems that all the above expressed ideas and concerns go beyond the typical transmission of the sound. The purpose of building respective music implementations is, on the one hand, to cultivate the concept of prenatal bonding, stress limitation, and qualitative stimuli provision and on the other hand, to foster the intra-uterine 'enculturation' (Raffler-Engel, 1993: 21) of the embryo. The present paper attempted to emphasise the need for music interventions during the prenatal period, demonstrating, through a literature review, the significant lack of respective implementations. Moreover, it aimed to gather together the basic elements that would constitute a prenatal music programme, facilitating this way the access to this subject. It is an undeniable fact that the involvement in a relevant experience could benefit not only the mother and the foetus, but also the relation with each other. At the same time, relevant endeavours would allow pregnant women to participate in a prenatal nurturing process using music. However, this process needs the constitution of further music interventions, organized in an active and interactive form which will allow and enhance the binary interaction between the pregnant woman and the foetus.

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5

'Making Music in the Wards Felt Like Lifting Off a Grey Cloud and Letting in a Ray of Sunlight': Emerging Findings From Medical and Music Student Experiences of Training with Hospital Musicians

Rosalind Hawley, Julia Humphreys, and Shanath Ramachandran

1. Introduction

Studying to prepare for the professions of music or medicine share similar pressures. Long hours of study, pressures to achieve high standards and anxiety in being able to perform at the best of one's ability affect students from both disciplines. In

both professions, there are dangers of experiencing burnout and stress which negatively impact on professional abilities and confidence levels. During post-session reflective discussions with students as part of LIME Music for Health training modules, where students go to paediatric hospital wards to participate in making music, it is apparent that experiences of engaging in music making with children and families in hospital gives students a new perspective on their abilities to communicate. Whilst the focus of the training module is centred on how to use music to assist children in dealing with the stresses and anxieties often associated with hospitalization, the experiences created through music making also offer students a space to consider their own wellbeing needs, and to consider the abilities of music making in alleviating feelings of stress and anxiety associated with their own studies. This paper discusses the learning opportunities experienced by participating students during training and shares our emerging findings which we believe support the argument that such programmes benefit the wellbeing of music and medical students. It includes a case study contribution on student burnout written by medical student Shanath Ramachandran as a result of his participation in the programme. We use our findings so far to argue for further research as to how participation in professional music, health

and wellbeing placements supports the wellbeing of music and medical students at a crucial time in their career development.

2. LIME Music for Health

Medical Notes: Music at the Heart of Life at The Royal Manchester Children's Hospital, is an award-winning ward-based music programme run by LIME Music for Health. Funded by the UK charity Youth Music with support from the Manchester Hospitals Foundation Trust, the programme delivers a series of ward-based professional musicians' residencies, conference and music festival events and training programmes each year which place music at the heart of the hospital environment. In 2018, the programme was awarded the NHS in the North Excellence in Supply Patient Experience Award, and in 2016 a key specialist strand of the programme (Songbirds) was highlighted as an example of good practice by the National Children's Bureau and The Council for Disabled Children in 'listening to the individual child'. Based on a European model of hospital music making developed by Musique et Santé and documented by Preti and Welch (2004, 2009, 2012, 2013) and Preti (2013), the programme includes separate undergraduate modules for music and medical students from The Royal Northern College of Music and The University of Manchester Medical School.

Over 100 music students and 50 undergraduate medical students have undertaken training placements since 2012. Evaluation of the programme in 2016 by Salford University School of Health and Society found that musical interaction:

- supported children's resilience in dealing with hospitalization;
- transformed the hospital experience, empowered children and families in hospital;
- enabled parents to reconnect with their child after a life changing medical event, promoting feelings of hopefulness in dealing with challenging circumstances.

In addition, the evaluation team found that medical students reported the training improved abilities to communicate with children in hospital, and music students reported being better able to cope with stress and anxiety related to performance practice[1].

3. Preparing for the Music Profession

It is already documented that pressures associated with life in the music profession can affect an individual's sense of wellbeing

[1] The full report can be downloaded at usir.salford.ac.uk/40341/ accessed 30/10/18

and their ability to cope with the daily pressures of their work (Brodsky, 1996). Studies of Music Performance Anxiety (MPA), predominantly focused to date on the western Classical music tradition, have demonstrated that whilst a heightened level of arousal is to be expected as a musician prepares for a performance, significant increases can impact on a musician's ease, comfort and ability to perform, affecting memory, confidence, and self-esteem. These increases can cause physiological changes in the body which in turn make the technical demands of performance more difficult to achieve (Matei and Ginsborg, 2017).

In combatting these effects there is some evidence to suggest that opportunities for orchestral musicians to apply musical skills in contexts away from the concert hall have a positive effect on senses of wellbeing and engagement. Existing studies of orchestral musicians participating in community-based education programmes in schools show that these experiences impact on states of professional and personal wellbeing, career perception, and professional development. Abeles and Hafeli (2014) reported that orchestral musicians working on a school-based programme in the USA had opportunities to express creativity, develop meaningful relationships with schools and pupils, become aware of the potential impact on individual

students' lives, and to serve the community. They also stated that orchestra musicians' perspectives of their career paths appear to be enhanced by providing opportunities for them to work closely with students, particularly in under-resourced schools in their communities. In the UK, these findings are echoed in recent research commissioned by London Music Masters where musicians working in primary school settings reported on the development of professional and interpersonal skills, and musical, cognitive and teaching skills. Ascenso (2015) argues that community engagement offers orchestral musicians unique opportunities to develop these skills and that such participation impacts on a musician's sense of identity, in making meaningful creative contributions and on feelings of wellbeing.

To date, there is little research focusing specifically on the professional practice of musicians working in hospital settings (Preti and Welch, 2013), and a lack of specific research on the benefits of music students participating in training programmes related to the profession. The research highlighted here however suggests that there is potential for such opportunities, when included within a student's learning experience before entering the music profession, to impact positively on a student's musical identity, promote positive messages of wellbeing and possess the potential to counteract some of the symptoms of performing

under pressure which may arise during conservatoire training and may support resilience on entering the music profession.

4. Medical Training, Study, and Anxiety

The link between symptoms of stress and anxiety, and the rigours of a course of study (in particular a medical degree), is well recorded within the literature (Bunevicius et al., 2008; Hassed, et al., 2009; Hope and Henderson, 2014), with higher levels of reported symptoms of anxiety than that of the general population (Rotenstein, et al., 2016). This becomes evident from the commencement of a medical course when stress, depression, and burnout become emergent threats (Dyrbye, et al., 2005). The consequences of continued elevated levels of stress can negatively impact upon tasks that are both essential and commonplace within clinical practice, namely; concentration, working memory and recall, as well as the cognitive features of decision-making (LeBlanc and Vicki, 2009). Medical educators therefore have a duty of care to both medical students and patients to develop curricula with features that recognize and respond to psychological morbidity. Methods for early detection, prevention and treatment are all key to ensuring the wellbeing of medical students and the creation of resilient future doctors (Puthran, et al., 2016).

5. 'Consequences of Burnout' – extract from 'Medical Humanities and Burnout' by Shanath Ramachandran, Year 4 medical student APEP Report, 2015

Studies investigating student mental health suggest that burnout is associated with both depression and anxiety (Bugaj et al., 2016). Further, burnout appears related to increased substance and alcohol abuse amongst students as well as consequent co-morbidities (Dyrbye and Shanafelt, 2016). A study of 4,402 medical students in the USA found that 32.4 percent met the criteria for alcohol abuse; of these students, 80 percent were suffering burnout (Jackson, et al., 2016). Importantly burnout is linked with an increased likelihood of suicidal ideation; a hypothesized reason for this is that burnout may precipitate a form of formal mood disorder (Dyrbye, et al., 2016).

Suicide rates are higher amongst medical students compared to an age-matched population, with this trend also observed in physicians. A study of 2,648 medical students in the USA showed 17.4 percent had thoughts of suicide during their course (Dyrbye, et al., 2012). It also demonstrated that recovery from burnout decreased the prevalence of suicidal ideation, thus suggesting a causative association (Dyrbye, et al., 2012). Interestingly, a triad of burnout, alcohol abuse and suicidal ideation significantly increased the risk of suicide attempts (Dyrbye, et al., 2016). In addition to health consequences,

burnout impacts upon a student's career. It is linked with a higher incidence of student's dropping out of their medical school course (Dyrbye, et al., 2010). A study of 2,248 students in the USA noted that 25.9 percent of students had seriously entertained the possibility of dropping out and the risk of dropping out was estimated to be five-fold (Dyrbye, et al., 2010). We do not possess similar data in the UK; however, this study and others indicate that a similar phenomenon is possible although geographical and cultural differences can exist (Cecil, et al., 2014).

A further consequence of burnout is the impact upon patient care. Studies suggest that burnout is linked with a reduction in the professionalism of students and doctors alike (Bugaj, et al., 2016; Dyrbye, et al., 2016). Students suffering with burnout are more likely to engage in unprofessional behaviours such as cheating or plagiarism (Dyrbye, et al., 2016). Furthermore, students suffering with burnout self-report a reduction in the quality of patient care. Burnout can impede cognitive reasoning, which is an essential skill required in a doctor to ensure the safe delivery of healthcare with the patient at its centre (Bugaj, et al., 2016). A study in the US looked at the differences between those suffering from burnout and those not by analyzing the results of a standardized examination of medical knowledge; the results

were that those with burnout performed significantly more poorly. Students suffering with burnout also report a reduction in concentration throughout the day; this could represent a significant risk to the patient (Dyrbye, et al., 2016).

Burnout is also linked with heightened apathy towards one's own work. The result is a reduced level of empathy amongst the student; where empathy is considered to be one of the cornerstones of a good medical practitioner. These students also report a reduction in altruistic feelings toward society as well as an increase in cynicism regarding both their work and society as a whole (Bugaj, et al., 2016; Dyrbye, et al., 2016).

6. Training Methodology: Acquiring Skills for Hospital Music making

Although currently run as two distinct programmes of training, music and medical students undergo a similar learning pathway centred on understanding how bedside musical interactions are developed on paediatric hospital wards with children, families, and staff. Led by members of the Lime Music for Health team, both programmes include observing specialist musicians working on hospital wards, participating in training sessions to develop techniques to facilitate non-verbal, child-centred, music making and then participating with the specialist musicians in

music making at patient bedsides. The aim of this pathway is for students to experience first-hand how music can connect groups of people when in hospital. In doing so they learn how musicians 'talk' in music to children without using words and use techniques of music making that change the tone, dynamic, or emotional quality of musical sound to be responsive to the communication of an individual patient of family group. Students learn how to listen when they are musicking with others in hospital, as they practice key roles of mirroring, accompanying, supporting, observing, and sharing during ward visits. Students also have the chance to explore their voice creatively, using song and variations in tone quality and vocal sound to mirror and musically converse with patients.

The acoustic environment of the hospital ward is also studied, particularly in relation to the addition of any sound made in music making. Similarly, how musicians move their bodies when in the process of making music to avoid appearing imposing or intimidating to young patients is observed. Students learn to develop simple musical activities from a repertoire that encourages patient-directed music making in conducting and turn-taking games and call and answer conversations – meaning that students must listen first to someone else, before making their own response. The overall ethos of the experience is for

child patients to be at the centre of creative work, to be leaders of it, and for their 'voice' to be heard using an approach that supports holistic and person-centred healthcare. Music making at a patient's bedside creates an autonomous space away from medical hierarchy, where patients and families connect and communicate, often without words, through music, similar to the concept of music asylums explored by DeNora (2013). This training enables students to become part of this experience and understand its value, as they develop skills to be responsive to a child's communicative musicality by developing skills in using often-simple sounds and gestures to build much valued spaces for interaction (Malloch and Trevarthen, 2009).

7. Embodied Learning: Becoming 'One' Through Hospital Music Making

During placements, students meet children and families with a wide range of medical needs. Some interactions can be challenging, for example when meeting patients with complex healthcare needs and disabilities where perceptions of communication and responsiveness are challenged. This is when the skills learned in musical interaction come to the fore; guided by the specialist musicians, students practice new ways to communicate. They gain confidence in using these skills through absorbing the performance processes demonstrated by the

specialist musicians and 'being in the moment' during music making acts. This embodied way of learning has been highlighted in studies of musical learning relating to non-western musical traditions. In her study of learning to play the gamelan at the Eastman School of Music, Rachel Brashier observed that 'the acquisition of musical knowledge can be seen as a process of constant, in-real-time process involving both cognitive and sensory abilities' (2017: 1). Brashier references the work of Trimillos and Harnish, and highlights the importance of a student being able to '"absorb" the music until it becomes "part" of the learner' (Harnish, 2004: 127). She states that '… the actions and intentions of the teacher or expert are also sensorially reinforced by the space, physical artefacts, and social experiences of the ensemble setting in which the music is taught' (2017: 2). For students on placement with the team at the children's hospital, this sensory approach to learning is also relevant – observation, listening and touch all become part of hospital musical interaction as students communicate with the children whilst acutely aware of the clinical environment and its effects on young patients.

8. Royal Northern College of Music (RNCM) Training Module

LIME's Music for Health module at the RNCM engages with UG and PG students who have expressed an interest in using music

in a therapeutic context. Each year, around ten students sign up for the module. The placement begins with a three-day intensive training, where students come together to work with members of the LIME Music for Health team in a practical day of workshop activities designed to build skills and awareness in musical interaction and communication. Students explore how to use their instrument or voice to 'talk' or play in sound; they explore following non-verbal direction and using child-centred techniques for musical interaction. The students also explore using percussion instruments and body percussion to make music. They are encouraged to start to think of music making as a 'multi-sensory experience', rich in auditory, tactile and visual communication. Students also learn songs and repertoire that they will be using on the wards and practice improvising around simple musical structures. They then make their first visits to the hospital to observe the music team working and meet key staff who give talks on infection control procedures, professional conduct, safeguarding issues and the emotional challenges that can arise in this context. Students then go on to complete placement visits throughout the year with the team on the wards working in small groups of two or three students per session, completing a reflective portfolio, assessed as part of their degree at the end of the placement.

Figure 1. Music students from the Royal Northern College of Music participate in a music improvisation workshop in the RMCH hospital foyer as part of their training with Lime Music for Health. Photo: Kate Catling, property of and copyrighted to Lime Music for Health.

9. Manchester Medical School Training Module: Quality and Evidence Personal Excellence Pathway (PEP)

The PEP modules are an innovative feature of the undergraduate MBChB programme, where students follow a flexible framework of modules between Years one to five. In Years four and five, students select a four-week Quality and Evidence PEP (QEPEP) module in a topic of their own choice, from a wide variety of subjects, including 'traditional' and 'non-traditional' topics, such as Medical Humanities. The modules equip students with the necessary skills to investigate and analyze patient outcomes, preparing them for medical careers that call into question the evidence required for best practice.

From academic year 2018/19, students will select one QEPEP in Year four and one in Year five. During each of these QEPEP modules, students are assessed on the production of (usually) both a QE Report and Lay Document (with an accompanying Work Report). The Lay Document can take the form of any communicative medium, and in the past has included song, poetry, children's toys, colouring books, and photography. Students are encouraged to consider the most creative and effective means via which they can deliver a healthcare message to their target audience.

Overall, the aim is to enable the student to develop QI expertise in an area of clinical practice that interests them. The QEPEP 'Communicating Through Art and Music' is one such module and aims to explore the power of music and art in developing and understanding the patient/doctor relationship, to create a holistic, therapeutic approach to medicine. During the QEPEP, students work in small groups and are tutored in plenary sessions by professional musicians and composers to explore the role of music in communication. This theory is then applied in separate sessions undertaken on the paediatric wards of Royal Manchester Children's Hospital with Lime Music for Health.

10. Findings: Music Students

In evidence collected during interviews discussing experiences on placement with Lime Music for Health students cited interactions with others during ward sessions, moving focus away from the self and being creative as beneficial learning outcomes from their placement (Hawley, 2014). The training can open doors for students to see that there are other previously unconsidered employment pathways to explore when they enter the profession and that skills gained on placement can feed directly into these future career choices. One student described how her experience on placement developed her abilities to interact, and in doing so helped her to conceptualize aspirations for her future career:

> It's introducing us to the real world... it brings out some of your personality in your playing and is showing us how to interact with the parents and kids... This is something that has opened me up quite a lot and I would really love to have something like this in my career… I think this is enhancing my other experiences... It also gives you more ideas to be creative.

For music students, participating in hospital music making provides temporary relief from the pressures of conservatoire study. New techniques of communication are learned as the focus needed to facilitate a musical interaction shifts from their

own concerns around performance and technical execution towards responding effectively to a child's communication. Students have reported that the placement experience helps with gaining confidence to improvise, promotes value in learning from, and playing music with new peer groups and in new musical configurations, and assists in creating feelings of mindfulness. Students have also provided verbal feedback that they felt better able to deal with practicing without being too self-critical, better able to cope in rehearsal situations, and more confident to perform. Students also value making a human connection through music and making a difference to others as they develop their musical communication with patients. This is highlighted in a comment from a music student who made music with a young patient over several visits:

> It was great to see 'A' again and keep the communication going. It felt [like] she recognised me from last time. (Student reflection)

In instances where several participants are involved in music making around the bedside of a child, students must balance their own contribution with that of others, whilst simultaneously listening carefully to a child's musical interpretation. This experience of deep listening can be very satisfying, and this quote highlights the sense of enjoyment and fulfilment created

by one music student's experience of participating in music making at the bedside:

> I particularly enjoyed today's session as the atmosphere was calm and there was space in the music to listen and absorb the responses of the patients and fellow musicians.

Using music to support others is key to hospital music interactions and can be immensely rewarding for students as they see how their music can be of help to others, building their own self-esteem in the process. In this audio example, two music students assist in providing a supportive musical framework that gives space for a young boy recovering from a brain injury to improvise a solo melody on a whistle. The recording takes place in his hospital bedroom. A range of percussion instruments have been selected by the boy to be used in the composition, including a wah-wah tube, chosen for his mum to play. Students use shakers to keep a steady pulse and take part in a vocal mirroring of the boy's phrases, as the harmonic structure created by Mark on guitar holds the music together. The boy is sat up on his bed with us situated in a semi-circle around the end of the bed – mum is sat in a chair by her son. The students' music making is simple and uncluttered, using only voice and percussion, allowing space for the boy's melody to be clearly heard:

Audio mp3 here

11. Findings: Medical Students

The concept of assessing and improving the quality of healthcare in the UK is not new. The responsibility that medical programmes graduate future doctors with the skills to 'apply the principles and methods of quality improvement to improve practice' is embedded within the General Medical Council 'Outcomes for Graduates' (2018) document.

We have found that the process of participating in music making at the bedside gives medical students permission to adopt a temporary identity and observe the clinical environment from a new perspective. Students have stated they learn new ways to engage with patients, which are focused in non-verbal and child led interaction, where a child's emotional and sensory needs can be met in music. The seemingly simple act of offering a small child a percussion instrument to play, when contextualized by the experience of being in hospital, requires more thought than first imagined: a child may already be anxious from being hospitalized, or wary of approaches made by new people. They may be unsure of what a musician may want from them. Or they may be feeling scared by the expectation of a painful procedure. Standing up instead of kneeling down, approaching a child too quickly, appearing too 'wooden' or fixed to a spot, playing too much, or too little – all can make the music making less fluid,

responsive experience. By a process of revisiting the wards, meeting the same patients during their placement and using the same repertoire and musical structures, students begin to absorb these techniques, and eventually to use them independently. Observing how to move towards a bedside, listening to how a piece of music is played – lively, or slow, with space and silence – and exploring the touch and feel of the instruments shared with child patients and families form the basis of the students' learning during placement.

This experience offers immense benefits to the self-esteem of students at a crucial time in their study, as they contribute to creating personalized musical experiences responsive to a child's communication. Here one of the medical students explains how through musical interaction they were able to evaluate the strategies they used in communicating effectively with a patient:

> We played music for a young baby and seeing him so calm and cheerful was an absolutely satisfying feeling. This session challenged me as it requires a different approach compared to a clinical point of view. The rapport is established in huge part, from our body language and our ability to be versatile. Thus, I felt that I was constantly mindful of my own expressions as I did not want to appear intimidating to the children.

Once on the ward, music making must take place with an understanding of the experience from the perspective of patients and staff. The space, physical artefacts, and social setting referred to by Brashier (2013) about gamelan teaching come into play here too: the hospital environment influences *how* a musician offers music to another. The process of music making becomes a channel of information exchange between musicians and patients, or family, or staff: a musician's decision making is always informed by a response, reaction or immediate situation relating to somebody else.

The acoustic environment of a hospital ward can appear disjointed and unpersonal, with private and personal spaces negatively affected by sound (Rice, 2003, 2013). Musicians test the emotional 'temperature' of the ward first and watch carefully to pick up on subtle clues and cues transmitted by non-verbal communication before adding sound. This process is repeated for each individual child and musical interaction. Involvement in a non-clinical, non-verbal approach to communicating, using music with patients, family and staff gives a new perspective to understanding a patient's experience of hospital, as explained by a student here:

> The chance to be part of bringing music onto the ward provided me with an entirely new viewpoint from

> which to see the clinical environment. Usually on the wards, as a medical student, one is forced to be quite serious and is quite constrained by the need to spend time learning. Coming in as musicians removed us from this 'clinical' role and allowed us to see the ward more from a patient's point of view. This was heightened by our being encouraged to bring ourselves down to the children's level in height, showing us how the ward appears to them.

12. Discussion

Through becoming part of music making within a children's hospital, students are exposed to the benefits of music making for patients and for clinical staff. By becoming 'one' with the musical experience in hospital, they have a sense of how it *feels* to be *in* music *in* hospital and go forward with an understanding of how musical interaction can contribute to the holistic treatment of patients in hospital.

Experiencing the training has influenced career choices, with some students stating that because of doing music in the children's hospital, they are more interested in studying paediatrics or music therapy as a future career. Some medical students talked about keeping a small musical instrument with them as they train further to be a doctor so that they could draw upon their skills learnt with us to engage patients and children in the future.

The sensory embodied processes explored in hospital music making enable students to experience, and share in, the feelings and experiences of patients in hospital. The skills acquired in learning about hospital music making provide music and medical students with opportunities to develop new communication techniques, build confidence in their own abilities to communicate and interact with others and to be aware of the benefits of music making with patients, families, and staff in hospital. This training experience is focused on a patient-centred approach and highlights the emotional needs of patients. It readdresses a balance of power within the clinical setting, giving even the most non-verbal of patients a chance to be in control.

For music students, the training can open doors to new career choices when entering the music profession and assist in creating a balance during a time of pressured study that promotes a positive reconnection between identities of music and the self:

> Today was special in the sense that I was reminded that while we are here to be an inspiration and encouragement to the patients, they too can be an uplifting source to us. And isn't that so with everything in life? No one is always the giver or taker, and this is the beauty of human interaction. (Music student)

During the QEPEP module, medical students observe first-hand how staff respond to the music making. They hear the difference made to the auditory and emotional environment of a paediatric ward when carefully placed music and sound is introduced. Valuable interactive skills are developed and enhanced that will be of benefit to their future medical training, reflected here in student feedback: 'It has made me more self-aware of my actions and how I approach patients and staff. It will help me remember that clinical solutions alone do not treat the whole person.' Overall, the module aims to cultivate student exposure to humanities and arts, exploration of Quality Improvement, experience in communicating with paediatric patients and fostering of future patrons of the arts via visits to cultural events. Uniquely, the QEPEP module incorporates a cultural field trip (this could be a suitable play, art exhibition, and dance or concert performance).

The QEPEP requires students to produce a Lay Document or a Quality Evidence Report, and many of our students have had their work showcased on a wider academic platform. Particularly, some of the Lay Documents produced by students at the end of the module have been introduced or piloted into medical environments, increasing the direct impact of student learning and its contribution to the medical setting. New

evidence can then be collated from these documents to support areas of evaluation and research. A dementia colouring book for adults 'Colouring My Memories' was trialled at Salford Royal Foundation Trust. This project was given financial support in 2016 when the QEPEP was the recipient of funding from the Faculty of Biology, Medicine and Health Social Responsibility in the Curriculum Fund. The funding linked the QEPEP to the following aims of the University of Manchester Social Responsibility Priorities: Community Engagement and Cultural Engagement.

Experiences during the training can be a much-needed oasis from the pressure of study, particularly for those who have creative as well as medical skills and interests. The opportunity could be instrumental in alleviating increasing feelings of burnout during medical training and supporting the continuation of the study. This hypothesis was explored during a ten-week research project (Applied PEP module) completed by a year four student in 2015, which concluded that 'there is an association between the drop in burnout level exhibited by students and the year three PEP project. Furthermore, the feedback derived from the questionnaires suggests that, under the correct conditions, a greater incorporation of medical humanities into the existing medical curriculum would reduce

the risk of burnout'. This structure is reflected in the music student training, where students complete a reflective portfolio and video journal to support their practical learning. Each year students have gone on to take elective independent professional projects in music and health settings and master's placements inspired by their Music for Health training.

From feedback collected, we can see that the experience of making music on the wards has had a positive outcome for students from both professional disciplines. Although the number of students taking the modules is only a small percentage of the yearly intake of students, in taking just one element of learning from the experience and incorporating it into their own personal vision for music and medicine there is scope for these students to make a change within music and medical professions of the future. We see a benefit for training methodologies offered by a specialist musician in hospital programmes to be further embedded in clinical and musical student training programmes. We propose that similar applications of the model could be replicated at other institutions, with either student-selected modules or where there is an existing Medical Humanities programme. In medical school the 'hub and spoke' model works best, whereby students are enabled to provide and perform music via a series of plenary

tutorials, followed by practical application of their skills in a clinical setting. This also allows for students with no musical ability or experience to partake in the module and complete project work.

The impact of making music with patients, families, and staff on hospital wards highlights the transformative benefits of the arts in healthcare not only for patients but also for music and medical professionals of the future. Further study of these benefits is needed to assess the impact in greater detail.

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Musicology Research
Issue 6: pp. 135-158

6

Depression in Higher Education: Shame, 'Courage', and Making the Political Personal

Zaina Shihabi

1. Introduction

She had blue skin,
And so did he.
He kept it hid,
And so did she.
They searched for blue
Their whole life through,
Then passed right by –
And never knew.
– Silverstein (2011, 20)

In 2011, a collection of poems by the late American poet Shel Silverstein was published. 'Masks' immediately stood out to me, and quickly became one of my son's favourites. As I continued to

read it to my son over the years, I found myself asking: Why? Why did they not speak out? Why did they not yell out 'I am blue! Is anyone blue too?' Over the years and through many difficult days, I also began to ask myself: Why do we live in a culture that glorifies strength of individualism, yet belittles the vulnerable, the open, and the bare? Why are those who speak out considered 'brave'? Why are we so conditioned to be ashamed of our truth? After all, is it not the human condition to connect to others; to bare our souls and reveal ourselves to others in the hopes that someone may look us in the eye and proclaim 'me too' or 'I understand', and by doing so, puncturing the overpowering loneliness surrounding us? What are we all so afraid of?

These are among the many questions I asked myself throughout my Higher Education journey, not only as a postgraduate student here in the UK, but also as an undergraduate student in the United Arab Emirates in the early 2000s. The questions were inspired by my personal journey as a student who suffers from anxiety, panic attacks, and bouts of depression, and the research is informed by a social constructivist theoretical framework, which John Creswell (2013) writes is 'often described as interpretivism' (Creswell, 2013: 24). Those undertaking research underpinned by social constructivism 'seek understanding of the

world in which they live and work [by developing] subjective meanings of their experiences' (ibid.); thus, the interpretation formed by the researcher and influenced by the researcher's background becomes the analysis of the research itself. The method of analysis I have applied is autoethnography, a form of self-narrative in which the 'scientist or practitioner performing narrative analysis pertaining to himself or herself as intimately related to a particular phenomenon' (McIlveen, 2008: 3). I provide an interpretation of the self-narrative within and outside the context of socio-cultural surroundings of two cultures: A somewhat 'Westernized'[1] version of my experience in the Middle East where I lived prior to moving to England, and one 'outsider's' experience of being an international postgraduate student in England against the backdrop of recent research surrounding international students and mental health. A concomitant critical discussion on the concept of 'shame', how society defines 'courage', and the potential of making the political personal is also included.

2. Placing myself in the research

Bartleet and Ellis define autoethnography as 'an autobiographical genre that connects the personal to the cultural, social, and

[1] By 'Westernized' I refer to the fact that I attended an American University in the UAE, and due to my 'culturally American' upbringing in Saudi Arabia, sought out others 'like me': Americans, Americanized Arabs, or any other Westernized individuals or groups.

political' (2009: 7), and Deborah Reed-Danahay views autoethnography 'as a genre of writing that places the self of the researcher and/or narrator within a social context' (1997, 2017). Bartleet and Ellis write that when musicians and other creative artists engage with autoethnography they are concerned with 'what their work "awaken[s] or evoke[s] in the spectator, how it creates[s] meanings, how it [can] heal, and what it [can] teach, incite, inspire, or provoke"' (Bochner and Ellis, 2003 as quoted in Bartleet and Ellis 2009: 9). My personal narrative and my interpretation of it thus far play a large role in who I am as a researcher, singer, and writer at this point in time. Although I am from the Middle East, I grew up 'culturally American' in a gated community residential camp owned by Saudi Aramco, Saudi/American Oil Company.[2] Although I dreamt of being a composer and a singer, I experienced gender-biased obstacles and limitations due to being from a conservative Arab family. My family did not support my plans to study music in the United States, and I was sent to a nearby university in the UAE due to its proximity. The American University of Sharjah (AUS) offered limited Majors at the time, none of which were the subjects I was interested in. During my time at AUS I suffered from anxiety and depression, and halfway through my degree, my sister passed away. I could not find the help I needed unfortunately, and as my

[2] Saudi Aramco: http://www.saudiaramco.com/en/home.html.

mental health deteriorated, so did my grades, attendance, and ability to concentrate in classes. Some lecturers bullied me, considering me lazy, and others just ignored me. I managed to graduate with a BA in Mass Communications in 2006, and began a career in media, events, marketing, and editorial. I got married in 2010, gave birth to my son in 2012, and in 2013 after a change in personal circumstances, I found myself boarding a plane to Liverpool with my one-year-old to start an MA in Education and Music, and a new life.

After beginning my PhD in 2015, my mental health began to significantly suffer once again. I was able to 'get by' by engaging as much as possible with my university and being very proactive. At that time, however, I was not able to gain support in order to organize postgraduate events, and found myself very isolated from others who were completing a PhD, and hence, I sought connection outside my university. I joined the National Association for Music in Higher Education (NAMHE) in 2015, took part in many conferences throughout my time as a postgraduate student, and began putting together my own research profile. Halfway through my PhD, I had an internal viva in order to confirm my studies as a PhD researcher; this experience took a substantial toll on my mental health, and I seriously considered quitting my PhD. Around that time, the

NAMHE committee invited me to be a speaker for a panel for Black and Minority Ethnic (BME) perspectives in Higher Music Education during the committee's annual conference in May. As part of this panel, I discussed implicit bias experienced from a personal perspective, and linked it to international and minority student issues raised by studies such as those conducted by the UK Council for International Student Affairs (2015-2016) and a 2014 thesis by Eze Ogbonnia Eze, which discusses the experiences of ten Nigerian students studying in the UK at various universities. The former reports that the most common reason The University of Plymouth found based on their research as to why students do not use counselling services at the university is due to the belief that one should have the ability to 'sort out my problems by myself' (UKCISA, 2015-16: 6). The latter study claims 'anxiety, depression, loneliness, feelings of isolation and breakdown are among the difficulties faced by international students' (Ward, Bochner and Furnham, 2001 as quoted in Eze 2014: 7) and provides recommendations as to how UK Universities can support students who may be experiencing difficulties whilst studying abroad in the UK. Recommendations from Eze's study included adjusting student expectations prior to moving abroad by providing positive and negative student testimonies, taking more of an initiative towards organizing intercultural events, and making plans to develop a specific

student-centred approach towards counselling for international students. As I read through the research, I found myself identifying with many of the symptoms of other international students. For example, I was very adamant that I can deal with my own problems by myself, and that admitting that I was feeling isolated, fearful of failure, lonely, and homesick would suggest that I had 'failed' in some way, or that I wasn't 'tough enough' or 'up to the challenge'. Although the research for the presentation was led by my need at that time to talk about mental health due to my own personal circumstances, after conducting the research, I was relieved (and saddened) to find that I was very much not alone, and it was not only international students that seemed to be suffering. Key findings provided by the Institute of Public Policy Research (IPPR) in a report by Craig Thorley (2017) showed that 'in 2015/16, 15,395 UK-domiciled first-year students disclosed a mental health condition, which is almost five times the number in 2006/07' (Thorley, 2017: 4). The study also found that 'just under half of students who report experiencing a mental health condition choose not to disclose it to their HEI, between 2007 and 2015, the number of student suicides increased by 79 per cent' and 'in 2014/15, a record number of students (1,180) who experienced mental health problems dropped out of university, an increase of 210 per cent compared to 2009/10' (ibid.). Recent YouGov UK data revealed

one in four students in the UK suffer from mental health and wellbeing issues, and list depression and anxiety as the most commonly reported ailments (YouGov, 2016).

It was alarming to see how prevalent mental health and wellbeing issues had become in UK HEIs, and I quickly began searching for existing HE initiatives created to combat this problem. Although in the past few years there have been a variety of initiatives within HE developed to provide support for students (see for example HEPI's 'The Mindful University', 2017; The Mental Wellbeing in Higher Education Working Group's (MWBHE) and Universities UK (UUK) 'Good Practice Guide', 2015; Student Mind's 'University Mental Health Charter, 2018) and although more students are willing to report mental health issues, particularly younger (such as first year students), it seems many people would prefer to keep such issues private. The Equality Challenge Unit report (2015) revealed that nearly half of students and staff did not disclose a mental health condition to their universities. Reasons given for students not wanting to disclose having experienced a mental health condition to their universities included not wanting other 'students to think less of them' (Equality Challenge Unit, 2015), and for staff, the main reasons included for not revealing their mental health conditions to other staff members included 'not wanting to be treated

differently, 'not wanting to be thought less of ' and 'not wanting them to tell anyone else' (ibid.).

3. Reaching Out

After the annual conference, I sent out an e-mail to members of the NAMHE committee to request their support in approaching the Royal Music Association Student Representative to suggest a collaboration on a Mental Health and Wellbeing event. They were extremely supportive, and upon contacting her, the RMA Student Skills Officer Núria Bonet responded with great enthusiasm and ran with the idea that became an RMA study day co-organized and co-funded by the RMA, BFE and NAMHE at the University of York St John in May 2018.[3] I was truly struggling when I contacted Núria, and I was looking for something that could bring people together and provide a safe space for them to be honest about their struggles, where they can talk about their experiences, and learn from and support one another. In hindsight, I was seeking somewhat of an all-inclusive version of a 'consciousness-raising' event to discuss mental health and wellbeing. Consciousness-raising events became popular in the USA in the 1960s with feminists seeking to create a safe space to discuss personal matters of women including 'feelings perceived as private, taboo or shameful' (Barber,

[3] This has since become an annual event.

Russell, Jolly, Cohen, Johnson-Ross, Delapy, 2013). The 'personal is political' became the slogan of the Women's Liberation Movement, born out of such meetings that politicized the personal accounts of women to create collective change. Carol Hanisch wrote in 1969, 'one of the first things we discover in these groups is that personal problems are political problems' (Hanisch, 1969). But what happens when the political is no longer personal, when individual problems are overlooked, and students fall through the cracks as we spend our time ticking the appropriate boxes? How do we ensure that what we are providing to support our students is reaching them on a personal level?

The presentation I gave at the Study-day event was the inspiration for this paper, and the literature I found was the source of my realization that shame plays a large role in what keeps us from being able to make the political personal. It seems to me that we are willing to discuss mental health and wellbeing in HE at a corporate level, organize events surrounding such issues, bring in experts, blog about it, use social media to raise awareness by posting about it, and write articles about it; so long as the conversation does not become personal. The stigma associated with talking about mental health and wellbeing may have decreased, but it is arguable that our attitudes towards

those who admit to being afflicted by it have not changed sufficiently enough to allow for open, personal discussions. The fact that nearly half of students and academics in HE would rather suffer in silence than tell others is a clear indication that the fear of what others may think still exists despite initiatives to lessen the stigma surrounding mental health and wellbeing issues. In a call-in radio segment aired October 2018 by the LBC (Leading Britain's Conversation), a London-based radio station, a young man using a pseudonym shared the tragic story of his friend's suicide and confessed to having had very serious thoughts of suicide himself. 'James' describes how no one knew that their friend was suffering, and that they still have no idea why he killed himself. When Iain Dale, the show's presenter, asked him why he did not share his experiences with his friends, he said 'it's very difficult to speak to people who are close to you when you have a certain kind of […] persona of being the life and soul of the party', that it is 'very difficult to admit any form of weakness', and that you must 'smile through it' (LBC, 2018). James's description of the shame of admitting his mental health is suffering, which he believes is a weakness, is a very common theme amongst the literature. For example, I argue that the fear of 'not wanting to be thought less of' by academics (Equality Challenge Unit, 2015) is related directly to shame.

4. What is Shame?

Growing up, shame was constantly used in my culture as a way to prevent bad behaviour. Whilst in health class we talked about 'taboo' topics such as suicide and eating disorders, I was firmly told by family members as far back as I can remember that suicide was the worst possible sin, and mental health issues are mostly due to being 'far away from God' or living a sinful life. A 2012 study by Aseel Hamid and Adrian Furnham examines attitudes of Arabs living in the UK towards psychological help or counselling. The participants included 'two hundred and four adults aged between 18 and 65; 104 British Caucasians, either British, Welsh, Irish or Scottish, all born within the UK and 100 Arabs, either West Asian or North African, 69 percent born outside of the UK' (Hamid and Furnham, 2012: 745); half of both ethnic groups were aged 18-25. Hamid and Furnham found 'shame-focused attitudes, confidentiality concerns, and ethnic identity' to be among the factors that impact Arab attitudes towards seeking psychological help (ibid.: 741). Through a review of the literature, the authors found that 'research in the Middle East shows that Arabs tend to hold a negative attitude towards seeking professional psychological help' (Al-Adawi et al., 2002; Al-Krenawi and Graham, 1999, 2000; Savaya, 1995, 1998 as quoted in ibid.: 742). The research also shows that within Arab culture, mental illness can be thought to be a 'punishment for

sins' by God (Al-Krenawi et al., 2000 as quoted in ibid). The researchers also noted that the longer an individual lived in the UK, the more likely they were to view seeking help more positively.

Brené Brown, an American Professor who studies shame and vulnerability, calls shame 'an epidemic in our culture' (Brown, 2012, TED). She writes in her 2015 book *The Gifts of Imperfection*:

> We need to consider the myth of self-sufficiency. One of the greatest barriers to connection is the cultural importance we place on "going it alone." Somehow we've come to equate success with not needing anyone. Many of us are willing to extend a helping hand, but we're very reluctant to reach out for help when we need it ourselves. As if we've divided the world into "those who offer help" and "those who need help." The truth is that we are both. (Brown, 2015: 20)

Brown sheds light on a very important 'division'; an 'us vs. them' or 'strong vs. weak' division that seems to exist in society, and lists three things in her book that we need to consider about 'shame' (ibid.: 38):

> 1. We all have it, unless you are incapable of empathy and do not have the ability to connect with others.
> 2. We are all afraid to talk about it.

3. The less we talk about it, the more control it has over our lives (ibid.).

Shame, writes Brown, 'keeps worthiness away by convincing us that owning our stories will lead to people thinking less of us; [it] is about fear […]' shame causes us to be afraid that 'people won't like us if they know the truth […]' if they knew 'how much we are struggling' (ibid.: 39). Brown goes on to explain that those who share their stories are practicing 'shame resilience' and that 'courage is telling our story' (ibid.: 40).

5. What is Courage? Who is considered 'brave'?

If the essence of being human is our ability to connect to one another, as it is 'in our biology' (ibid.), then how is connecting with each other by telling our stories 'courageous'? Although Brown does differentiate between what she calls *'ordinary courage'* which derives from the root of the word and its original meaning which is 'to speak one's mind by telling all one's heart' (ibid.: 12), she also acknowledges that the meaning of the word has changed and now 'courage is more synonymous with being heroic' (ibid.). In a 2012 article in *Psychology Today*, Melanie Greenberg explains how courage is a blanket term, and is used to describe physical courage such as the hero of a story, social activists such as Martin Luther King Jr., and entrepreneurs who

take risks to realize a dream such as Steve Jobs. She goes on to describe 'six attributes of courage', which include 1) feeling fear yet choosing to act, 2) following your heart, 3) persevering in the face of adversity, 4) standing up for what is right, 5) expanding your horizons; letting go of the familiar, and 6) facing suffering with dignity or faith (Greenberg, 2012). I argue that the term 'courage' or the act of 'being brave' can be problematic when associated with mental health and wellbeing due to its association with heroics, as it can, on one hand, potentially place people who are sharing their experiences on a metaphorical pedestal that others may fall short of. Meanwhile, on the other hand, the individual on the pedestal can suddenly feel exposed after being labelled 'courageous'; *The Scarlet Letter* comes to mind.[4] Often when I would share a fear or discuss a concern with someone, I do not receive a 'me too' or an 'I can relate' response, in fact, most of the time the response I receive is related to how 'brave' I am to 'speak out about such issues'. This response feels very premeditated, almost like a learnt script. Rather than portray the image of 'courage', I would prefer to portray the image of being human, as I believe it is arguable that this image of 'courage' that is being spread about mental health and

[4] *The Scarlet Letter* (1850) is a novel by American author Nathaniel Hawthorne, in which the main protagonist, Hester Prynne, is sentenced to wearing a scarlet coloured 'A' after giving birth to a child while her husband is away to signify that she is an adulteress. The letter is a symbol of her 'shame', and allows the townsfolk to humiliate her.

wellbeing awareness is reinforcing the 'us vs. them' division. I argue that calling someone courageous alleviates the responsibility of having to relate to them; it immediately draws a line that separates, as Brown describes, 'those who offer help' and 'those who need help' (Brown, 2015: 20).

A 2009 study in the *British Journal of Guidance & Counselling* highlights issues of the perceived stigma attached to HE students actually seeking help by disclosing their problems to members of staff. The authors note that 'social psychologists suggest that stigma is associated with attitudes or stereotypes that are learned and mediated by a number of psychological constructs, in terms of cognitive beliefs, feelings and associated behaviour' (Quinn, Wilson, MacIntyre, and Tinklin, 2009: 406). The larger the divide between those who seek help and those who give it becomes, and the more we associate seeking help with courage, the more likely the stigma associated with 'admitting you need help' will continue. Other findings by the authors include students' worry about disclosing mental health for fear of this being perceived as 'a form of weakness that may affect their future career prospects' (Chew-Graham et al., 2003 as quoted in ibid.), and combined with the students' reluctance towards speaking to staff about their problems, members of staff felt they are not 'experienced enough or qualified to support students' (ibid.). A 2001 study by

Sanderson found that students felt 'there was a need for lecturers to develop more awareness and understanding to ensure that they respond appropriately when, for example, a student felt the need to leave a class when they were feeling distressed' (Sanderson, 2001 as quoted in ibid.: 407).

6. Challenging Attitudes in Academia

Studies have revealed that a significant percentage of academic staff are experiencing high levels of stress and mental health and wellbeing issues. A recent study by the *EMS Community Medicine Journal* (2017) revealed that out of a sample of 158 Academic staff participants, 43 per cent reported to have at least a mild mental disorder, and a study in 2011 found that the higher the number of students assigned to staff, especially postgraduate students, the more likely they were to experience 'burnout' (Watts and Robertson, 2011). A 2017 article for Wonkhe by Anna Bull (University of Portsmouth) and Kim Allen (University of Leeds) cautions against the 'highly problematic' solutions put forth by the Higher Education Policy Institute's report in 2017, which aims to address and provide solutions to tackle student mental health issues. 'By suggesting that academic staff must lead in the delivery of "positive education", the report 'shows little awareness' of the conditions academics face within HE, which include 'increased workloads, casualisation, anxiety-producing

policies such as the REF and TEF, and resource constraints', all of which contribute to the high levels of stress and deterioration of mental health and wellbeing in academics in the UK (Bull and Allen, 2017). On anxiety within HE, Richard Hall (De Montfort University) writes:

> An outcome of the re-engineering of HE under marketisation and financialisation is that the University has become an anxiety machine. Inside this machine, academics and students are subject to exploitative and normalised anxiety-driven overwork as a culturally-acceptable self-harming activity. Thus, relocating the discussion of mental ill-health as pathologically-inherent in the weak, and widening the examination of the role that anxiety plays in the re-engineering of the University as a business, is crucial. (Hall, 2017)

Hall makes an important point about anxiety and overwork being culturally accepted within HE. An 'Academics Anonymous' article in *The Guardian* claims early career researchers such as PhD students 'take the view that if you're not doing overnight experiments, missing meals, or binge drinking, you're not doing it right' (The *Guardian*, 2014), and with studies showing that research students fear being considered incapable or 'tough enough' to handle academic stress and expectations, the culture of accepting that a 'stressed-out, always on the verge of burnout' life is expected if you want to be an academic. Rather than placing blame or assigning responsibility, it is arguably more effective to

provide support, facilitate proper training, and change attitudes towards mental health within HE.

7. Conclusions

Although initiatives have been developed recently to combat mental health and wellbeing issues amongst students and staff, such as the government's commitment to investing an 'additional £1 billion in mental health services up to 2020/21' (Thorley, 2017: 33), some reports, such as the one by IPPR claim that while the investment is welcome, it 'will result only in modest increases in the availability of care and treatment' (ibid.), as research shows that mental health and wellbeing issues, suicide, and stress levels due to a variety of factors have increased significantly in recent years (Thorley, 2017; YouGov 2016). Studies have also shown that a significant percentage of academics are experiencing anxiety, high levels of stress, and fear. Research conducted by Kinman and Wray in 2013 for the University and College Union (UCU) found that 'two UK surveys of academic and academic-related staff conducted in 1998 and 2004 found high levels of job-related stressors and a level of psychological distress that exceeded that reported by other professional groups' (Kinman, 1998; Kinman et al., 2006 as quoted in Kinman and Wray, 2003: 6; Kinman and Jones 2004).

The recommendations made in this paper are focused on changes in attitudes rather than specific University or Government-led projects or initiatives. My aim is to draw attention to the fact that the political must also be addressed on a personal level. I reflect on studies that have shown that we not only have an increase in mental health and wellbeing issues in students, but also in academic staff. I draw upon my own experiences as an outsider (an international student) and an insider (a UK-based student and an early career researcher and part-time lecturer in UK HE) to provide a foundation and rationale for these recommendations. As mentioned, it is my belief that attitudes towards those who admit to having mental health difficulties need to be addressed, as research has shown that a large percentage of both students and academic staff did not disclose a mental health issue to their universities due to a variety of fears. Many themes emerge from recent studies and newspaper articles discussing the decline in mental health and wellbeing in students and staff in HE. Fear of failure, fear of being viewed as incapable, worrying about what others may think, anxiety induced by pressures to perform, and being labelled as weak are some of the most commonly listed reasons for not wanting to disclose a mental illness. By addressing shame and courage with regards to mental health and wellbeing, and possibly changing attitudes by

doing so, we can potentially begin to dissolve the barriers that divide 'us vs. them'.

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Musicology Research
Issue 6: pp. 159-199

7

University Music Students: Mental Health and the Academic Supervisor

Elizabeth Haddon

1. Introduction

Student mental health is an increasing concern within higher education, frequently reported in the media in connection with student welfare, policy, and provision (Shaw and Ward, 2014; Weale, 2018). Mental health has been defined as 'a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' (WHO, 2014). Mental Health First Aid England proposes a continuum: individuals may experience good-to-poor

mental health and diagnosed-to-non-diagnosed mental illness (MHFA, 2016).

In England, 'one in four adults experiences at least one diagnosable mental health problem in any given year' (NHS, 2016: 4), and 'half of all mental health problems have been established by the age of 14, rising to 75 percent by age 24' (NHS, 2016: 5). The National Union of Students (NUS, 2015) found that 78 percent of 1093 student respondents experienced mental health issues, 80 percent reporting stress, 77 percent anxiety, 69 percent depression and 33 percent suicidal thoughts; while these issues are reported by more than a quarter of students (YouGov UK, 2018), many students remain undiagnosed. A study of full-time undergraduate UK students (14,057 respondents) shows a decline in self-reported ratings for 'life satisfaction', 'life worthwhile', 'happiness', and 'low anxiety' compared to previous years and lower scores for these than for the general population (Neves and Hillman, 2017).

Among music students, a study on depression and anxiety found that 'nearly one quarter of [287] participants reported being negatively affected by their mental health' (Wristen, 2013: 25); moreover, in common with the findings of Spahn, Richter, and Zschocke (2002), many did not seek professional help. Music

students may struggle to manage factors such as competition, perfectionism, music performance anxiety, dealing with feedback on their work, time management, playing-related physical problems, and difficulties in detaching themselves from their studies (Wristen, 2013). They may also have concerns about their capacity to engage in a profession which has identified further demands including workload, poor working conditions, socio-economic pressure, anxiety about downtime, gender-related issues, and conflation of identity with being a musician (Gross and Musgrave, 2016). Gross and Musgrave's study of 2211 professional musicians in the UK revealed that 71.1 percent had experienced anxiety and panic attacks, and 68.5 percent experienced depression; 54.8 percent thought there were gaps in provision of health support for musicians. Counselling, signposting and information, drop-in centres, and phone lines, all specifically for musicians, were identified by participants as urgently needed.

Despite recent initiatives within higher education to promote awareness of and support for mental health (MWBHE, 2015; MHFA, 2016), it may be difficult for music students to engage in proactive behaviours concerning their health due to factors including anxiety about potential stigmatization (Wristen, 2013) and workload commitments constraining availability to book

and attend appointments. Students may find that service providers are unable to cope with demand, resulting in long waiting lists for both internal and external support. Therefore, in higher music education the academic supervisor and instrumental teacher can become key figures in supporting students with mental health issues; as identified by Hughes, Panjwani, Tulcidas, and Byrom, 'responding to student mental health problems appears to be an inevitable part of the role of an academic' (2018: 3). However, despite the increasing focus on mental health in higher education, there is still under-representation of the student voice. This article focuses on students' perceptions of the role of the academic supervisor in supporting their mental health and investigates the views of music students at a UK university.

2. Methodology

The study received ethical approval from the relevant university ethics committee and involved undergraduate and postgraduate music students at a UK Russell Group university. All music students received an emailed invitation to participate and could choose between completing an online survey created using Qualtrics Survey Software or undertaking a semi-structured interview with the author. It was emphasized prior to data collection that the researcher would not request information

about personal mental health issues and that participants' responses would be anonymous. Open questions were constructed to elicit students' views on the role of the academic supervisor, institutional support and responsibility for mental health. The interview data will be reported in a subsequent publication; this article discusses the survey data, gathered from 65 respondents. The data were collated and coded by hand; an iterative process of content analysis enabled categorization and detailed consideration of emergent themes derived from the data (Hsieh and Shannon, 2005). During the process of data analysis and write-up, researcher reflexivity was deployed to retain objectivity and to assist in achieving inclusion of all views presented by respondents. Within the following text, participant quotations are provided to ensure representation of the student voice; as there were no discernible differences between students from different years, their study year/programme details are not indicated.

3. Respondents

The survey respondents' ages ranged between 20 and 58; of those who disclosed their year of study there were 16 undergraduate respondents; six in year 1; four in year 2 and six in year 3; 27 MA respondents (of whom 14 were studying taught programmes), and eight PhD students (three in their final year). 85 percent were

studying full-time. Of the 55 who answered the question 'have you experienced any mental health difficulties before you came to university?' 50.91 percent stated yes; 49.09 percent stated no. These figures changed in response to the question 'have you experienced any mental health difficulties at university?' with 58.18 percent of the 55 who responded to this question stating yes; 41.82 percent stating no. Students were reassured that they did not need to state the nature of any difficulties and reminded that the survey responses were anonymous. While 14 students had spoken to their supervisor about the difficulties they experienced; 41 had not. 15 students had spoken to another member of academic staff; 40 had not.

4. Findings

The findings are thematically presented in relation to students' perceptions of the role of the supervisor; students' support preferences; students' perceptions of the training undertaken by supervisors; support boundaries; perceptions of the effects of supporting students with mental health issues on supervisors; views on ideal support, and discussion of departmental culture and responsibilities.

4.1 Student Perceptions of the Role of the Academic Supervisor

Participants observed that higher education 'is a time of disruption and change which can either trigger mental health issues for the first time or can exacerbate pre-existing ones'. It was noted that 'many mental health issues only establish themselves in this age range (18-25)' and 'many people may not know that what they are experiencing is a diagnosable mental health issue' and so may not know where to seek help. Furthermore, it was perceived that 'quite often students with mental health issues are insecure and doubt whether or not they actually "need" this professional help'. These responses establish some of the complexities for higher education students, who may find it challenging to engage with professional health support; they may therefore seek advice from their academic supervisor, rather than other services.

Information given to new students promoted the role of the supervisor, and therefore students viewed their supervisor as the 'main point of contact' and 'first port of call for almost all processes within a university'. Students felt that supervisors have a 'sense of responsibility' and the experience to help students, and viewed them as 'friendly, informal and supportive academically and at a human level'. Furthermore, 'supervisors are generally aware of life within the department, therefore can

understand better and sympathize with students if their difficulties are caused/intensified by their musical work/environment'. This connection to context meant that 'academic supervisors are more likely to understand how [students] are feeling and why they are struggling mentally at university than a mental health professional who isn't part of their department'.

The 'immediacy' of support from an academic supervisor compared to delays in waiting for an appointment with a GP or other support was noted. The bi-termly structure of supervisions created a framework: 'the academic supervisor is really the only person of support and authority who [students] see regularly, without voluntarily arranged appointments'. Several respondents indicated that their supervisor had emphasized that they should arrange further supervisions if they experienced any difficulties, describing them as 'likely to understand the problems', 'easily approachable', able to 'actively listen and effectively signpost', and treating students as 'independent adults'. Therefore, ease of access and positive supervisor qualities facilitated the development of personal relationships in which students could discuss their concerns.

While one student felt that speaking to a supervisor 'can be less scary than going straight to a medical or counselling source' and 'does not come with the pressure and the labels of booking a formal therapist appointment', another thought that 'most students are not aware of what the university can provide in terms of support'. Therefore, the supervisor was seen as the main source of support and information. This would include listening, understanding, reassuring, providing 'comfort', 'possibly calming a situation down', advising and helping students cope with pressure and deadlines, completing documents for mitigating circumstances, extensions to deadlines and leave of absence as well as providing information about other services and resources, both within the university and externally. However, it was noted that support needed to go beyond granting extensions to deadlines: 'extra time doesn't make a difference, it's trying to make a plan to get focused and getting back on track'. Therefore, although short-term professional support may be available, the academic supervisor becomes a 'crucial part of the equation' as they can 'assess whether the student's work will suffer as a consequence of mental health challenges' and should be able to help 'to the point of ensuring that the student's degree can continue (should they still wish it to)'.

The benefits of discussing issues with a supervisor might also extend beyond the immediate situation: 'they would understand in future if my mental health affected my performance or behaviour', and the supervisor could prepare other teaching staff to recognize a student's condition and to consider how to support them. Using a supervisor as an intermediary could be easier than speaking directly to another lecturer. These comments indicate knowledge of a supervisor's ability to facilitate certain services to support academic work; further comments indicate the importance of knowledge of mental health issues and the value of emotional support, as students indicated that the supervisor's role needed to go beyond facilitating academic procedure.

Students recognized that a supervisor 'should be aware of any pre-existing conditions and at least attempt to recognize any potential neurotic tendencies' and able to 'assess the severity of the situation'. While one student felt that the interaction would not be therapeutic, it was a 'safe place' to discuss problems, with 'some degree of emotional support' and empathy offered by a supervisor. Students recognized the potential impact of the supervisor's attitude:

> It can make a huge difference for a supervisor just to be understanding, willing to listen, supportive, etc.

> without overstepping boundaries or offering advice they're perhaps not qualified to give; recommending that a student could seek help if they needed it and it's okay to ask, and signposting to the right place, can go a long way towards validating someone who has been previously afraid to tell anyone what they're experiencing.

These comments position the supervisor in a crucial role and also indicate expectations of a range of capacities: procedural competence for processes relating to academic work; communication skills; knowledge of mental health issues and diagnostic ability; knowledge of other services and support, and the personal capability to create a safe space in which to relate to students with empathy.

4.2 Support From a Supervisor or a Stranger?

When asked about their own preferences for talking to someone they knew or someone not previously known to them, more than half of the respondents thought they would prefer to talk to someone they knew, although several said this would depend on the issue, its causes and severity. A distinction was made between 'knowing' and 'approachability': 'I would definitely find it easier talking to somebody I knew, but more importantly, somebody I felt I could approach. You may not necessarily "know" your supervisor'. This may have been why some students would talk to friends and family first, being 'better able

to predict how they will respond'. This could connect to issues of trust: 'taking that first step is often extremely difficult and being able to do it with someone you trust probably makes it easier'. However, for some students, this was extremely challenging: 'I find that I can't even tell my supervisor that I'm not okay when they ask me, let alone my friends and family', and 'I don't know how to bring up the topic myself much of the time'.

In deciding whether to talk to a supervisor, a student might consider many factors: they may not want to 'face them in the department' or they may want to maintain a 'professional relationship' with their supervisor. They might worry about feeling 'judged and pressured', and could fear 'repercussions, however small' and be concerned about how these might impact on the existing relationship. Students might feel embarrassed or 'awkward' and potentially 'terrified of being pitied'; therefore, they may not want to reveal their feelings. Additionally, they might not 'know what qualifies for help' so they may think it is not legitimate to ask a supervisor about their concerns. Furthermore, a student 'might not talk completely openly' if unsure of the supervisor's capacity to help, although they might raise an issue to see what further support might be available to them. As negotiating these challenges seems fundamental to accessing support, it seems vital that supervisors have the

capacity to help students initiate and build conversations in which they can articulate their feelings; this may include demonstrating not only willingness to help but also their knowledge of appropriate support and their ability to relate to the student.

4.3 Supervisor Training

Students were asked whether they thought academic supervisors received any training in understanding mental health. A small number (4) were unsure; 14 of the 40 who answered this question felt that they had access to training though this may not be mandatory. The remainder thought that supervisors had no training, and therefore students 'cannot expect them to be fully knowledgeable in complex mental health matters'. However, it was felt that 'mental health should be at the forefront especially in a degree with performance elements and auditions so all the staff should have training on how to spot signs of mental health [issues] and how to talk to people with mental health [issues]'. Therefore, staff 'should at least know what to look for' and should possess awareness, even if this is not substantially medical or therapeutic. The variance of ability in relation to this aspect was noted: some lecturers are 'better at handling mental health than others'. This may have resulted from lecturers' own experiences, training, interest in this area, and their personalities.

In fact, all staff in this department are required to attend compulsory mental health first aid training at the start of the academic year, provided by the university. However, at present, this is not officially communicated to students, and the visibility of the training may be worth consideration as part of a strategy to improve provision.

Despite generally indicating that they believed supervisors received no mental health training, the student perceptions of the role of the academic supervisor discussed previously suggest some tensions between expectations and perceptions of supervisory capability. If, as students indicate, a 'duty of care' towards students is viewed as an essential part of the supervisory role, then it may be worth considering how this is manifest and made visible to students, and whether existing training is sufficient to create capability to support students effectively. It may well also be useful to consider how the importance of training is communicated to staff, as some comments indicated a belief that mental health awareness and support may not have been emphasized within academic job descriptions, and therefore, academics may have varied views on the relative importance of different areas of their role which may impact on their attitudes to mental health training and student support.

4.4 Support Boundaries

Students were asked whether it was possible to define the boundaries of support that might be offered by a supervisor. Confidentiality represented one boundary: supervisors needed 'a limit to how much they share with other members of staff', including teaching colleagues as well as health professionals during the process of onward referral.

The confidentiality boundary also extends to staff contact with a student's family. One respondent felt that 'mentally ill students need the parent/teacher/student relationship so everyone is aware of the situation' and hoped that 'more parents would support their children if they were made aware of the full situation which is often difficult for them to explain'. However, university policy dictates that staff will not contact a student's family; this can protect a student from potential negative consequences of parents' reactions to hearing of difficulties. Therefore, the wider context of relationships could impact on the necessity and extent of supervisor involvement; it was thought that some students 'do not have supportive families and it therefore naturally becomes in the hands of the supervisor as they are seen as the next responsible "adult"'.

Student perceptions of the supervisory role will influence the extent to which they understand the potential for support. A supervisor may be viewed by a student as someone who is 'constantly there' who will not 'disappoint'; student preferences may mean that 'the only support they wish to have may be their supervisor'. In these cases it was felt that 'the only limit is the supervisor themselves really, the information and support they are aware of, and the time they wish to devote to resolve/discuss issues'; however, 'if the support needed goes beyond office hours then the supervisor shouldn't be expected to do that'. These factors indicate the potential for ill-defined and fluctuating boundaries and also connect to communication of departmental policy on supervision: 'students/departments need to make clear and understand the limits (roughly) so not to overuse the supervisors'.

Another boundary was identified through a distinction between academic and psychological support: 'Academic supervisors should not pretend to be mental health specialists'; 'if they are out of their depth that could be quite dangerous'. It was observed that:

> Supervisors should not be 'helping' as in trying to give advice when they don't have proper training in boundaries and dealing with vulnerable adults etc., but [should be] supportive, responsible, prepared to

> talk (or more importantly listen) about difficult things and signpost.

Furthermore:

> Supervisors with vulnerable students have a critical responsibility to remain appropriate and professional because if they were to inadvertently abuse their power and overstep a line too far they could damage that student's ability to trust/have faith in other authority/teacher figures in future.

This highlights the importance of training, and the need for clarification of the supervisory role: 'while the academic supervisor can be an excellent first point of call and a listening ear' they 'should not be advertised as a solution', and support should be 'non-therapeutic'. A comparison was made between supervisory support for academic work and for mental health:

> If you approached them with an academic problem, say, struggling with an essay, they can look at the situation and recommend what to do next, but they don't shoulder your burden and start writing your essay. A similar boundary should be made, whilst still remaining sympathetic.

This suggests that the focus of supervision should be on 'what the department can do to help the individual rather than discussing any problems an individual might have in a lot of depth'. Therefore, it may be useful to consider how to create

awareness for both staff and students of the value of boundaries and greater definition of the academic role.

A further boundary relates to the need for academics to remain impartial: 'the supervisor should not be affected by [their] knowledge of the problem to be more lenient in terms of assessing the assignments'. However, most respondents seemed uncertain as to how boundaries might be delineated: 'if training is implicated, perhaps this will help define the boundaries as there isn't a correct answer'. Many responses suggested that the boundaries would be defined by the supervisor-student relationship; one respondent felt that 'the limits might be put by the student; depends on how they want to be helped'. Although 'supervisors should be clear on the appropriate level of support they can offer' this could differ 'on a case by case basis' as 'no two supervisors are the same and the needs of no two students are the same. If defined boundaries are going to be implemented this will satisfy exactly no one'. Therefore, 'it is hard to define the boundaries as every situation is so different'.

These findings indicate the potential for some tensions in this area, particularly relating to expectations, responsibilities and the remit of the supervisory role. These findings resonate with those of Hughes, Panjwani, Tulcidas, and Byrom (2018), who found

that academics in their study expressed 'a conflict between the limits of their defined role and the natural responsibility they felt for supporting a student in distress' (2018: 6). Achieving appropriate support may need further consideration in terms of definition of role boundaries, particularly as this involves sensitive and critical personal issues in a context in which students can also be acutely aware of parity.

4.5 Student Awareness of the Effects of Supporting Students with Mental Health Issues on Academic Supervisors

Only two respondents thought that supervisors were unlikely to experience effects from supporting students with mental health issues. One of these felt that 'they should not be in a position of counselling so it should not affect them', while the other stated: 'I cannot think of anything negative when it is within the limits'.

Positive views included the proposal that a supervisor would have a better understanding of a student; the relationship might be strengthened through greater 'trust' and commitment, and supervisors may obtain 'satisfaction' through seeing students 'succeed and feel less helpless'. Furthermore, a supervisor 'could alter their behaviour to help students', though no indications were given as to how this might manifest.

These views contrasted with the majority of responses which focused on the more demanding repercussions for the supervisor; these largely mirror responses from academics in the study by Hughes et al. (2018) who identified considerable impact on academics as a result of supporting students. Academically, as previously noted, there may be assessment implications relating to impartiality; this might also connect to the perception that the demands of the situation may mean that a supervisor could 'possibly resent' a student. Supporting students with mental health issues could exacerbate an 'already heavy workload', causing a 'great deal of strain on the supervisor's health and wellbeing' and adding 'pressure on their work and home life'. It was observed that 'it makes a difference when you are not just looking out for someone and their work ethic/results/progress, but their overall mental health as well'. In some cases, the perception of the impact on supervisors might mean a student may feel they cannot ask for support: 'it's probably quite stressful and worrying for them [staff], which is why many students don't bring up the topic in the first place as they don't want to burden anyone else'.

It was observed that 'serious mental health issues can be distressing to witness', not least because 'seeing someone in distress should trigger similar feelings due to the emotional

contagion aspects of empathy'. Therefore, it was noted that supervisors could feel 'worried', 'stressed', 'dragged down' and 'overwhelmed' by 'a huge burden of emotional labour', particularly if they feel solely responsible. One respondent observed that 'sometimes I question whether I am a terribly under-qualified therapist, or a friend and I have no doubt that supervisors have the same thoughts'. Perceptions of responsibility could lead to difficulties regarding vigilance: 'when someone has overdosed or regularly self-harms, you cannot stop yourself from wondering what they are doing or if they are okay and your brain naturally jumps to the worst conclusions that you have to fight'. A supervisor might not only be concerned about a student but might also become 'very aware of the effect this is having on the mentally ill student's friends' and may feel a 'natural instinct to protect' them. Therefore, the area of their concern widens.

Additionally, student issues may reflect ones personally experienced by a supervisor, and 'knowing the causes if those are issues the supervisor is aware of in their own life may be distressing'. While it was suggested that 'supervisors should be wary of such negative effects of their important pastoral work and have suitable strategies in place to combat them as necessary', other responses indicated that 'they might have to

deal with some difficult cases that they are not necessarily trained to handle'. Ideally, supervisors 'should be trained in mental health support so they can know how to offer support without affecting their own mental wellbeing'. It was also suggested that they 'should have the option to receive support for vicarious trauma the same way counsellors do' as it was thought that supervisors do not receive support. Therefore, it may be helpful to ensure that staff are encouraged to make time to address their own mental health concerns, and for the institution to ensure that staff are aware of frameworks both within the workplace and externally to enable them to discuss issues which are affecting them, and for departments to review and revise staff support provision on an ongoing basis.

4.6 Student Views on Ideal Support Provision

Views on ideal support reflected different levels of awareness of existing services and potentially students' own struggles to receive professional support. While peers, parents and a 'special mentor' were mentioned as potential sources of support, most respondents stated that the university should provide support; this would be complemented through external services such as GPs and NHS mental health experts for medication, free counselling, and psychotherapy.

Within the university, three main areas were highlighted. The potential for 'regular meetings with a university-trained professional' through the university's formal support service was recognized; however, one student noted that 'waiting lists are way too long, the service is clearly underfunded and/or under-resourced and/or understaffed'. Additionally, it was felt that the service was 'too formal and includes too many box-ticking systems', which could lead to 'constantly feeling like you're being assessed'. Nevertheless, the service offers 'workshops on perfectionism and anxiety which a lot of music students go to' and it was suggested that bespoke sessions for music students could also be provided.

The supervisor was the most frequently mentioned ideal source of support, with recognition of their capacity to facilitate academic processes and refer students to other services. These could include college welfare teams: 'many cases of low-level mental health issues can be handled by college staff very effectively'. However, one student felt that college services were less accessible to those living off-campus; therefore, supervisors could reinforce communication of support structures to students in their second and third undergraduate years, as well as to new/continuing postgraduates and those in writing-up years, one of whom articulated 'substantial anxiety' and limited

'recognition and support' in relation to PhD write-up stress. Despite indicating other sources of support, the importance of supervisory oversight was highlighted: 'a really important part of a supervisor's potential role is perhaps to keep an eye out to make sure students don't slip through the net somewhere along this chain of referrals (if required) and end up not getting the support they need'. Oversight could also be essential in cases where 'sometimes the students will be so busy with work that they ignore their problems and they manifest in other ways'; supervisors are well-placed to recognize what is normal or unusual for a student, particularly within a performance-focused department in which staff work with students in ensemble rehearsal and performance contexts in addition to lectures, seminars, and supervisions and can therefore see a student's engagement in different contexts.

While one respondent believed that 'the music department does far more than many other departments', others suggested that extensions of university support could create roles for a 'mental health support person' or 'assigned members of staff to be the first point of contact' in each department: 'One unrealistic idea could be to have a few music welfare students and staff, who are trained to talk to the students about mental health, and able to sympathize with music department life'. Locating this support

from within the department was advocated: 'having someone to talk to who understands the actual real time demands of your course would be really helpful'. Students indicated that this role could be fulfilled by a 'pastoral supervisor, equipped with suitable counselling/therapy qualifications' who would 'understand the issues specifically facing music students' and would 'liaise with supervisors, lecturers, and other health care professionals to ensure that the wellbeing of the student is the first priority'. This person could possibly also 'fulfil some other teaching role' particularly for Year 1 undergraduate students, enabling 'all students to have the opportunity to spend some time with them, and therefore get to know who they are, and learn that the "pastoral supervisor" is someone that they can trust, and speak to in confidence'. The location of this role was also considered:

> Music students don't tend to get out of the department much; for many, music is the only thing they do so it is important that there is someone in the department where people feel comfortable. I believe this is why many music students would not go to the [student union] for advice and support. They are not comfortable outside of the department because they never have to leave it!

Further suggestions for support included greater provision of information, which could include a mental health awareness day and a mental health guidebook, 'full coverage of all support

services available at the university during induction, and widely displayed advertisements for national services, e.g. Samaritans, 111, Nightline, etc.'. This information should 'encourage awareness of warning signs' as 'most people are unfamiliar with the symptoms they may be experiencing (tiredness/anxiety/full head/bad thoughts/worries that they're losing it)'. It was felt that 'many people are not properly equipped to self-assess the state of their mental health… the student themselves should have some self-awareness, and be able to recognize their own mood changes, or neurosis development'. Awareness could be facilitated through 'guest talks by mental health professionals who can explain the many different types of support available'. Additionally, 'there could be workshops or discussion groups to talk about mental health problems in general' which might include mindfulness and other techniques. These suggestions indicate that while the supervisor has a central role in supporting mental health, additional support would be welcomed.

4.7 Departmental Culture and Responsibility

In addition to academic workload demands, mental health could be 'related to the lifestyle of a music student – high intensity, high pressure'; therefore, 'being a music student can affect your mental health negatively; for example, self-esteem and (performance) anxiety'. It was also suggested that 'performing

well tends to have a higher priority than treating the underlying condition'. Furthermore, one respondent felt that 'due to the very competitive nature of the department, many music students struggle with severe insecurities about their academic and musical abilities which can be incredibly difficult to deal with'. Elaboration of this point was provided by another respondent:

> One of the major problems in the department… is that a small number of people receive a great deal of performance opportunities and praise because of how they performed in one or two auditions, which can leave a lot of other students feeling left out and inferior, causing severe insecurities and subsequently these people don't want to perform as much or perform with a lack of confidence, and so these issues get worse and it becomes a vicious cycle… if there was a way for there to be more high-quality non-auditioned groups or a system to ensure that the best performance opportunities within the department would be shared more evenly across the students, it would make for a generally happier and healthier department.

While competition is frequently encountered within the professional life of a performing musician, this comment indicates a need for further reflection on the parity of opportunities as well as attitudes towards competition, particularly in a context where not all students are preparing to be professional performers. Music departments could usefully investigate how students experience competition and whether

decisions made by staff in regard to opportunity need greater consideration. It may be the case that staff assumptions about students' prior experience impact on awareness and attitudes regarding students' capacity for adopting positive attitudes towards competition and opportunity; not all students will have followed a route in which performance exams, competitive music festivals and other competitions are standard rites of passage. Therefore, students may need further support. The indication of insecurities also links to another comment which expressed the idea that staff could demonstrate greater concern for those students who have support plans, ensuring that there is 'non-stigmatisation'. No further detail was given, but the presence of the comment suggests some issues relating to this may have been experienced or observed by this respondent which could be investigated.

Additionally, staff attitudes relating to 'encouragement and enthusiasm' were identified:

> I would like a lot more positive feedback. I often feel like I am continuously scrabbling for approval and no matter how hard I work, often the feedback is 'you got 68, here is what you should have done to get a first', rather than 'You got 68! WOHOO! Well done! You are amazing! Keep going! Keep doing the things that you are doing, if you tweak these things next time you might be able to do even better but WELL DONE!' It

> can sometimes seem like the department is supportive if you are doing well rather than if you are trying hard (including performance). This has definitely had a negative impact on my mental health and my enjoyment of music.

This comment suggests that student perceptions of departmental culture are also influenced through feedback, and again connects to the role of the supervisor in providing encouragement. Marking criteria and feedback guidance urge staff to assess the work they are seeing in isolation, not in relation to previous work, and therefore feedback cannot indicate the marker's awareness of a student's development. Longitudinal developmental oversight can, however, be provided by the supervisor, and is an aspect worthy of further consideration in relation to supervision.

In addition to promoting awareness of mental health through information and support sessions, further ideas included 'general activities to show students there are other things to do (to relax) than always doing something musical and high intensity!' and events 'to help students relax and not have to worry about studying or practising for a bit, like food/film/playing fun easy music together/singing/petting dogs'.

While the responsibility for students' mental health was almost unanimously identified by students as their own, responses gave clear indications that students believed that the department, as well as the university and family, should take some responsibility for promoting and supporting mental health. As a student's mental health might be 'defined by their ability to cope with the workload', as well as influenced by potentially 'feeling marginalised or isolated in a not very diverse department', supervisors have a responsibility to consider how they can mitigate against these factors, and staff have a responsibility to consider how to promote a positive department culture which facilities positive mental health.

5. Discussion

The views detailed above, while expressed only by students within one UK university music department, are likely to be indicative of more widespread issues among music students, both at university and conservatoire, and additionally resonate with views of postgraduate research students expressed in Metcalfe, Wilson and Levacque (2018). Higher education brings challenges including engaging with a new environment, changes in support, concerns about managing study, and assessment requirements (MWBHE, 2015). Academic supervision may be the only structured and regular support available to some students.

This can result in complex demands for supervisors and, as revealed above, there is potential for variance in their capacity to support students.

HSE identified six main sources of stress in the workplace: demands, control, support, relationships, role, and change (HSE, 2017). The findings presented above suggest that these areas present similar concerns for music students as well as for academics. Demands consist of the challenges of negotiating pressure, a competitive environment, deadlines, high-intensity activities, self-esteem, insecurities, performance anxiety, and general anxiety. While workload hours were not discussed by these respondents it is likely that academic study, instrumental practice and rehearsal schedules, as well as part-time employment and/or volunteering activities, create substantial demands.

Higher education viewed above as 'a time of disruption and change', is likely to impact on control. Some students participating in this research reported feeling a lack of control concerning departmental opportunities and may be highly sensitive to parity and ability. They are also aware that they cannot control the outcomes of disclosing sensitive information to a supervisor; neither do students have control over support

provision. In situations which are already stressful, the limited extent of control could lead to increased stress and anxiety.

Students report concerns relating to their ability to understand their mental health, which suggests that factors beyond their full control have an impact on their capacity to deal with change. Change is endemic within higher education; for example, underpinning programme structure and requiring students to adapt and adjust to different lecturers and varied peer cohorts, and engagement in other contexts such as student societies and accommodation may also require negotiation of frequent changes. The supervisor can become one of the only constants within this context and may be seen by students as one of the few people who understands this situation. While instrumental teachers may also become significant sources of emotional support for students (Gaunt, 2008), the peripatetic nature of their university employment means that they possess less knowledge of departmental structures than academic staff, and have little procedural influence; therefore, academic staff have capacity beyond that of instrumental teachers to negotiate support for students, and could potentially be perceived as better able to relate to difficulties exacerbated by academic study. Nevertheless, it is also valuable to propose that any institutional provision does include instrumental teaching staff in relation to training and information concerning support for mental health,

particularly as these staff do see students more frequently during the course of the academic year than other staff and have a greater amount of one-to-one contact hours with students. It is also important to consider provision for the mental health of these teachers, as well as for academic staff.

In terms of relationships, 'knowing', 'approachability', and 'trust' are identified above as key factors affecting students' communication with supervisors; these could affect the extent to which students feel validated within the relationship, and, of course, are also vital in relation to instrumental tuition. Research on music learning indicates the importance of educators' capacities to engage emotional skills and positive psychology to develop learner engagement, wellbeing, and enjoyment (Campayo-Muñoz and Cabedo-Mas, 2017; Patston and Waters, 2015). Student comments suggest that a caring supervisor will respond with empathy and compassion. However, they may find it difficult to detach from the student's situation and may continue to engage in supporting a student even if the student receives professional support, particularly to check that support is indeed ongoing. These factors contribute to the challenges in boundary-setting and in boundary-maintaining, and in an environment where students and staff will see each other during lectures, seminars, tutorials, rehearsals, ensemble performances

and as audience members, it becomes more difficult for supervisors to define and maintain boundaries than it is perhaps for lecturers in other disciplines, or for the professional healthcare practitioner who will only see the student in a specific, defined, and time-limited context. Although a boundaried structure can be a highly effective framework for therapy, boundaries cannot be so tightly constructed and achieved in the context of a music department. This has significant implications for academic staff, who are very much less supported than healthcare professionals, as they receive no ongoing individual or group supervision as part of their employment and may not have received this within their training. While a university might encourage academic staff to consult an internal or external counselling service if needed, this is likely to make the demands on supervisors less visible to the department and to the institution, and therefore may remove the discussion of support, boundaries, care, and workload out of the precise context in which it needs to be articulated. This has worrying implications for the mental health of the supervisor, for departmental culture, and for the debate on mental health, which will not benefit from being sequestered.

Institutional support structures frequently operate using a platform such as a counselling service which connects to support

linked to student accommodation (college-based), health services, student societies (offered by peer students), and to faith services (offered by chaplains). Communication from these services can appear to operate in a disjointed counterpoint, repeating, overlaying, truncating or extending information, with the result that it can be easier to ignore than to engage with. It may appear to students that there is little coherence in the design of support provision, and negotiating potential discrepancies within this confusion may be overwhelming, particularly for those who are struggling. Therefore, suggestions of in-department support seem logical, particularly as music students are likely to be engaged in programmes rather different in nature from other subjects, in which a variety of skills, particularly performance, may be not only operate at different levels of competence but are also highly visible to peers, which can contribute to comparison and competition.

Promoting 'self-agency' and 'resilience' (MWBHE, 2015: 9) may positively help students negotiate the demands of grappling with aspects influenced by control, support, and change in relation to their studies and their personal development. According to Mind (2017), 'resilience is not just your ability to bounce back, but also your capacity to adapt in the face of challenging circumstances, whilst maintaining a stable mental wellbeing'. This can be

developed through lifestyle considerations, physical wellbeing, and support. It seems pertinent to suggest that this has implications for ongoing discussion of the extent of departmental remit; while provision needs to be in place to support those with mental health issues, music departments could fruitfully consider how they create a culture of wellbeing, and how prominent their attitudes to positive mental health are to students.

Provision of more support, as well as information about mental health issues, institutional and external support services, could enhance positive development of factors identified by these respondents: self-esteem, anxiety and performance anxiety, the delivery and reception of feedback, parity, and opportunity. This could also be influenced by student perceptions of their own role and responsibilities, particularly in terms of agency in finding support and in connecting with departmental and university culture, which further relates to their ability to influence and cope with change. This research has made some contribution to enhancing students' perceptions that their department has concern for their mental health; however, students need to be involved in discussion about how they would ideally like to be supported, which may facilitate provision which has relevance to students' needs, which is conveyed through clear

communication, and which engages staff, students and instrumental teachers in a positive culture. This is particularly complex in a context where students' area of study may influence their perception of music: it may become less of a stimulating or restorative art (MacDonald, 2013) and instead present sources of stress, further complexified by the relationships between performance, scholarship, competitive cultures, and opportunity. The interrelationship of these aspects in relation to mental health warrants further research. For staff, it is likely that greater support both within training and during employment may be beneficial in developing understanding of mental health, and in supporting wellbeing; furthermore, enhanced support for students with the potential for in-department and external services may create structures where students have choice, and timely access to support; all developments which will enhance departmental culture and benefit everyone.

6. Conclusion

This small-scale study has investigated views of a sample of music students at one UK university. While the sample size is small, the findings indicate tensions between support provision and demand, supervisory capacity and ability to meet students' needs, boundaries, staff training, student awareness of the effects on their supervisors when providing support, departmental and

institutional developmental needs. Additional comments from respondents expressing gratitude and relief that this research was taking place suggest that the student voice deserves greater representation in the ongoing discussions of mental health and wellbeing. Issues of communication, roles, agency and departmental culture are identified as concerns worthy of further investigation and institutional support.

Acknowledgments

Thanks to music students at the UK university for participating in this research, and to Charlotte Brook and Katherine O'Neill for assistance with data collection and to Dr Richard Powell for his helpful feedback.

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Musicology Research
Issue 6: pp. 201-227

8

The Inclusive Classroom: Wellbeing and the HE Musician

Andrew Lansley

1. Introduction

The focus of this study will be on the use of technology in addressing teaching and learning challenges faced by students diagnosed with autism spectrum disorder (ASD) in creative musical contexts within the classroom. I will be exploring the use of next generation technology using Living Education Theory to facilitate a transformative approach through action research (Atkins and Wallace, 2012: 171). This project will take the form of a collaborative student investigation involving two modules that challenge music and non-musical specialists in a creative context, where implications may suggest that barriers exist in accessing learning materials and engaging with group work within the

classroom. The aim of this study is to develop more inclusive learning environments, removing barriers for those who benefit from support with their mental health.

This study has been inspired from my own experience with ASD and the barriers I have faced in engaging with group work and through travelling the world performing music in challenging and ever-changing environments. Over time I have observed fellow musicians and students becoming overwhelmed with busy performance schedules, practice commitments, and the complex social and technical challenges these environments present. This made me reflect on the environments many musicians operate within and how this could be adapted to promote a more flexible approach in how learners work in creative and musical contexts. In order to gain an understanding, I identified areas of study that might be challenging to students with ASD and what could be done to address them. I decided to investigate the delivery of creative practice teaching to students and how materials were both prepared by myself and utilized by learners. Analysis will give broader insight(s) into my investigative process which guided the research over a period of 12 weeks.

A community of practice approach allowed me to draw conclusions from this study and provided a rational for the

interpretative, expressive use of technologies, exploring the application of these technologies to learner practice and responding to the experience of the cohort. The findings will critically comment and evaluate the practical merits in response to a review of current literature, module evaluations and qualitative commentary on the experiences of students. A conclusion will provide a brief summary of the main themes that have emerged as part of this investigation with key findings suggesting that technological enhancements to the delivery of a curriculum can provide benefits to learners.

Although it is hoped this research is able to offer a meaningful perspective to the current conversations around wellbeing of the creative learner and associated educational strategies, it was also important that the primary goal of this project was to directly benefit those students who had participated in it. As Lawrence Stenhouse once wrote 'What seems to me most important is that research becomes part of a community of critical discourse. But perhaps too much research is published to the world, too little to the village' (1981: 17).

2. Background

> Music educators, administrators and policy makers must play an active role in providing supportive environments where health and wellbeing is

> considered integral to expert music training.
> (Araújo et al., 2017: 1558)

It was the needs of the students that generated the first steps in setting up this project, with an anecdotal conversation with a learner that led to the establishment of a working group. During a class task held within a session I noticed a student had copied the lecture content into a new slideshow and had begun amending the text, slide colouration and font using Microsoft Office software installed on the in-class computers. The student was using these amended lecture slides to follow both the lecture content and the task brief. I made a comment to the student that her formatting was much easier on the eye than my own slides, to which she responded that she found it difficult to read the slides I had prepared due to the high contrast of black text on a white background. The student went on to share that she downloaded and amended my lecture slides each week and saved separate versions of her own. The experience of having difficulties looking at bright, contrasting colours is not unusual for those who experience sensory sensitivity – in their paper on atypical colour preferences in children with autism spectrum disorder (ASD), Grandgeorge and Masataka (2016) state:

> enhanced sensitivity to sensory stimulation in general that is characteristic of ASD would influence colour perception exhibited by people with this disorder, and

> this would result in aversion to some specific colours that are usually favoured by neurotypical people. (Grandgeorge and Masataka, 2016: 2)

It is widely recognized that colour perception is different with those on the autistic spectrum (Franklin et al., 2008) so this chance conversation with a student presented an opportunity to explore the development of amended teaching materials. With the student feeling they needed to access and change my lecture slides in order to absorb them, I felt the responsibility lay with myself to provide alternatives. There are materials already available to help design content for users on the autistic spectrum, such as resources available via the Home Office which provided a good starting point for reviewing and refining my teaching materials.

As this project came through a process of development rather than design, the self-selecting nature of the groups were defined by the needs of the learners rather than the requirements of the practitioner. There were five students across two creative production classes who were already declared as students with ASD. I contacted them individually to ask if they would be happy to help develop alternative lecture content and format that might help improve their ability to absorb the curriculum and address potential sensory issues that might otherwise impact on their ability to engage with the module content and associated in

class workshops. I felt that it was important these students were included as part of the research process rather than necessarily being a subject of it. As stated in a draft framework for inclusive autism research 'the vast majority of research in autism is still undertaken on autistic people, rather than *with* them, and is often not concerned with improving the day-to-day lives of people with autism' (Chown, 2017: 720).

As I had also been diagnosed with ASD, I felt I should share this with the working group in order to remain as transparent as possible. This was also in an effort to relate my own interest in this area to their experiences. In this sense, acknowledging the concept of educational influence was important as the idea was to encourage students to be critical in relation to the existing content and how it could be improved by leading by example. As McNiff and Whitehead (2009) state, 'in order to encourage other people to become critical you have to demonstrate your own capacity for critical reflection on your own thinking'. This was an especially important consideration in ensuring good professional and academic conduct was followed as far as was realistically achievable as a methodology was developed.

Having looked at the suitability of the group to undertake this project and considering the technological strategies that might facilitate any amendments to the curriculum content, it was

decided to review the most significant mental health challenges facing students in higher education against the obstructions they might face in class. This was done in order to better understand how these challenges might present themselves in learner behaviour and how they might be addressed through adaptive module content change.

The focus on wellbeing of the students with ASD was critical due to the occurrence of autism together with a number of mental health issues (White, Oswald, Ollendick, and Scahill, 2009). When considered alongside the reported growth in prevalence of students suffering from mental health issues in higher education – with some institutes reporting a three-fold rise in reporting (Weale, 2018), challenges such as anxiety or sensory problems might be enough to deter a student from attending a class for personal reasons. Furthermore, issues such as Obsessive-Compulsive Disorder, alongside numerous non-assessed disorders such as phobias and depression (Matson and Nebel-Schwalm, 2007), can contribute significantly to challenges with a student's life – let alone the ability to engage productively with a cohort and curriculum in a creative and meaningful way.

In order to better understand the wider context of mental health issues that are faced by students in higher education in the UK, I consulted the *Grand Challenges in Student Mental Health* report

published by Student Minds. This report provides a framework that intends to empower students in how they can develop 'skills to support one another and the knowledge to look after their own mental health' (Student Minds report, 2018: 4). This appeared to be an appropriate resource for this research as it sought to empower/enable the study group through active engagement rather than attempting to develop materials in isolation. The report includes a section that outlines 'The 10 Grand Challenges for Students and Staff' and several of these findings were discussed as part of group communication and in class conversations in order to ascertain how different mental health issues might present themselves as obstacles within a creative/musical module.

Stress

Students reported that anxiety around studies, being unclear on learning expectations and pressure to do well in class were significant factors in how they experienced their studies.

Poor general understanding about mental health problems

Some of the participants recounted feeling either marginalized or isolated by peers (and in some cases by health workers or teachers) and that they found it difficult to communicate the challenges they faced.

Finding the Confidence to Ask for Help

Students discussed this as existing alongside the challenges they faced with the poor general understanding about their conditions. They were aware of the help that was available from both academic and professional services, but it was suggested that seeking help was a strategy only adopted when other avenues of support (self-administered or otherwise) had been exhausted. During initial conversations with the group of participants, two areas of investigation were outlined in order to construct a development process aligned with their concerns about the stress of not being able to attend or ask for help and how this could be addressed by improving access to the curriculum online. This established two areas of development: lectures presented in alternative colouration and a touchscreen-friendly learning environment to improve remote access.

I found the research from Student Minds was appropriate to share with this group, but stressed that the focus of a weekly community of practice approach was to amend content delivery as opposed to addressing mental health problems directly. Using this weekly approach allowed further flexibility in enabling me to respond with almost immediate adjustments to delivery. This method seemed to be an effective one due to the regularity of sessions with the students with whom I would be working, and

allowed me to review and adapt in class processes as they were developed. From here I had a foundation with which to build a platform for using technology as an asset in testing a new delivery format and making adjustments based on feedback from learners.

3. Methodology

Following this analysis of challenges faced by students with ASD in engaging with learning resources, I was in a better position to begin outlining a methodology for the testing and review of amended or additional materials with the group. For the purpose of clarity, this paper will address the learners with ASD as *participants* when discussing this study in order to distinguish them from s*tudents* (who were passive in the development process) which I have used to identify the neurotypical (non-autistic) learners.

Action research was the preferred route due to the requirement to review the personal experiences of participants and the need to collaborate in how to best respond to their feedback. This allowed for a more robust interpretative and reflective process that incorporated a number of individual positions on the findings. This framework offered a more suitable basis for this research as it would account for these personalized experiences,

this method offering a 'pragmatic co-creation of knowing *with*, not *on*, people' (Bradbury, 2015: 34).

This research sought to unify the core functions of a community of practice with participants. To paraphrase McNiff and Whitehead (2009), this was done by addressing two critical components at all times with the learners: action (*what I did*) and research (*how I learned about and explained what I did*). This was an attempt to compensate for any unconscious bias so as transparent an approach as possible could be employed during this research. With a strategy to develop this idea established, I was able to define the two main aspects for investigation: preparing content that would be suitable for users on the autistic spectrum and the use of technology to facilitate module content redesign as the study progressed. The technological facilitation of curriculum adaptation was implemented via the institute's chosen virtual learning environment: Moodle.

The 2017 New Media Consortium (NMC) Horizon report identified Mobile Learning as a key adoption of learners in higher education. With next generation Learning Management Systems (LMS) launching within the next two to three years, this could suggest that emerging technologies can offer the tools to provide tailored variations of learning materials that put the

student first in how they choose to interact with any given curriculum. With a comprehensive and remotely accessible resource for students already in place, I was able to focus on the impact of amendments to lectures and format, as opposed to constructing an entirely new online learning resource. Both modules had significant online content developed already, with several years of refinement undertaken with learners through use of mid-module evaluations and learner feedback. Collaboration between the teacher and learner in creating a bespoke, personalized environment was outlined as one of the five domains of core functionality outlined in the Next Generation Digital Learning Environment report (Brown, Dehoney, and Millchap, 2015). Employing this approach would allow the participants to directly impact on the design, integration and accessibility of content as the study progressed.

Virtual learning environment developers have continued to add functionality that shifts the focus from enabling administrative tasks to deepening the act of learning (NMC et al) – it was important to recognize with the participants that the collaboration we were undertaking was a learning process in itself that did not just inform the way they were engaging with the curriculum, but how they understood the way they approached their own learning strategies. With Moodle used as

the online learning environment for this research, all participants were familiar with this format from their previous studies. As it was important to me that any amendments to the curriculum did not serve to disadvantage neurotypical students, I felt it was just as important to consider their experience so that I was not unknowingly attempting to solve problems in one area whilst simultaneously creating issues elsewhere.

The class resources for both modules were broken down into three sections:

1. Core information: *Module overview, staff contact information, scheme of work, assessment dates and rubric grids.*

2. Lecture series: *Weekly series of content for learners for use in class. All material is accessible from the first week of the semester*

3. Additional materials: *Reading lists, links, previous work, guest lecture content, submission guides, further reading.*

These sections informed a scheme of work (Figure 1.) that was designed to progress alongside the expected developmental trajectory of learners based on previous experience running the modules. When the study group of participants was formed

(week 5) the class were preparing for mid-module evaluations which take the format of a three-question form. This anonymous process provided broad qualitative information about the learners' experiences: what they were enjoying in class, what they found challenging and suggestions as to how teaching and lecture content could be improved. This allowed for a more general, class-based view to be considered alongside any amendments that would be made in an attempt to ensure learners who were not participants of the study group were not unnecessarily disadvantaged.

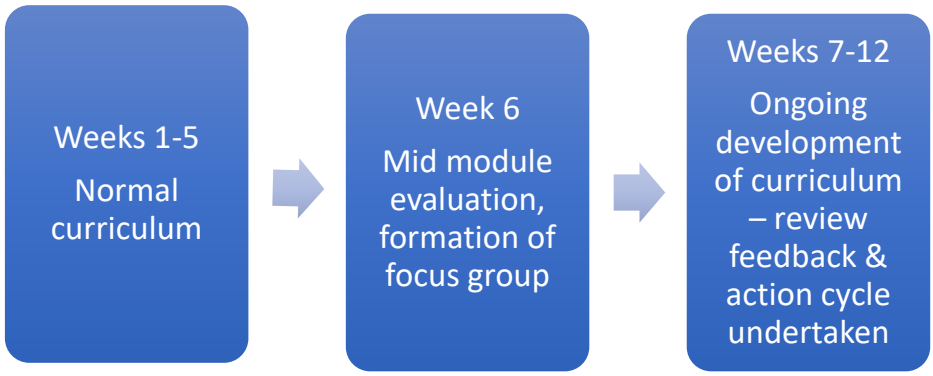

Figure 1. Curriculum development process over the duration of the project.

Reflecting upon previous conversations with the group of participants, as well as responses received from the students, two areas of investigation were outlined in order to construct a

development process aligned with the action research cycle:

- Lectures presented in alternative colouration
- A touchscreen-friendly learning environment

As outlined in Figure 2. and Figure 3., the cycle of action research was adapted to address both access to curriculum and sensory issues simultaneously. This allowed for findings to inform one another, with technology facilitating virtually all stages.

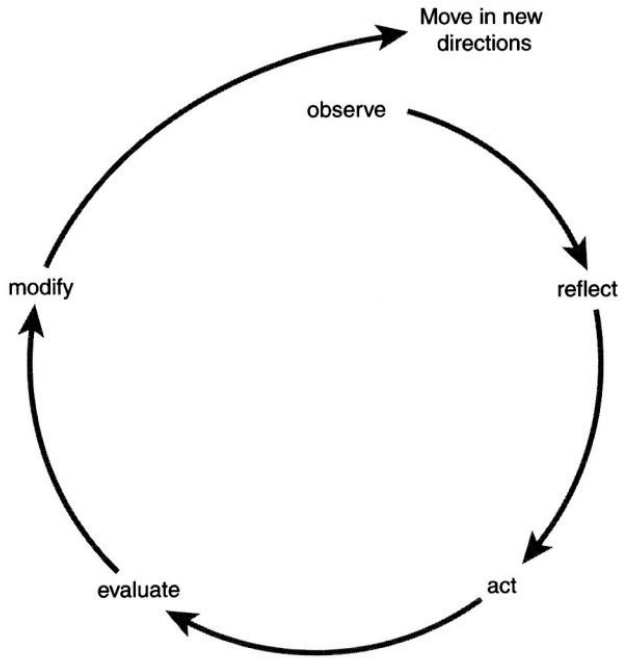

Figure 2. Cycle of action research (McNiff and Whitehead, 2009).

	Virtual Learning Environment	Slide colouration
Evaluate	A review of current online learning provisions was undertaken	Examples considered and discussed in group meeting
Modify	Moodle adjusted to touchscreen list format, including access to alternative slides	Two variations trailed, one selected and introduced to virtual learning environment
Observe	Study period of six weeks undertaken (Lectures 7-12), online activity recorded	
Reflect	Group meeting and email correspondence collating anecdotal evidence of usage and effectiveness	
Act	Moodle adjusted to grid format, additional navigational graphics incorporated	Slide colouration selected following group discussion, lectures amended and uploaded to course Moodle

Figure 3. Adapted process showing merged observation and reflection phases of the cycle.

Moodle Content

Originally, module content was presented in a list format, where users could scroll down through lectures sequenced week-by-week, with all content openly accessible from the start of the semester. Similarly, lecture slides were provided as part of this resource, with a single option of black text on white background. One of the first requests of the participants was to investigate touch-screen functionality so that materials could be accessed easily using a mobile device.

This was achieved by switching the aesthetic format of the learning environment from a list to a grid, which allowed the addition of pictures to each topic meaning that students could then access every section by touching a picture or icon rather than text (Figure 4.). Working with our learning technology team, I was then able to apply this amendment to the reading list, adding pictures of the book covers to links that would direct students straight to our library service (Figure 5.). The previous method of accessing reading lists via the Moodle system was by visiting a separate online resource for our library service, logging in, sourcing the text, and accessing. The impact of removing these steps was immediate, and responses received in the module evaluation the following week included a number of observations about improved clarity and functionality.

Slide Colouration

The participation group agreed amongst themselves that the colouration of the third iteration we discussed offered a good compromise (Figure 6.). This used a dark purple for text (HEX colour #3COA5E) and a light grey for the background of the slides (HEX colour #D9D9D9) which participants felt were much easier to read when compared to the contrasting black on white used on the original lecture slides (Figure 7.). Unfortunately, no records were kept of the development of different colourations, so could not be included in this report.

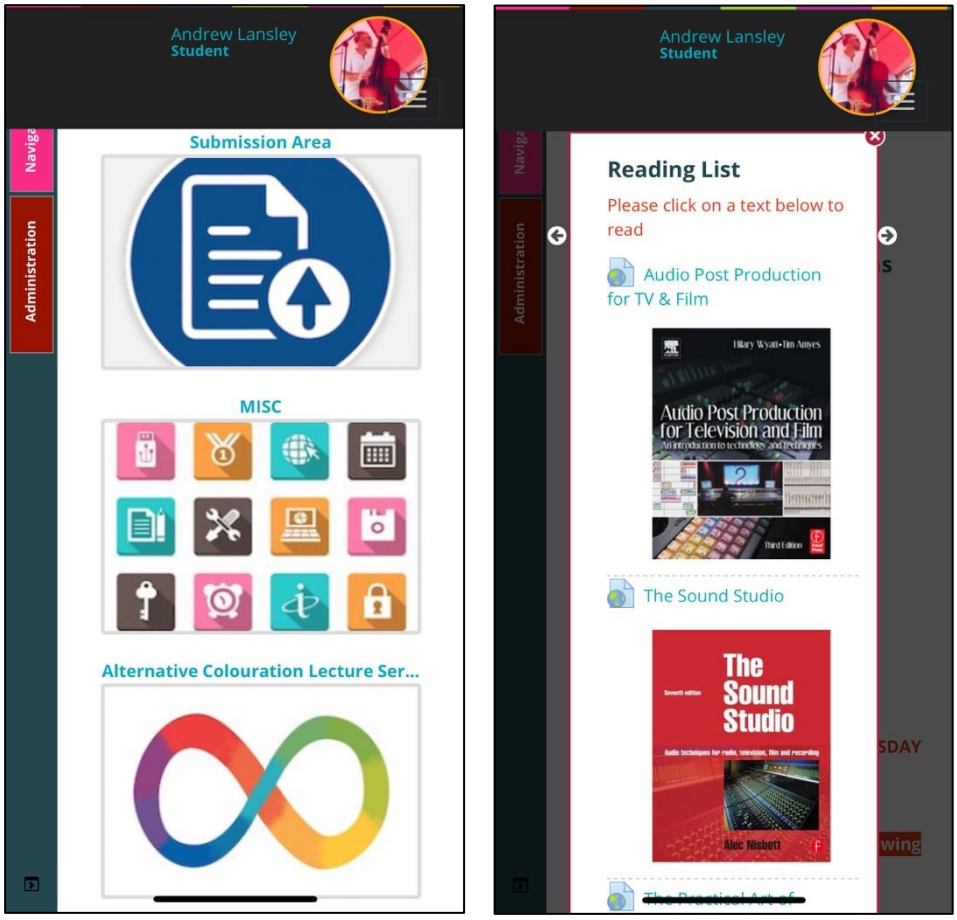

Figure 4 and 5. Curriculum formatted for mobile/touchscreen device use.

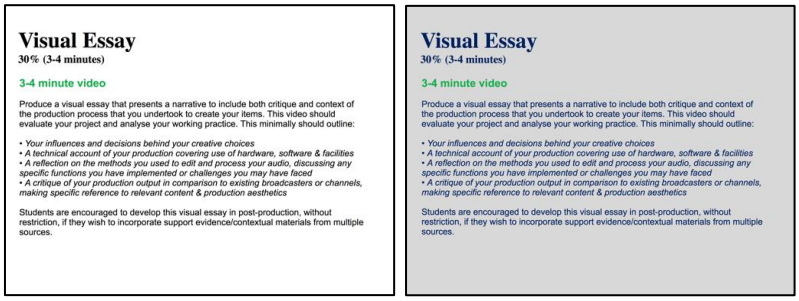

Figure 6 and 7. Lecture slides - colouration comparison.

These initial changes were reflected upon by the participants and feedback on the first round of modifications was offered through mid-module evaluations that were received from the entire cohort. Comments from the feedback included statements such as 'Moodle is amazing', 'easy to read and follow', 'clear and concise', as well as 'is very clearly set out, you have what you need, and it stops you wasting time'. I believe that these observations highlighted the improved experience they had following the first round of modifications in the action research cycle.

The touchscreen format and slide colouration were two of the practical outcomes that were developed within the group - that were then subsequently deployed within the curriculum. Group conversations with the participants were held weekly from this point, informing any further adjustments to the learning

environment that were made as the semester progressed.

4. Observations and Analysis

This project has presented a number of challenges in that it has been difficult to collect data during the development, with a focus on responding to student feedback and implementing changes taking priority. This has limited the evidence I am able to present in supporting these findings. The scope of this research would have similarly benefitted from a larger sample.

What this research method has done has helped me to establish confidence in how I can identify challenges to learners and apply effective solutions through curriculum changes almost immediately. That has enabled me to go on to consider other content that I teach and make similar adjustments in the hope that I can be proactive in preparing for specialized learner needs across the modules I teach. I have been able to investigate and discover themes that were introduced through conversations in class and feedback sessions with these students and believe that the informal nature of this process was instrumental in helping uncover the barriers some of the participants faced when engaging with curriculum.

In addressing the understanding of sensory issues it was found

that the development of alternative colouration of lectures was popular with participants, reviewing Moodle traffic data reports it appears that students who were participating with the study engaged more with the online learning resources once content was being developed, and were more communicable as a result. This is likely due to them being the focus of study and having an enhancement knowledge of the module content through more contact time with their module tutor.

In response to participants concerns about accessing content remotely through improving the format and design of the Moodles, overall mid-module feedback given for online resources (from participants and students) was very positive. Although this was taken very early in the research phase, the response was likely due to the existing clarity of formatting of module content and possibly due to an awareness that it was being developed and adjusted during the course of the semester.

One of the emergent aspects of the study was how supplementary content was formatted and presented. A 'how to' video outlining the use of a piece of audio sampling software was presented to the class in two formats – a link to a guide provided by the manufacturer and a three-minute video shot on an iPhone of the module tutor taking a student through the same

process. The conversational style video was preferred and this is likely to be the focus of another project following on from these findings.

Another theme that presented itself through the course of the project was how effective a coordinated staff approach was in recognizing the challengers these learners faced and how they could be supported. Assistance from faculty administrators ensured that resources and facilities were always appropriate and available, the learning technology team helped me to develop my understanding of Moodle and streamline how I used the platform to integrate alternative and additional content throughout an already well-established online provision. The institute's 'Student Helpzone' was able to offer anecdotal support and signposting to mental health and wellbeing resources that helped to inform this study as well as assistance from the Equality & Diversity Manager who was able to help provide ethical guidance in designing a strategy for what was a fairly informal piece of research.

Through applying a living education theory framework through action research (McNiff and Whitehead, 2009: 166) I have also been able to identify several developmental strategies that not only benefitted those taking part in the study groups, but the rest

of the students across both modules. I felt these methods also worked well when dealing with creative students working with sonic composition pieces, who also appeared to enjoy the design elements of adapting and testing the amended module content. Recognizable changes were discussed in several areas: personal growth, self-awareness and developing educational coping strategies, confidence in their creative abilities, as well as transformative attitudes towards their learning.

Within a few years (as well as with further consideration and collaboration), it is looking increasingly likely that it will be possible to develop a personalized virtual learning environment that removes the majority of obstructions that might be faced by learners who find accessibility, comprehension, collaboration, and socialization difficult when approaching creative work that is covered in this paper.

5. Conclusion

This short study has given me a framework to progress, but much more investigation is required. Using a multimodal approach to incorporating outcomes from within the study, a methodology began to present itself as a tool for onward exploration. The process of action research has allowed the study to respond quickly to findings, but a more robust methodology

should be adopted going forward; a larger sample of students, specifying particular musical focuses (e.g. practice, performance, composition, production) could all improve the quality of findings in these areas. Longer periods of practitioner development with cohorts across a more diverse spectrum of teaching materials and content could similarly generate additional research in this area. It can also be noted the students who find virtual learning environments off putting might find this process difficult to engage with, hence the importance of action research in a working group.

Considerations around big data emerging technologies and their analytical potential to deliver tailored educational experiences should not be discounted. Similarly, this affords the opportunity to explore the emergent partnership of data and didacticism - where learning technology resources could offer intervention and customization to material resources intuitively and individually. With further consideration and collaboration, it might be possible to develop a virtual environment that minimizes obstructions that might be faced by learners who find accessibility, comprehension, collaboration, and socialization difficult when approaching creative work.

In conclusion, I believe this study has identified genuine issues

students with ASD face in processing the colouration of lecture slides and accessing virtual learning resources. Through the formation of a working group, action research has helped analyze these issues and find solutions in how module content was presented and formatted. There was observable engagement with learning materials for the working group and amendments did not adversely affect the rest of the students. Several layers of educationalists involved meant rapid amendments to delivery was possible, minimizing disruption to any other students.

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Biographies

Alexander Douglas

Previously shortlisted for the Gresham Professorship in Music, Alexander Douglas triangulates across music, multiple humanities disciplines and mental health. An award-winning jazz pianist with an MA in Music Performance from Kingston University, he also holds an MMus in Ethnomusicology from SOAS in which he not only specialised in music of the Jews but undertook significant research into both the psychology and philosophy of music. A leading exponent of gospel music in the UK, he also holds an MA in Choral Conducting from the Royal Welsh College of Music and Drama (where his teachers included multiple Grammy Award-winner Simon Halsey), subsequently founding/directing the Huddersfield Bach Collegium. Alexander has also undertaken post-graduate studies in Philosophy and Mental Health and in Theology, and guest-lectured in several universities (including Cambridge University). At present he curates the archive of the Worfield Charity Concert Trust at the University of Wolverhampton. He is an Associate of NHS

Research and Development NW, a Fellow of the Royal Society of Arts and an independent researcher across music, language, religion, and mental health.

Sebastian Hachmeyer

Sebastian Hachmeyer is a doctoral researcher in the departments of Music and Geography at Royal Holloway University of London. His academic formation is in environmental sociology and human ecology. He worked in the Kallawaya region of Bolivia between 2014 and 2016 on various topics related to music, climate, healing, ecology and environment. He is a researcher of the *Centro de Culturas Originarias Kawsay* in Cochabamba, and a member of the editorial board of the Bolivian Journal of Musicology *Contrapunto. Revista de Musicología de Bolivia*. His current PhD research takes an ecomusicological perspective and focuses on the sustainability of the Indigenous flute making on the Bolivian highlands and the sustainable use of the native woody bamboos used in their construction.

Sofia Deligianni

Sofia Deligianni is a music teacher specialised in early years. She lives in Cyprus and works at Mousika Dromena, an early childhood music centre. She graduated from Ionian University with a bachelor's degree in Music Education and Psychology of

Music (2017) and continued with a master's degree in Community Music at the University of York, UK (2018). During the Erasmus Placement programme in the UK, she worked at a music nursery as an early years music teacher and supported the nursery practitioners' music learning. She has also been involved in delivering music sessions in the Mother and Baby Unit in women prisons, as well as in the Children's Unit, Elderly Ward and Stroke Rehabilitation Ward of the York Teaching Hospital. In addition, she has provided music workshops in care homes and mental health organisations. She is also a member of the music-educational group 'Don Echotes', which published the children's CD-book 'Kratisou pano mou' (2016).

Rosalind Hawley

Ros Hawley is Co-director of Lime Music for Health in Manchester. She has over 25 years' experience in devising and leading therapeutic live music programmes with children, young people, and families in educational and healthcare settings in partnership with music organisations, orchestras and ensembles in the UK and Europe. Her work includes training students from The Royal Northern College of Music and The University of Manchester Medical School in modules on music and communication in healthcare settings. She is currently completing a PhD on her practice as a musician working in hospital at SOAS, London.
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Julia Humphreys

Born in Chester, Julia Humphreys is a doctor (in General Practice and A&E) and a Senior Clinical Lecturer at Manchester Medical School. Prior to MBChB, she completed a BA (Hons) in English, and lived in Japan and Russia, working as a language teacher. She has a particular interest in medical humanities and narrative medicine. She is the Lead for Personal and Professional Development for Years 3-5 at Manchester Medical School, as well as Lead Tutor for the student-selected Medical Humanities module 'Communicating through Music and Arts'. Julia is currently completing her master's in Creative Writing at the University of Manchester, School of Arts, Languages, and Culture.

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Shanath Ramachandran

Dr Shanath Ramachandran completed his MBChB and intercalated MSc at the University of Manchester Medical School, graduating in 2018. He is also an alumni student of the Personal Excellence Pathway (PEP) module 'Medical Humanities - Communicating Through Music and Art', having been awarded an Honours grade for final project. He also completed an Applied PEP research project on 'Medical Student Burnout', collating and analysing data from the Medical Humanities module. He is currently a Foundation Year 1 Doctor at Leighton Hospital, Crewe.

Zaina Shihabi is an early career independent international researcher, based between the UK, the UAE, and Jordan. After passing her PhD recently (with no revisions) supervised by Dr Laura Hamer (The Open University) and examined by Professor Pamela Burnard (University of Cambridge), and Dr Manuella Blackburn (Liverpool Hope University), Zaina has now turned her attention towards research and publications concerning twentieth-century Arab women composers and songwriters. Her PhD thesis is an inter- and transdisciplinary historical investigation of the position of female composers and songwriters in A-Level music syllabi provided by leading Examination Boards in England between 1980 and 2016. Zaina's other research interests include mental health and wellbeing in Higher Education, research structures and approaches. Zaina was awarded a Funding for Women Graduates (FfWG) emergency grant in 2018 by the British Federation of Women Graduates (BFWG) Charitable Foundation. Her most recent publications include 'Mapping Trends and Framing Issues in Higher Music Education: Changing Minds/Challenging Practices' (2017) in the *London Review of Education;* and a book chapter titled 'A Brief Historical Investigation of Twentieth Century Arab Women Composers' to be included in a *Handbook on Women's Work in Music* by Routledge in 2020.

Elizabeth Haddon

Liz Haddon is a Senior Lecturer in Music at the University of York, where she devised and leads the MA in Music Education: Instrumental and Vocal Teaching. Her research focuses on pedagogy, and also includes work on empathy in relation to piano duet rehearsal and performance, and she is the co-editor of two volumes on creativity in higher music education. Her work is published in leading peer-reviewed journals and her three books are published by Ashgate and Routledge.

Andrew Lansley

Andrew Lansley is a senior lecturer in Music at the University of Gloucestershire and a musician. His current research is based around autism, wellbeing and musical communities. He is currently writing a book on audio production called 'Sound in Media' for Routledge.

Contributor's Review

Sofia Deligianni

It was a real pleasure collaborating with the editorial team of Musicology Research, and seeing my work develop through thoughtfully and positively-framed feedback. It is essential (especially for new researchers) to know that they will be clearly guided throughout the publication journey, and that their work will be securely handled. I personally decided to contribute on this issue, firstly, because the theme was of great interest and helped me to expand my thoughts, and secondly because a journal with a peer-review process whilst at the same time being open-access will allow public access to my scholarly work.

Contributor's Review

Alexander Douglas

Musicology Research Journal has done me a great service by giving me my first opportunity to publish research in an area that I have thought about, blogged about, and spoken about - but nothing more than that - until now. It is clear that there is a broad and catholic approach to musicology and its cognates, and as such I was finally able to find a home for some of my ideas. I felt well-supported as an author going through peer-review for the first time and can comfortably recommend the journal to fellow (not-only-early-career) researchers.

Contributor's Review

Elizabeth Haddon

Musicology Research has demonstrated consistently excellent practice through clear communication, a robust peer-review process, and an efficient progression from submission to publication. It has been a pleasure working with the editorial team, and a privilege to be able to contribute to a high-quality journal which focuses on extremely relevant and timely issues.

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MUSICOLOGY RESEARCH JOURNAL

Issue 6

Spring 2019

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