When Music Speaks: Mental Health and Next Steps in the Danish Music Industry

Part 2 – A Review of Models of Musicians' Mental Health Interventions

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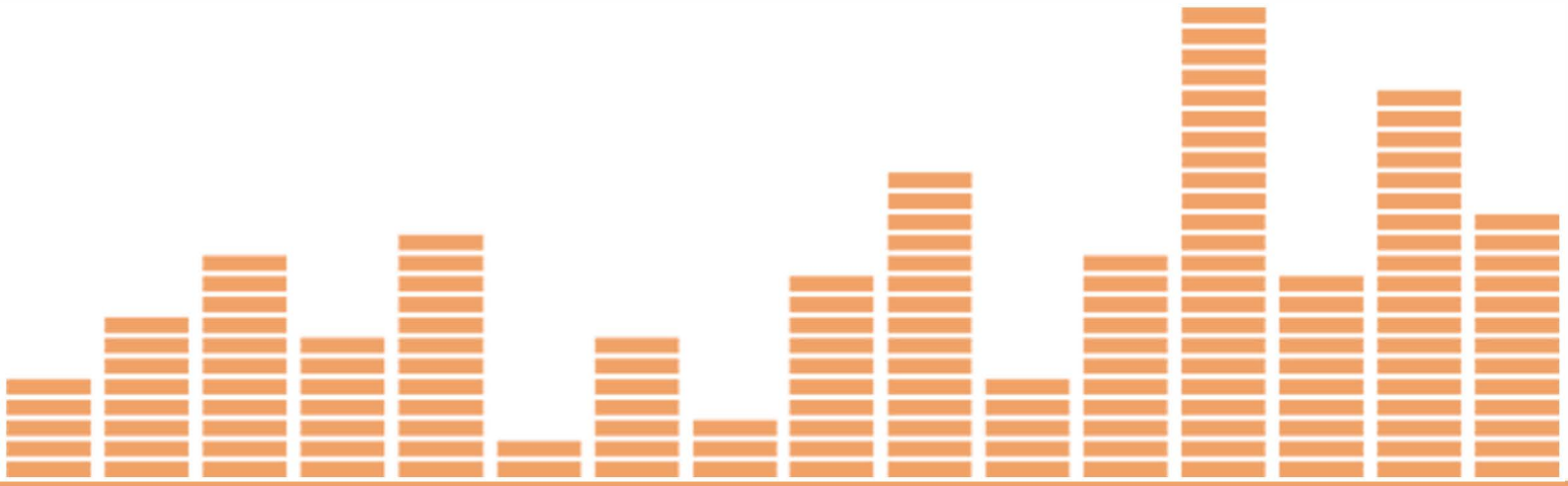

Velliv Foreningen

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Executive Summary:

- There is **a need for peer-reviewed scholarship** on the effectiveness of musicians' mental health interventions**.**

- An initial review of global mental health interventions for musicians was undertaken as part of this report from which **four models of practice were discernible**: telephone helplines; preventative models; therapeutic approaches, and peer support models. These are not mutually exclusive nor necessarily exhaustive.

- We have named examples of organisations throughout who are included as examples of best practice that draw on these models (wholly or in part).

- Of the four models explored below, and with reference to our survey findings on Danish music creators, we would suggest that **both therapeutic and peer support models offer the most favourable evidence base.** Resilience-based, preventative methods are potentially promising for musical performers at specific career stages and in certain demographics despite a lack of peer-reviewed evidence to date, and helplines based on need in a crisis are, on balance, likely to offer less utility in the Danish context given our survey data.

- Of all of the four models we have explored, a more holistic and/or multi-faceted approach is likely to yield the best results, which is indeed adopted by many of the organisations named.

- The best examples of musicians' mental health interventions **embed mechanisms in order to rigorously evaluate effectiveness** amongst service users across different modalities, time scales and musician demographics, and share these findings with stakeholders, with service offerings adapted accordingly.

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Introduction: The Musicians' Mental Health Landscape

The last decade has seen an explosion in mental health interventions targeted specifically at musicians. These kinds of initiatives have a longer history in the United States, for example Musicares (launched in 1989), The Sweet Relief Musicians Fund (1994), and The SIMS Foundation (1995). However, with increased academic interest in musicians' mental health mirrored by industry commitments to try and create positive change, the range of interventions focused on the health and wellbeing of musicians in other territories has broadened significantly.

These interventions have taken a number of forms, ranging from online materials and guides (e.g. Mind, UK), financial assistance to access clinical help (e.g. SMASH, USA; INSAART, France), to those focussed specifically on the challenges of the live music industry (e.g. Roadie Medic, UK). However, it is possible to observe *models of practice* evident within this landscape, with many of the providers highlighted below as examples of best practice. These models are not mutually exclusive. Many of the providers below offer more than one model in a more holistic, integrative approach. However, they represent helpful thematic categories for analysis in the absence of a pre-defined typography to draw upon. These models include:

(i) Telephone helplines (e.g. Support Act, Australia; Music Minds Matter, UK; MusicSupport, UK);
(ii) Mentorship, coaching, or approaches rooted in training derived from approaches in sport (e.g. Girl and Repertoire, UK; Mental Voice, Denmark);
(iii) Traditional forms of therapy and counselling (e.g. Music Industry Therapist Collective, UK; Music and Mind, UK), and;
(iv) Peer support (e.g. Backline, USA; Tonic Rider, UK).

The emergence of interventions within these four relatively broadly defined areas is enormously welcome and represents significant progress in seeking to help those who may be struggling in a professional field which, evidence now indicates, is highly stressful in complex ways. However, there has recently been increased interest in how, when, in what ways, and for whom, these kinds of interventions are understood to be *effective* for musicians[1]. In other words, how well do these interventions work, for whom, under what circumstances, and how can or should effectiveness be measured? In a context where the *Danish Partnership for Sustainable Development in Music* is seeking to develop new evidence-based initiatives and interventions aimed at supporting the health and wellbeing of music-creators in Denmark, knowing the answers to these questions is key. This is what this report seeks to address.

This report will synthesise the latest scholarly data on the effectiveness of these four models of intervention. Given the large scope of this enquiry, this report primarily draws on meta-analysis, and systematic/scoping reviews from these fields. It is important to note that this report is not a systematic review from which clinical recommendations are being made, nor is it a scoping review. The approach and ambition are more aligned to that of a rapid review i.e. a review conducted within a specific time period (in this case three months), and for a specific purpose (in this case to help inform the decision-making of the *Danish Partnership for Sustainable Development in Music* alongside the other strands of the 'When Music Speaks' project). It is therefore not possible to eliminate the possibility of bias in the

[1] Musgrave et al. (2023); Visser et al. (2022)

interpretations offered nor limitations in the search criteria adopted. Additionally, all information on service providers has been taken from information in the public domain e.g. the organisations' website, and we did not speak to or interview any service provider as this was beyond the scope of this report. Additionally, *this report is not a review or evaluation of any specific service provider or organisation (named or otherwise*); it is a synthesis of literature on *models* of mental health practice, where organisations are named *only* as *examples* of where these models are used (or drawn upon) within the music and mental health space. At the same time, it is the case that the peer-reviewed literature on musicians relating to these models specifically is only just emerging, with only a handful of global studies, so this tiny body of work will be supplemented by evidence from the wider population to understand the circumstances under which each model is likely to be most effective and when it might not. In doing so, we will seek to reveal the potential suitability of each style or model of intervention, which we will then later combine with interview data from music creators working in Denmark, to be outlined in a future report. We will then be able to make recommendations to the Partnership around how best to support the health and wellbeing of music creators in Denmark.

Part 1: The Helpline/Crisis Model

1.1. Introduction:

Telephone crisis helplines are an established and integral part of the mental health intervention landscape, with most countries having at least one such service[2]. In offering immediate and anonymous support, regardless of time or location, they help those who are in considerable distress but may not otherwise engage with in-person services[3]. In recent years, crisis support has expanded to incorporate new technologies such as SMS and email/online chat-based services, alongside apps and telephone services[4].

In the context of musicians' mental health, a number of prominent examples of organisations with helplines as part of their offer include:

- BackUp Tech (UK)
- MentalTalk (Mental Voice, Denmark)
- Minding Creative Minds (Ireland)
- Music Minds Matter (Help Musicians, UK)
- Music Support (UK)
- Support Act (Australia)

A number of dedicated crisis helpline services for musicians have been set up, but we found no peer-reviewed empirical work on their effectiveness. The public-facing sections of these services principally characterise their effectiveness in terms of both counsellor credentials/experience and availability/promptness. Music Minds Matter (UK), for example, state on their website that they are "available 24 hours a day, seven days a week" and manned by "trained support staff" and "qualified counsellors", while Music Support (UK) on their website highlight "trained industry peers who all have personal experience of the music and live events industries", while promising to return messages within 24 hours. Likewise, Support Act (Australia) state that they offer "professional counsellors who understand the challenges of working in music and the arts", accessible "24 hours a day, 365 days per year". While these factors are undoubtedly hugely significant with regard to *both* the effectiveness of services *and* their appeal to potential users, more systematic peer-reviewed work is needed to establish more directly how beneficial these services are to the target group. In the absence of any specific data of this kind, our discussion below is informed by data on mental health helplines from the wider population, acknowledging a degree of uncertainty over the extent to which these processes and relationships may map onto musicians specifically.

1.1.1. Context:

Telephone helplines as an approach to mental health intervention are broadly inspired by a *crisis* model pioneered by the charity Samaritans, founded in the United Kingdom in 1953. That is, they are often aimed at providing crisis interventions at moments of extreme emotional distress, (e.g. suicidal thoughts). It is important to acknowledge this for two reasons. The first is an empirical one; our initial survey findings for the *Danish Partnership for Sustainable Development in Music* indicate a relatively low level of severe anxiety or depression, or qualitative expressions of suicidality in open comments, amongst our sample

[2] World Health Organisation (2018)
[3] Trail et al. (2022)
[4] Krysinska & DeLeo (2007); Luxton et al. (2011)

of Danish music creators[5]. Whilst these characteristics are certainly higher in certain demographic categories (namely younger music creators and female music creators, for example), the overall incidence of severe mental ill-health was relatively low. The second reason is a more conceptual one which concerns how well we presently understand what constitutes a crisis for musicians as service users. That is, a feeling of helplessness and reaching a personal crisis point is not always equivalent to suicidal thoughts; if giving up a musical career feels like a crisis it might not equate with actual loss of life but a loss of a *primary identity*[6]. That said, it may still be experienced as a crisis for the individual i.e. something they may need to recover from.

Usage statistics clearly indicate that crisis services are in demand in the wider population; the Samaritans helpline in the UK has reported responding to over 10,000 calls per day[7], while Lifeline Australia has reported dealing with over 3,000 calls daily[8]. In 2020-21, over 50,000 people signed into the Samaritans self-help app, while over 11,500 used an online chat platform during its piloting stage[9]. This demand also appears to be rising; in 2014, the Helplines partnership reported that the UK mental health helpline MIND had experienced a call volume increase of 50% over the preceding few years, with an increase of 30% in suicide-related calls. Similar volume increases have been reported by crisis helplines in the US, Australia, and Finland[10]. Likewise for musicians, Music Minds Matter reported during that in the wake of the COVID-19 pandemic, calls to their helpline by musicians had increased by 39% from 2021 to 2023 (1,138 calls to 1,586 calls). Likewise, the number of mental health sessions facilitated from these calls increased from 2,688 to 5,507. Music Support foregrounds similarly impressive numbers of their website too, showing (at the time of publication), 1,076 helpline calls alongside appearing at 29 major UK festivals. Clearly these services are in-demand, and they appear to work as a point of asking for, or seeking out, help for the service user which, in itself, is always acknowledged as important in mental health treatment. Being able to speak to somebody at the end of the phone in a moment of exasperation or crisis might, in its relative simplicity, be of great value. How one evaluates the overall effectiveness of this types of provision is, however, more complex. Here, we examine the challenges facing such evaluation.

1.2. Helpline Effectiveness in the General Population

Challenges of Measurement

The first point that it is crucial to emphasise is that empirical research on crisis support is difficult due to the ethical and methodological constraints of testing participants accessing services anonymously and briefly while in considerable distress. Scholars have pointed out that many studies are unable to report the demographic details of their sample due to the anonymous nature of helpline usage; in other words, we often do not know *who* these helplines are helping[11]. Likewise, others underlined the fact that many deemed too at-risk are often excluded from research, making it difficult to draw conclusions regarding the efficacy of interventions for those most in need of them[12].

[5] Musgrave, Gross & Carney (2023)
[6] Gross & Musgrave (2020); Musgrave (2022); Oyserman & James (2011)
[7] Samaritans (2021)
[8] Lifeline (2021)
[9] Trail et al. (2022)
[10] Tyson et al. (2016)
[11] Mazzer et al. (2021)
[12] Trail et al. (2022)

Given this, work examining the effectiveness of such services in the general population has employed a variety of approaches to measure a range of outcomes. Most common has been the change in the mental/affective state of users during calls. This has been assessed by mechanisms such as silent monitors or standardised measures. Studies have reported decreases from beginning to end of calls in suicidality and related factors such as mental disturbance, hopelessness, psychological pain, and intent to die[13].

Likewise, user satisfaction surveys of helpline users have generally reported the majority of feedback to be positive[14]. These indices should, however, be treated with a measure of caution. Self-reported caller satisfaction does not necessarily index mental health *improvement* or lessening of suicidal state. Response rates in satisfaction studies also tend to be poor (40-80%)[15] because of the confidential nature of calls.

Other variables that have been measured in order to assess effectiveness include service reutilisation rates[16] and counsellor evaluation[17]. Studies have suggested effectiveness based on these criteria, although firm conclusions are, again, difficult. Re-engagement with a service, for instance, may not indicate satisfaction (indeed, it might suggest the *opposite*), while evaluations from counsellors themselves are overly subjective and frequently biased towards favourability[18].

Factors of Influence: Counsellor Characteristics

A key factor examined in the helpline/crisis model effectiveness literature is counsellor characteristics; in other words, who is on the other end of the phone, in what ways they are qualified, and their approach adopted toward intervention. Positive outcomes have been reported as more likely when counsellors/helpline staffers did not pass judgement on the callers' feelings, offer suggestions, nor direct the caller towards solutions[19]. This is sometimes called a Rogerian approach, or non-directive approach. Training has also been suggested to be important; one study found positive emotional outcomes more likely when callers spoke to counsellors who had received the ASIST (Applied Suicide Intervention Skills Training*)* programme, compared with when they spoke to those who had not[20]. ASIST-trained counsellors were more likely to be supportive and collaborative, with callers reporting becoming less depressed, less overwhelmed, less suicidal, and more hopeful during interactions. In more general terms, higher counsellor experience levels have also been found to relate to positive outcomes[21], such as a longer duration of call[22]. Helplines, in other words, need to be staffed by crisis-trained professionals who are prepared to be available for whatever length of time they are needed.

Limitations: Timescale and Demography

[13] Chiang (2011); Gould et al. (2007); King et al. (2003); Mishara & Daigle (1997); Shaw & Chiang (2019); Strohl (2005); Tyson et al. (2016)
[14] Gould et al. (2007); Lee (1999); Motto (1971); Slem & Cotler (1973)
[15] Hvidt et al. (2016)
[16] Apsler & Hoople (1976); Gould et al. (2007); Speer (1971)
[17] Apsler & Hoople, 1976; Gilat & Rosenau (2011)
[18] Hvigt et al. (2016)
[19] Mishara et al. (2007)
[20] Gould et al. (2013)
[21] Gould et al. (2016); Mishara et al. (2016)
[22] Ramchand et al. (2017)

The short-term benefits of using a crisis helpline have been seen to at least partially endure 2-3 weeks after initial contact, as indicated by follow-up assessment[23]. However, studies examining longer-term outcomes are comparatively rare, have used differing timescales, and are vulnerable to dropout rate, increasing the risk of bias[24]. Indeed, when thinking about helplines as methods of referral to treatment and their relationship to waiting lists, it is appropriate to reflect on the impact of waiting time. That is, is there an optimum time users could wait before the waiting itself becomes a source of stress in their lives? This is an area warranting further investigation.

Additionally, a number of studies have identified barriers to engagement with helpline/crisis services, thus lessening their overall reach and effectiveness. Males, for instance, are less likely than females to access services[25], while it has also been suggested that systemic barriers may also prevent youths from historically marginalised groups (e.g. lower socioeconomic and/or culturally/sexually diverse groups) accessing services[26]. Thus, demographic barriers to access may also represent a significant factor in determining the overall effectiveness of crisis line interventions.

The Role of New Technology

There is evidence that younger individuals are more likely to engage with options such as online chat/email/SMS, rather than traditional helplines[27] and that they are more likely to use these technologies to discuss weightier, severe issues[28]. Given the higher level of distress among younger respondents to our survey of Danish music creators this might be an area warranting further exploration. Empirical work examining the effectiveness of newer technologies is, unsurprisingly, rarer than that on telephone services, but has generally suggested effectiveness[29]. As with telephone services, the approach of counsellors seems key; service users' satisfaction and positive change during the contact were found to be related to counsellors' responsive approach (e.g. active listening[30]).

Direct comparisons of different modes of delivery (i.e. phone vs. online) have, however, offered mixed results. Both Fukkink and Hermanns (2009a; 2009b) in the Netherlands and Urbis Keys Young (2002) in Australia have reported online services to be more beneficial than phone services. On the other hand, King et al. (2006), found that telephone counselling had a greater impact on distress reduction than online counselling, as well as scoring significantly higher in terms of both session impact and therapeutic alliance. However, it is worth noting that this study is now over 15 years old and, given changes in uses of technology both during and post-COVID-19, likely requires further investigation. The discrepancy in findings may also be explained by the range of outcome/effectiveness measures employed by these studies. Fukkink and Hermanns used a questionnaire indexing wellbeing and perceived burden, while the other two studies employed standardised measures (Urbis Keys Young measured outcomes in their sample using the EQ-5D quality of life measure, while King and colleagues used the General Health Questionnaire). Nevertheless,

[23] Gould et al. (2007); Strohl (2005)
[24] Hoffberg et al. (2020)
[25] Backett-Milburn & Jackson (2012); Gould et al. (2006); Shaw & Chiang (2019)
[26] Goldbach et al. (2019); Mathieu et al. (2021); Teare et al. (1995)
[27] Haner & Pepler (2016); Mokkenstorm et al. (2017)
[28] Callahan & Inckle (2012); Fukkink & Hermanns (2009a); Haner & Pepler (2017)
[29] Gould et al. (2021); Haner & Pepler (2017); Sindahl & van Dolen (2020)
[30] Mokkenstorm et al. (2017; 2020); Sindahl et al. (2019)

although more work is clearly needed, the comparative effectiveness of online services - in some contexts - is suggested.

1.3 Conclusion

Investigations into the benefits offered by crisis intervention services have provided promising evidence of their effectiveness. Studies have also highlighted factors that may influence the effectiveness of services either directly (e.g. counsellor characteristics, modality), or indirectly (e.g. caller expectations and attitudes, demographic barriers to access). However, variations in the ways effectiveness has been measured - as well as the fact that many of these (e.g. in-call improvement, self-reported user/counsellor evaluation) may not give a sufficiently nuanced or unbiased picture - means that the generalisability and compatibility of findings are limited. Authors who have undertaken reviews of the empirical crisis intervention literature have noted that quality is generally low, risk of bias high, and consistency low[31], with no common definitions or standardised measures of either outcomes or expectations noted[32]. Outcome variables measured have included mood, distress, suicidality, service satisfaction, plans of action, and referrals[33]. This reflects the broad range of benefits offered by crisis services, but also makes it difficult to integrate findings from different studies in order to draw firm conclusions. Furthermore, only one randomised controlled trial has been conducted to date[34]. While this reflects the difficulty of setting up an experimental study with anonymous, one-off service users, as well as the ethical issues with care being deliberately inferior - or even withheld - for control participants, more research involving group comparison is necessary to gain a fuller understanding of services' relative benefits compared to either baseline care or alternative intervention approaches. This is particularly the case for musicians where no data in this respect could be found.

A good place to conclude is to look at an example of a service that has sought to evaluate impact in a systematic way to see if lessons can be learned for the music industries. Samaritans' evaluations of their crisis intervention service, in employing a variety of methods, have arguably offered the most robust and multi-faceted evidence of effectiveness to date. Published user assessments from 2006 and 2007 showed that 73.5% of suicidal callers felt that contact had helped them decide not to end their life. An independent mixed methods evaluation - which included observation of call centre activity, interviews with callers and volunteers, online caller survey, and textual analysis of emails and responses – showed users had high levels of satisfaction and perceived contact as helpful[35]. Qualitative interview data provided additional insight into help-seeking attitudes, reasons for contact, and expectations of the service. While not direct measures of effectiveness, these data, by offering several metrics with which to assess efficacy, are undoubtedly highly instructive, and may offer a model for existing musician helplines to evaluate their effectiveness in what is currently a hugely under-researched area. We suggest that peer-reviewed data of this kind is needed to evaluate the impact of these helplines in the lives of musicians.

[31] Hoffberg et al. (2020)
[32] Mazzer et al. (2021)
[33] ibid
[34] Gould et al. (2013)
[35] Coveney et al. (2012); Pollock et al. (2010); Stace & Wyllie (2011)

Synopsis of crisis/helpline model

- Helplines are in demand, and evidence shows that they are well used.
- Telephone helplines are generally aimed at those experiencing the most extreme forms of mental health crisis (such as suicidal feelings) and should therefore be understood as often responding to acute need or extreme distress. Our survey evidence on Danish music creators suggests this kind of need may potentially be relatively low amongst this population.
- It is hard to collect robust data on the effectiveness of crisis helplines. Indeed, little to no peer-reviewed data exists on the effectiveness of these services for *musicians* specifically. Evaluative work by providers such as Samaritans may offer models of best practice for future research.
- Appropriately trained, specialist service providers are often understood by users to help and can be a very effective first point of contact, offering a listening ear, help, and potentially advice to signpost the person to the next service provider. The lack of long-term peer-reviewed data on effectiveness suggests a telephone helpline is likely to be most effective as a first stop.
- New technologies may offer promising methods for younger or more disadvantaged groups to access this kind of service.
- The issue of *who* gets further help can present challenges. Certain groups are seen to use these services less than others; this is likely to significantly impact the reach, and thus potentially the effectiveness, of helpline services.
- The question of which service users get referred to the next tier of help – as well as how and why - is a sensitive area. Firstly, the service provider must be able to define who they will be helping e.g. who qualifies for help, and secondly how much and what help is offered. Help via this model is inevitably subject to criteria such as time limits based on budgetary restraints, and is also dependent on the experience, qualifications and training of staff.

Part 2: The Preventative Model: Resilience Building and Beyond

2.1. Introduction

The idea that prevention is better than cure has long been prevalent in both the scientific and medical worlds - for example, the UK's National Health Service recent emphasis on preventative measures[36] - and is a key facet of many religious belief systems (notably Protestant traditions) whereby preventing transgressions is understood as better than atoning for them. The experience of musical ambition and career building is closely connected to these ideas of sins and sinners; of passions and desires[37] that need to be 'kept in check' and disciplined. In line with these broader concepts, recent years have seen the launch of a range of musician-focused mental health and wellbeing interventions that adopt a preventative approach. Each of the examples below are distinct, but have been conceptually grouped together as they all share the aim of prevention through practices such as mentorship, coaching or training (alongside their other service offerings), e.g.:

- Counselling for Musicians [training offering] (UK)
- CURA/GAM [training offering] (France)
- Girl and Repertoire [Mentorship offering] (UK)
- MentalVoice [coaching offering] (Denmark)
- The Centre for Mental Health in the Music Industry [training offering] (UK)
- The Continuance Foundation [training offering] (USA)

Resilience as a Concept

A concept which links many (but not all) of these approaches is that of 'resilience'. Psychological resilience, and its relationship to well-being and everyday psychosocial functioning, has received increased theoretical and empirical attention in recent years[38]. The American Psychological Association defines the concept as "the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress"[39], while a recent review described it as "an effective adaptation to, or a navigation (or management) of, significant sources of traumatic stress or adversity and the capacity to absorb disturbance to harness resources effectively"[40]. Others have suggested that the concept is best understood in less individualised terms; a "dynamic process"[41] or psychological state that emerges over time as a result of the interaction between personal factors and environmental resources such as psychological climate and level of social support[42].

The recent increase in interest in the concept has been observed with regard to a range of populations, notably professional fields where optimal performance is paramount and/or the risk of stress or trauma is elevated e.g. education[43], critical care[44], military[45], disaster relief

[36] Iacobucci (2014)
[37] Dobrow (2015); Dobrow Riza and Heller (2015)
[38] Bicalho et al. (2020)
[39] Palmiter et al. (2012)
[40] Denckla et al. (2020)
[41] Luthar et al. (2000: 543)
[42] Bryan et al. (2019); Fletcher & Sarkar (2013)
[43] Hartley (2011)
[44] Arrogante & Aparicio-Zaldivar (2017)
[45] Crane et al. (2019)

workers[46] and police[47]. It has been suggested that resilience programmes are viable in a range of settings[48].

Authors have also stressed the importance of helping musicians develop psychological resilience[49]. Despite this, there is very little work on resilience, or the effectiveness of resilience training, in this group. The one available study is by Kegelaers, Schuijer, and Oudejans (2021) who conducted a preliminary study involving classical musicians only, and which did not involve either a control group or the assessment of a specific intervention. Despite these limitations, preliminary evidence was offered of a negative relationship between measured resilience and symptoms of depression and anxiety in this group (i.e. as resilience *increased*, symptoms of depression and anxiety *decreased*). However, as per all forms of musicians' mental health intervention, there is very limited (and often no) evidence to draw upon when reaching conclusions. Put simply, we have no evidence to ascertain how effective practices of resilience building via coaching or other methods are for working musicians and how they impact mental health and wellbeing. Given this lack of evidence we must draw our insights from elsewhere.

2.2. Parallels between musicians and sportspeople

Perhaps the most prominent area where research into resilience *has* been conducted is elite sport[50]. Elite sportspeople are exposed to an environment which shares many parallels with specific kinds of music-creators in that it is highly evaluative[51], involving both active engagement with failure and adversity[52] and a specific combination of stressors[53] such as selection and funding issues, injury, the need to maintain standards, media evaluation[54], differing body-image conceptualisation[55], and high-impact consequences of success or failure[56]. Elite student athletes face these challenges in addition to academic demands, with studies suggesting this group are at elevated risk of depression[57], stress, substance use disorders[58], and subclinical eating disorders[59].

The overlap between the demands faced by professional/elite sportspeople and specific kinds of musicians is therefore, from one perspective, considerable. This is not only in terms of stressors themselves - e.g. pressure, comparison, long practice hours, personal sacrifice, performance anxiety, injury - but also the fact that each combination of stressors may arguably be considered professionally 'unique'. In addition, *both* elite athletes[60] *and* musicians[61] have been suggested to be at elevated risk of developing mental health problems.

However, there are differences between the two groups which it is crucial to acknowledge when evaluating the evidence-base. Firstly, the elite sport model is *performance based* and

[46] Kendra & Wachtendorf (2003)
[47] Paton et al. (2007); van der Meulen et al. (2018)
[48] Vanhove et al. (2015)
[49] Araújo et al. (2017); Osborne et al. (2014); Wiggins (2011)
[50] Fletcher & Sarkar (2012); Galli & Vealey (2008)
[51] Papathomas & Lavallee (2012)
[52] Gupta & McCarthy (2022)
[53] Pritchard & Wilson (2005)
[54] Sarkar & Fletcher (2014)
[55] Hausenblas & Downs (2001)
[56] Papathomas & Lavallee (2012)
[57] Cox et al. (2017); Proctor & Boan-Lenzo (2010); Weigand et al. (2013); Wolanin et al. (2015); Yang et al. (2007)
[58] Barry et al. (2015); Mastroleo et al. (2013)
[59] Bratland-Sanda & Sundgot-Borgen (2013); McLester et al. (2014)
[60] Cox et al. (2017); Proctor et al. (2010); Weigand et al. (2013); Wolanin et al. (2015); Yang et al. (2007)
[61] Kenny et al. (2014); Vaag et al. (2016); van Fenema & van Geel (2014)

often corporeal (of the body). This may not apply to all music-makers e.g. songwriters and producers may not be performers. Secondly, top-level sport exists within a matrix of competition and judgement to a much greater extent than art, which is not as stringently defined by these parameters. In other words, sports have *rules* which must be abided by and judgements vis-à-vis who is the 'best' are defined in this context and based on these rules; art and expression may involve the mobilisation of rules, but are not *evaluated* against these rules. Thirdly, there is a difference between being the best in your field in the sporting arena, which is temporal and of the present moment, and releasing music where the music is released (on Spotify for example) against the entirety of recorded history. Finally, it is worth reflecting on the suitability of conceptualising creative expression as competition. There are many ways in which practising music is good for you, however, the competitive elements of musical career building have been found to be psychologically damaging[62]. This is not to deny that many elements of professional musical life do involve being subjected to hyper competitive environments, but the way musicians are evaluated is much more ambiguous than sporting rules. We recommend, therefore, that caution be exercised regarding how and when this analogy is applied, and the extent to which it is beneficial to musicians' health and wellbeing not assumed. That being said, we have conducted an analysis of the effectiveness of resilience techniques in sport to see what might be learned and applied in the case of the mental health and wellbeing of musicians, particularly those at specific career stages, whose experiences might map more closely onto those of sportspersons.

2.3. Resilience in sportspersons as a model for musicians?

Research has suggested that the development of resilience is important to the achievement of sporting success[63]. Key to this relationship are adaptive and coping skills such as responding to stressors with positive affect, maintaining an optimistic future outlook, and controlling stress responses[64], qualities that result in the ability to deal effectively with specific stressors (e.g. injury rehabilitation), or even turn them into opportunities for growth[65]. More generally, a positive relationship between resilience in athletes and wellbeing has been shown[66]. An international consensus statement in 2019[67] suggested that the implementation of sport-specific resilience training methods is essential to fostering mental health in sports. In this respect, the approach has been seen to be favourable towards professionals with the kinds of demands placed on them as per athletes, which is arguably the case for certain musicians, particularly those working in the world of pop or at a very high level of professional status.

One early formal resilience training programme for athletes used cognitive-behavioural theory to help Olympic athletes learn "general optimism" and de-catastrophising skills by challenging core assumptions, as well as automatic thoughts surrounding poor performance[68]. The specific goal of this strategy, however, was the improvement or maintenance of athletic *performance,* rather than developing resilience in general, with the evaluation placing an emphasis on performance-based outcomes as opposed to wellbeing outcomes. This is crucial to note as the focus of our analysis here is specifically concerned with improving health and wellbeing. Rothlin et al. (2016) have argued that measures of athletic performance may be too "distant" when attempting to directly assess the efficacy of mindfulness or psychological

[62] Gross & Musgrave (2020)
[63] Fletcher & Sarkar (2012); Gould et al. (2002); Holt & Dunn (2004); Remes et al. (2016)
[64] Fletcher & Sarkar (2012); Galli & Vealey (2008); Tugade & Fredrickson (2007)
[65] Codonhato et al. (2018); Tamminen et al. (2013); Zurita-Ortega et al. (2018)
[66] Nezhad & Besharat (2010)
[67] Breslin et al. (2019)
[68] Schinke & Jerome (2002); Schinke et al. (2004)

skills training, as they are too susceptible to other factors such as physical conditioning, identity of opponent, or even weather.

Challenges of Measurement

More recent work on the efficacy of resilience interventions for athletes has assessed the construct in a more multi-faceted way, indicating that benefits may be nuanced and differ according to contextual factors, something which by extension is likely to be true for musicians too. Kegelaers et al. (2021) employed mixed methods to examine a programme for female basketball players involving planned disruption training - designed to foster coping skills under pressure - coupled with an introductory resilience workshop and guided self-reflection. While semi-structured interviews indicated that the programme was effective in helping athletes develop qualities associated with resilience such as increased awareness, stronger communication, and leadership, standardised measures of individual and team resilience given pre- and post-test only demonstrated improvement at the *collective* level. This is interesting given findings which point out that resilience in athletes can also manifest at the collective, or team, level[69]. In the context of music careers, team relationships and networks are crucial[70], but can be very fragile. For example, if a band splits up or a musician gets 'dropped' by a record label this can be perceived as career ending. This is unlike team sports specifically where the team is always bigger than an individual player.

These findings also suggest that the 'effectiveness' of a resilience intervention in this context may be contingent on the measures used to assess it. The need for a sport-specific standardised resilience measure, something stressed by a number of authors[71], is further underlined. Indeed, we might reasonably conclude here that if this is the case, then a *musician* specific measure might be required too, further complicating how we understand the effectiveness of interventions like these. The use of a multi-faceted approach to measure outcomes, whereby effectiveness is measured both quantitatively and qualitatively, and component adaptive coping skills and wellbeing are prioritised over outward performance-related indices, is needed to better understand interventions of this kind.

In 'at-risk' groups

Resilience as a concept is well studied amongst groups which might be defined as 'at risk' or vulnerable e.g. the elderly[72], adolescents[73], and migrants[74]. In this context, Chandler et al. (2019) assessed the efficacy of a five-week, strengths-based resilience programme aimed at diverse, at-risk college athletes using a raft of quantitative measures as well as qualitative analysis of participants' reflective writings. Data from both spheres indicated that the programme was effective in a number of ways. Participants who had received the intervention showed improved decision-making, lowered perceived stress, and increased resilience compared with a control group, while the qualitative data indicated that athletes had improved at managing their emotions, making connections, and requesting support. Interestingly, participants with adverse childhood experiences who had taken part in the programme showed greater improvement in emotional self-awareness compared with those without, suggesting that some programmes may also be of particular benefit to athletes who

[69] Fletcher & Sarkar (2013)
[70] Musgrave (2023)
[71] Galli & Gonzalez (2015); Gucciardi et al. (2011); Sarkar & Fletcher (2013)
[72] Lamond et al. (2008)
[73] Xiao-Nan et al. (2011)
[74] Aroian & Norris (2000)

have suffered more general adversity. This may be of interest when considering the extent to which we think of musicians as a population as being at-risk or vulnerable (given the elevated levels of mental ill-health amongst population). On a more granular level, it may be that these kinds of approaches might be best directed toward the most vulnerable or minoritised groups *within* the population of musicians.

Length of intervention

Length of intervention may also be a significant factor with regard to the efficacy of resilience programmes. Studies examining the effectiveness of one-off interventions have suggested that they rarely result in an increase in knowledge or behavioural change[75]. Sullivan et al. (2023), however, using a range of outcome measures, suggested that shorter programmes might still bring benefits. They examined the Scarlet & Grit, an annual one-off programme for elite college athletes using key sport psychology/resilience principles such as mind-set, grit, radical acceptance, and self-compassion. The authors found that although the programme did not lead to an increase in athletes' knowledge of these strategies, intention to use coping strategies increased from pre- to post-intervention. This indicates that while one-off programmes may have limited efficacy in terms of key/knowledge outcomes, they may benefit athletes in other ways related to the development of resilience, and thus may still be worth implementing in certain contexts when a longer programme is unachievable. However, again, here the mental health and wellbeing improvements were not foregrounded. A key limitation of this study, therefore, was that the authors were not able to take post-intervention measures of resilience and wellbeing. More research is thus needed on the factors that may influence the effectiveness of shorter interventions, and how they may benefit athletes and, by extension, musicians.

2.4. Conclusion

Studies directly examining resilience interventions for athletes have assessed or measured effectiveness in different ways. Overall, there is promising evidence that they benefit athletes on a number of levels, not only directly improving measured resilience but also enhancing related qualities such as leadership, self-awareness, support seeking, and communication. Effectiveness should be assessed in as many ways as possible, to give the fullest and most varied picture achievable. Ideally, standardised measures of resilience and resilience-adjacent/component qualities should be administered alongside qualitative approaches - e.g. self-reflection, semi-structured interviews – that give insight into how the programme was received and experienced, although it should be acknowledged that this approach can sometimes result in inconsistent findings regarding the nature and level of effectiveness[76]. Informal feedback from participants, coaching staff, or parents, while undoubtedly instructive, is arguably best viewed as an index of an intervention's appropriateness, rather than a neutral measure of its effectiveness. Likewise, athletic performance alone may be too susceptible to the influence of other factors[77]. Future work on the effectiveness of resilience interventions should attempt to more extensively examine the influence of potentially mediating or moderating demographic (e.g. gender, personality, educational status) and environmental (e.g. sport, competitive level) variables.

[75] Eaton et al. (2012)
[76] Kegelaers et al. (2021)
[77] Rothlin et al. (2016)

More generally, authors have emphasised the need for a holistic approach in the context of interventions such as these. Sarkar (2017) recommends that resilience in athletes should be approached in a multi-faceted and supported way, with the delivery of adaptive coping skills training bolstered by as many formal and informal psychosocial training methods and developmental experiences as possible, from personal mentoring with successful predecessors to expert coaching and access to counselling during difficult periods. Also arguing for a well-rounded approach to resilience training are Fletcher and Sarkar (2016), who suggest any intervention should involve three core aspects: a challenge mind-set, resilient qualities, and a facilitative environment, with the latter enabled by striking a balance between pressure and support. This is important, as too much pressure could lead to an unhealthy environment characterised by negative factors such as blame, conflict, and unhealthy competition[78]. Evidence has been offered, for example, that the aim of "performance enhancement" in an intensive coaching environment can lead to abusive practices[79].

With respect to musicians, this insight is key, and we think this emphasis on holistic approaches makes a great deal of sense. That is, any one of the models being explored here are likely to be insufficient on their own (hence many of the service providers offering them in tandem with other services), and in the context of resilience/training/coaching specifically, it is likely to be applicable only to certain musicians, and where utilised needs to be combined with other elements from the models of intervention explored here, such as (for example) short form education courses, forms of therapy (either online or face-to-face) and subsequent support from, for example, peer-to-peer groups or mentors. Evidence suggests that, for musicians, a challenge mind-set may be encouraged by the teaching of basic cognitive-behavioural or acceptance techniques[80], while psychological skills (e.g. goal-setting, relaxation techniques) can help musicians navigate career challenges[81], deal with performance anxiety[82], and improve practice efficiency[83]. A facilitative environment can be provided by music institutions and organisations working to increase mental health literacy, reduce stigma, and encourage help seeking[84].

Finally, it is worth reflecting on whether, in the context of musicians' mental health, we want musicians to be more r*esilient* and therefore ameliorable to the existing conditions of their work, or more *resistant* and seeking to *change* the conditions of their work (see Neocleous, 2013 for more on this). In practice, both of these are likely to be true.

[78] Kegelaers et al. (2021)
[79] Stirling & Kerr (2014)
[80] Juncos & Paiva e Pona (2018); Osborne et al. (2014)
[81] MacNamara et al. (2008)
[82] Clark & Williamon (2011); Hatfield (2016)
[83] Bakker et al. (2016); Clark & Williamon (2011)
[84] Wiggins (2011)

Synopsis of the preventative model

- When drawing on models informed by resilience and/or informed by models from elite sport, one needs to be sensitive of the salient differences between musicians and sportspersons.

- Studies on resilience training amongst athletes have provided evidence that it can lead to improvements in wellbeing, with cognitive behavioural techniques offering good models. These might, in certain circumstances, be applied to specific groups of musicians, working in specific ways, at specific career stages.

- Existing peer-reviewed evidence on the effectiveness of these approaches among musicians is scarce.

- Any intervention of this kind must be suitably targeted e.g. may be of greatest benefit amongst at-risk groups, or musicians in very specific genres/career stages with particular ambitions, and must be sustained (and therefore invested in) over a long time period.

- This model, as per others, is likely to be most effective when understood as a holistic package of complementary interventions.

Part 3: The Therapeutic Model

3.1. Introduction:

Anxiety disorders are the most common class of mental disorder globally[85] and the second most frequently encountered mental health problem in primary care settings[86]. Lifetime prevalence has been estimated to be as high as 28.3%[87] with women twice as frequently affected as men[88]. As well as underpinning physiological problems such as disturbed sleep, headaches, gastrointestinal/cardiovascular problems[89], anxiety disorders have been shown to impact sufferers' quality of life and psychosocial functioning[90] – a finding mirrored in work on musicians who suffer from anxiety too. Anxiety has been seen to leave sufferers at higher risk of, for example, academic underachievement, early parenthood, depression, substance abuse, and suicidal behaviours[91]. Indeed, some of these features e.g. substance abuse and suicidal behaviours, are observable within certain musical genres and scenes too[92].

Findings from our survey of music creators in Denmark which utilised the Hospital Anxiety and Depression Scale suggested that anxiety was by far the most prevalent issue facing music makers[93]. 45.8% of our respondents received scores indicating abnormal levels of anxiety. Age was a significant variable; 68.7% of survey respondents under the age of 40 had scores indicating abnormal levels of anxiety (25.8% mild, 31.8% moderate, 11% severe) compared to 33.9% of over 40s scoring abnormal levels of anxiety (15.6% mild, 14.9% moderate, and 3.4% severe). Additionally, anxiety was seen to be most acute in the age band 25-29 years. For those in this age band, 78.2% received scores indicating abnormal levels of anxiety, with 15.5% of 25-29 year olds scoring for severe anxiety. The variable of gender was also significant; 65.4% of female respondents had scores indicating abnormal levels of anxiety compared to 39.1% for men (females: 24.3% mild, 27.6% moderate, 13.6% severe | males: 17.5% mild, 18.1% moderate, 3.5% severe). In this context, the high levels of anxiety amongst music creators in Denmark reflects broader statistics around anxiety in the general population in Denmark where women and younger people are seen to be more at risk, albeit suggesting potentially elevated levels amongst musicians.

In response to findings such as these, a range of therapeutic interventions targeted at musicians have emerged in recent years. A number of prominent examples which either directly offer - or facilitate access to - therapy, include (but are not limited to):

- British Association of Performing Arts Medicine (BAPAM) (UK)
- INSAART (France)
- Mental Health Alliance (USA)
- Music Industry Therapist Collective (UK)
- SIMS Foundation (USA)
- Wellbeing in the Arts (UK)

[85] Kessler et al. (2007)
[86] Ansseau et al. (2004); Kroenke et al. (2007)
[87] Baxter et al. (2013)
[88] Grenier et al. (2019); Gustavson et al. (2018)
[89] Nabi et al. (2010); Pelletier et al. (2017)
[90] Comer et al. (2011); Hendriks et al. (2016); Kessler et al. (2005); Olatunji et al. (2007); Priest (2012); Sareen et al. (2006)
[91] Woodward and Ferguson (2001)
[92] Kenny (2016); Stack (2009)
[93] Musgrave, Gross & Carney (2023)

It is of course not possible to evaluate every form of therapeutic intervention available to musicians - and the wider population - in a report of this length. We have thus focused our analysis on the most widely researched and tested psychological therapeutic approach[94]: Cognitive Behavioural Therapy.

3.2. Cognitive Behavioural Therapy (CBT)

CBT aims to identify damaging beliefs and behaviours and replace them with more positive thought processes and adaptive behaviours in order to foster the development of coping mechanisms, with the therapist acting like a coach throughout[95]. Although initially developed as a treatment for depression[96], it has also been shown to be effective for anxiety disorders[97]. It is now considered the benchmark intervention for anxiety and, accordingly, is the most commonly used evidence-based treatment[98]. CBT for anxiety focuses on changing maladaptive beliefs about the likelihood and true cost of anticipated harms by combining cognitive (e.g. restructuring) and behavioural (e.g. exposure) techniques[99].

There is no empirical work looking specifically at the effectiveness of CBT for musicians, although Visser et al. (2022), in their scoping review of work on musicians' engagement with and attitudes regarding therapeutic interventions, report a case study of a working rock musician who endorsed cognitive behavioural and "self-psychology" techniques[100]. In addition, counselling has been seen to be an approach endorsed by musicians[101]. Despite the lack of detailed evidence for particular approaches, potential insight into how such approaches may work with this group is offered by the wider literature, which we draw on below.

Measuring Effectiveness

Studies examining the effectiveness of CBT on anxiety have generally used standardised measures – normally a self-report instrument or validated clinical interview - to assess anxiety symptom severity pre- and post-intervention. Meta-analytic reviews have reported CBT to lead to symptom improvement in individuals with Post Traumatic Stress Disorder[102], General Anxiety Disorder[103], Seasonal Affective Disorder[104], Obsessive Compulsive Disorder[105], and Panic Disorder[106], as well as anxiety disorders generally[107]. It is likely, however, that methodological issues have at least partially contributed to studies' reported CBT effectiveness levels. Many have used 'passive' control groups, most commonly those comprising treatment-as-usual (TAU) or waitlist (WL) individuals. TAU samples tend to be heterogeneous and not structurally equivalent to corresponding experimental samples, while using a WL group does not control for potentially confounding variables such as patient expectation. Studies involving these control groups may thus inflate the observed relative

[94] Cuijpers et al. (2016)
[95] Cuncic (2023)
[96] Beck et al. (1979)
[97] Barlow et al. (2007); DeRubeis & Crits-Christoph (1998)
[98] Hofmann & Smits (2008); Kaczkurkin & Foa (2015); van Dis et al. (2020)
[99] Hofmann (2008); Smits et al. (2012)
[100] Raeburn (1997)
[101] Berg et al. (2018)
[102] Bisson et al. (2013)
[103] Cuijpers et al. (2014)
[104] Mayo-Wilson et al. (2014)
[105] Öst et al. (2015)
[106] Pompoli et al. (2016)
[107] Bandelow et al. (2015); Cuijpers et al. (2016); Olatunji et al. (2010); Otte (2011); Watts et al. (2015)

efficacy of any treatment. Meta-analyses of studies using the more systematic approach of pill or psychological placebo control groups have, indeed, generally observed smaller effects[108], but still found CBT to be significantly more effective in comparison to these controls[109].

Long Term vs Short Term

In terms of long-term CBT outcomes, meta-analyses have generally indicated medium symptom reduction up to two years after treatment[110], although some of these involved studies examining the effects of time only (i.e. pre vs. post vs. follow-up) with no control condition[111], making it difficult to separate the effects of long-term treatment outcome from those associated with other factors. Furthermore, not all findings regarding long-term CBT benefits have reached statistical significance; the effects of CBT for anxiety-related disorders reported by Bhattacharya et al. (2023) at six-month follow-up were small, but insignificant.

Accessibility

A positive element of CBT is that it is understood as being relatively accessible. However, part of the reason for this stems from the fact that CBT practitioner training is often relatively short and cheap. This in turn, though, means that CBT can be delivered in a variety of ways, and this is often part of the reason it is seen to be cost effective and delivering a service that responds to need. CBT can involve individual or group sessions, and can be administered either face-to-face or online. There are also apps that provide CBT methods directly to the user in the form of self-training methods. Findings regarding the relative efficacy of group vs. individual CBT are contradictory; while group CBT has been associated with smaller effects in some contexts e.g. military veterans[112], Bhattacharya et al. (2023) reported no significant difference, in the studies in their meta-analysis, between the effectiveness of group vs. individual CBT. Meta-analyses comparing CBT delivered remotely and online – e.g. messaging feedback from psychologists, chat forums, and/or guided modules - with the more traditional face-to-face approach have suggested no difference in effectiveness[113], indicating that the approach may be adaptable in this sense. This is an important consideration where services and/or resources may be stretched. The ability to access CBT remotely may also be helpful for touring musicians and/or those with hectic schedules. Lastly, musicians as a group are typically highly financially precarious with low (or at best, unstable) earnings; CBT's cost effectiveness may represent another strength in this context.

Finally, despite the evidence broadly suggesting its efficacy in certain contexts, CBT can by no means be considered universally effective as an anxiety intervention. It has been indicated that only around 60% of patients overall may respond to CBT/anti-depressant-based programmes, with many continuing to suffer from residual symptoms after acute treatment has ended[114]. In this sense, while CBT may well prove effective for certain musicians with certain needs and wants, it may be that other musicians may benefit more from other approaches either explored in this report or beyond. Having the right service, for the right musician, is therefore key.

[108] Bhattacharya et al. (2023); Carpenter et al. (2018)
[109] ibid; Hofmann & Smits (2008)
[110] Bandelow et al. (2018); Carpenter et al. (2018); Montero-Marin et al. (2017); Springer et al. (2018)
[111] Bandelow et al. (2018); Springer et al. (2018)
[112] Haagen et al. (2015); Straud et al. (2019)
[113] Ahern et al. (2018); Andrews et al. (2018); Carlbring et al. (2018); Chow et al. (2022)
[114] Bystritsky (2006); Springer et al. (2018)

3.3. Mindfulness-Based Interventions

Mindfulness-based interventions (MBIs) are approaches which derive from Buddhist tradition and, broadly, focus on helping participants pay 'non-judgmental attention' to the present moment in order to disengage from dysfunctional cognitive routines[115]. MBIs, of which the most common are mindfulness-based cognitive therapy (MBCT) and mindfulness-based stress reduction (MBSR), are increasingly seen as effective treatments for a range of psychological disorders[116], with the Canadian Network for Mood and Anxiety Treatments already recommending MBCT as a first-line psychological treatment for relapse prevention and as a second-line acute treatment for depression[117].

Other authors have highlighted the potential of MBIs to be more cost-effective than more traditional therapeutic approaches such as CBT, as they may require practitioners to undergo less professional training and take less time to deliver[118]. On the other hand, the low barriers to entry into this arena can undermine the credibility of interventions.

Reviews and meta-analyses of the effects of MBIs on anxiety have broadly indicated effectiveness, with MBIs showing the largest effect size for anxiety symptoms when compared to other mental health problems[119], as well as comparable efficacy to other established treatments[120]. Where MBIs have been examined directly against CBT, they have generally been found to be comparable in effectiveness. A meta-review of the effect of MBIs on anxiety found both moderate overall efficacy in comparison to passive control groups (e.g. TAU), and equivalence to other therapeutic approaches[121]. This latter finding was observable when comparison groups included a CBT intervention[122]. Haller et al. (2021) reviewed 23 studies and found that while MBIs were broadly similar in effectiveness to CBT for both primary (i.e. validated clinician- and patient-rated symptom scales delivered directly – or soon after intervention) and secondary (i.e. 6- to 12-month symptom follow-up, depressive symptoms, quality of life) outcomes, this was partially mediated by the *type* of MBI. Acceptance and Commitment Therapy (ACT) and MBCT were found to be comparable in benefit to CBT, with MBSR showing significantly lower effects. No difference between any of these MBIs, TAU controls, and CBT was observed with regard to 6- and 12-month follow-up measures. Results for studies incorporating secondary measures of depression and quality of life showed similar patterns. Singh and Gorey (2018) also reported no difference between the effectiveness of MBIs and CBT on anxiety symptoms. Li et al. (2021), in their review, however, reported that MBIs were *superior* to CBT for anxiety symptoms.

This broad equivalence between MBIs and CBTs, while encouraging, comes with caveats. Firstly, studies comparing MBIs with CBT in Haller and colleagues' review[123] are low in number; these authors thus stress the need for caution when interpreting findings. Secondly, anxiety symptom *type* may be a factor in the observed level of effectiveness of MBIs. Abreu-Costa et al. (2019) found that while they were as effective as cognitive-behavioural interventions (CBIs) in treating internalizing and distress symptoms, CBIs were more

[115] Kabat-Zinn (2003); Snyder & Lopez (2011)
[116] Gotink et al. (2015); Mayo-Wilson et al. (2014); Perestelo-Perez et al. (2017); Tacón et al. (2003); Vollestad et al. (2012)
[117] Parikh et al. (2016)
[118] Chiesa & Serretti (2010); Hofmann & DiBartolo (2014); Knight et al. (2015); Moore et al. (2012); Singh & Gorey (2018)
[119] Khoury et al. (2013)
[120] Goyal et al. (2014)
[121] Fumero et al. (2020)
[122] Goldberg et al. (2018); Hodann-Caudevilla & Serrano-Pintado (2016); Strauss et al. (2014)
[123] Goldin et al. (2016); Herbert et al. (2018); Kocovski et al. (2013); Koszycki et al. (2021); Piet et al. (2010); Stefan et al. (2019)

effective at reducing fear symptoms such as phobias. Related to this is the suggestion that MBIs, while effective for those suffering anxiety *symptoms*, may be not as effective for those with a clinical anxiety *diagnosis*[124]. This is important in the context of our survey, given that we observed a relatively large discrepancy between the small number of respondents who stated that they had received a mental health diagnosis for anxiety, and the number of respondents suffering from 'severe' anxiety as measured using the HADS-A scale. This suggests there may be some (although it is hard to be precise about how many) who are not only anxious but also unknowingly suffering from clinical anxiety, for whom CBT may be more effective than MBIs. Indeed, the superiority of MBI over CBT for anxiety symptoms reported by Li et al. (2021) disappeared when only studies involving diagnosed individuals were analysed. This may indicate that components involved in CBT but not MBIs, such as exposure/habituation, may be more effective in addressing more extreme/fear symptoms of anxiety, with elements or principles shared by the two approaches (e.g. those involving cognitive restructuring or changing thought processes) more effective for internalizing and distress. The fact that studies have tended to use clinical groups incorporating individuals with a range of anxiety disorders means that not enough data is available for different disorders in order to fully explore this question.

A number of methodological issues also make it difficult to draw firm conclusions regarding the effectiveness of MBIs. As with CBT studies, their effectiveness has generally been assessed using standardised, validated self-report or clinical interview measures of symptom severity taken at both pre- and post-intervention. Fumero et al. (2020) point out that other changes brought about by mindfulness interventions, such as the use of acceptance, self-awareness, and more general wellbeing, should also be measured. Assessing these, in addition to secondary, or indirect, outcome measures such as attrition, treatment adherence, and relapse prevention, would help to give a more nuanced understanding of the effectiveness of MBIs. Secondly, these authors also highlight inconsistencies across studies in terms of both sampling – clinical vs. non-clinical, diagnosis, stage (e.g. acute vs. recurrent), age – and intervention. That is, a range of MBIs have been used, and these have varied with regard to factors such as content, overall length of intervention and session length, making it difficult to integrate findings. Third, little attention has been paid to factors other than those relating to the interventions themselves; these may also influence effectiveness. Therapist type and training have, unsurprisingly, been shown to play a role[125], but more work is needed to examine how the influence of both these, and other potentially significant variables, may intersect with the effects of exposure to the interventions themselves.

3.4. Conclusion

Authors have highlighted that accessibility, affordability, and the perceived suitability of interventions may all be potential barriers to musicians adopting particular interventions[126]. In these respects, and given the evidence regarding their effectiveness, it seems reasonable to infer that both CBT and MBI approaches can be successful in treating anxiety in musicians. It is important to note, however, that it has not been possible in a report of this kind to conduct a review of all kinds of talking-based, therapeutic interventions e.g. psychodynamic therapy, psychotherapy etc. While the status and frequency of use of both CBT and MBIs have led us to focus on these approaches here, we cannot discount the possibility of other therapeutic approaches also proving highly beneficial to the musician population. Finally, models such as

[124] Hofmann et al. (2010); Strauss et al. (2014)
[125] Carsley et al. (2018); Kreplin et al. (2018)
[126] Berg et al. (2018); Gross & Musgrave (2017)

CBT or Mindfulness must, as per our comments above on resilience training, be balanced against the need for wider structural reforms. That is, the psychosocial challenges of musicians' working lives must be confronted *as well as their ability to cope with or manage them*. Therapeutic approaches might therefore represent one part of this overall picture.

Synopsis of the therapeutic model

- Cognitive Behavioural Therapy (CBT) is widely regarded as the benchmark intervention for anxiety and is the most commonly used evidence-based treatment. Given the high levels of anxiety amongst our survey of Danish music-makers, an approach incorporating this method appears to be desirable.

- As with all intervention models, evaluation of the effectiveness of therapeutic approaches is challenging. While evidence among musicians suggests they are supportive of therapeutic interventions (Berg et al., 2018), treatments must be evaluated as robustly as possible, with multi-faceted, mixed-methods approaches being employed to assess efficacy over both the short and long-term.

- Accessibility of treatment is a key concern for musicians, with cost a primary factor. Any integration of therapeutic interventions such as CBT or MBI (or any other for that matter), must thus prioritise cost-effectiveness to ensure uptake.

- Given the mixed peer-reviewed evidence regarding the longer-term effectiveness of CBT, it is likely to need to be combined with other approaches in the longer term. There thus needs to be more research in this area.

Part 4: The Peer Support Model

4.1 Introduction:

Mental health peer support (PS) – whereby socio-emotional support is given to people suffering from mental health problems by those with lived experience[127] - has, in recent decades, been regarded as an increasingly viable treatment modality that can complement traditional approaches[128]. The model is perhaps best known for forms of addiction treatment such as Alcoholics Anonymous (AA), founded in the United States in 1935, and Narcotics Anonymous (NA) founded in 1953. Today, it plays an increasingly important role in mental health treatment[129], viewed as an essential factor within a recovery-oriented framework[130], and present in policy documents and other system-level recommendations[131]. Despite musicians highlighting informal support from industry peers as important for wellbeing[132], we found no formal peer-reviewed empirical work into the effectiveness of this approach for this group.

In the context of musicians' mental health, a number of prominent examples of programmes incorporating PS as part of their wider range of services include:

- Backline (USA)
- Entertainment Community Fund (USA)
- The Back Lounge (UK)
- Tonic Rider (UK)

The UK organisation Tonic Rider has, since 2021, offered a six-week intervention, involving weekly ninety-minute online group support sessions followed by optional drop-in sessions and themed workshops on subjects such as emotional resilience, self-care, and music performance anxiety, among other interventions such as courses, workshops, counselling and psychotherapy. These offers are for musicians of all levels, as well as crew and industry professionals, and their services have been rolled out for early career musicians, starting in September 2023, via the Young Classical Artists Trust. In the United States, Backline offers weekly and monthly online and in-person drop-in group support sessions, as well as workshops on specific topics including tour health, navigating relationships, and grieving, as part of their wider offer. Another scheme of note in the US, albeit one aimed more generally at entertainment professionals, is that provided by the Entertainment Community Fund (ECF), which consists of themed online group programmes covering a wide range of topics, including anxiety, grief, self-care, mindfulness, and cognitive-behavioural skills. Some also target specific groups e.g. parents, caregivers, and more.

Three common themes can be identified in the way these services are presented by the respective organisations. Although not measurable or comparable indices of effectiveness in themselves, all relate to factors that undoubtedly increase the efficacy and appeal of interventions. First of these is the *assertion of credentials*; sessions of this kind (whether by these organisations or others) are often led by a range of professionals including qualified therapists, licensed mental health professionals, social workers, mental health nurses, and

[127] Puschner (2018); Repper & Carter (2011); Solomon (2004)
[128] Davidson et al. (2012)
[129] Byrne et al. (2016); Gillard et al. (2015); McCarthy et al. (2019); Moran (2018); Otte et al. (2020); Pathare et al. (2018)
[130] World Health Organisation (2013)
[131] Department of Health (2017); Farmer & Dyer (2016); Mutschler et al. (2022); Myrick & Del Vecchio (2016)
[132] Heyman et al. (2019)

others. In the context of the literature explored below which discusses the concept of 'role clarity', this is of crucial importance. Second, all highlight the involvement of – and opportunity to interact with - *music industry peers*. This shared lived experience is understood as key when engaging with musicians, and indeed other groups who stand to benefit from the PS model. Lastly, all services underline the *favourable conditions* fostered by their sessions, such as safety, confidentiality, and support. For example, Tonic Rider emphasise on their website that their initiative offers a "confidential, non-judgemental and supportive space for participants to share experiences and gain the benefits of understanding, validation and support." Both US initiatives mentioned above also highlight the safety and confidentiality of sessions.

4.2. Features of the Peer Support Model

PS programmes differ according to structure, content, duration, and format, targeting a range of populations and outcomes[133]. They can be delivered in one-to-one or group settings[134], and may be unidirectional, with support given by a paid worker to a recipient, or reciprocal, as with mutual support groups[135]. Formal PS workers (PSWs) operate in a range of settings including hospitals, community health centres, and transitional programmes[136]. Suggested core features of PS, which may thus apply across delivery contexts, include interpersonal connection and common lived experience[137], shared responsibility[138], self-determination, and the use of lived experiential knowledge[139]. Specific recovery-enhancing mechanisms proposed include personal identification and the modelling of positive behaviours[140], and 'upward' comparison with role models[141]. PS has also been suggested to be less susceptible to the barriers (e.g. cost, availability) faced by professional/traditional mental health services[142] as well as less threatening to those in need of help[143], giving it the potential for wider reach. This chimes with existing work on musicians' mental health interventions which have suggested that both accessibility and speaking to those who understand the realities of musicianship are key factors[144]. Additionally, PSWs, in being able to establish stigma-free relationships with peers, have been suggested to engage with them in a different – and indeed potentially more positive - way than other mental health professionals[145].
Studies examining the effectiveness of PS for mental health problems have indicated that it benefits a range of conditions[146], reduces symptom distress and improves quality of life[147], and, when provided in support of traditional services, lowers hospitalisation rates[148]. Reviews and meta-analyses have also been generally positive[149], although authors have also pointed out the scarcity of quality empirical evidence[150]. Furthermore, as PS is a relatively new field, the concept has not been definitively defined[151], leading to diversity in terms of

[133] Chien et al. (2019); Lloyd-Evans et al. (2014)
[134] Burke et al. (2018)
[135] Bellamy et al. (2017)
[136] Gillard et al. (2020); Repper & Carter (2011); Vigod et al. (2013)
[137] Bird et al. (2014); Faulkner (2017); Leamy et al. (2011); Steigman et al. (2014)
[138] Mead (2003); Mead & MacNeil (2006)
[139] Repper & Carter (2011); Slade et al. (2014); Solomon (2004)
[140] Bandura (1977); Solomon (2004)
[141] Festinger (1954)
[142] Glasgow et al. (2001); McCarthy et al. (2007)
[143] Bryan (2014)
[144] Gross & Musgrave (2017)
[145] Ibrahim et al. (2020); MacLellan et al. (2017)
[146] DeAndrea & Anthony (2013); Mahlke et al. (2017); Walker & Bryant (2013)
[147] Cyr et al. (2016)
[148] Sledge et al. (2011)
[149] Bellamy et al. (2017); Chinman et al. (2014); Lloyd-Evans et al. (2014)
[150] Chinman et al. (2014); Lloyd-Evans et al. (2014)
[151] Yim et al. (2023)

implementation methodology and service delivery[152]. Authors reviewing the PS research literature have noted the range of ways in which effectiveness has been understood and operationalised, and thus the variety of outcome measures – standardised and otherwise - that have been employed.

Smit et al. (2022) attempted to address this heterogeneity in their systematic review and meta-analysis, evaluating measured PS effectiveness within three recovery categories: *clinical* (e.g. psychiatric symptomatology), *personal* (e.g. perceived recovery, sense of purpose, personal agency), and *functional* (e.g. quality of life, vocational and social functioning). PS was associated with small-to-significant effects - at post-test and/or 6-9 month follow-up - for both clinical and personal - but not functional - domains. Yim et al. (2023), noting the lack of definitional agreement of PS among reviewers, conducted an umbrella review into the efficacy of formal, paid PS only. Their umbrella review, like Smits and colleagues, evaluated effectiveness within three outcome domains, albeit with a slightly different conceptualisation: *clinical* (e.g. symptom severity, hospital admission rates, relapse rates), *psychosocial* (quality of life, social participation, employment, functioning) and *recovery-oriented (*hope, empowerment, self-determination). They found that while reviews had reported improvement in all three, a greater number had observed improvement in recovery-oriented outcomes, suggesting that PS may have a unique effect within this domain. In the context of the findings from our survey on the mental health and wellbeing of Danish music-makers, where clinical-level symptoms were less prevalent than sub-clinical ones, these findings are pertinent. They suggest that while PS may still be beneficial to those with clinical symptoms, it may be particularly effective in fostering improvements in functioning and other recovery-oriented factors in individuals experiencing more mild or moderate difficulties.

4.3. Modes of Delivery

Other reviews have directly examined the effectiveness of specific delivery modalities. A key variation of PS is individual vs. group delivery[153]. Reviews separating group PS have also suggested greater benefit for personal recovery factors, such as hope[154] and empowerment[155], than for clinical ones. Lyons, Cooper, and Lloyd-Evans (2021) attempted to more systematically examine this, reviewing eight group peer support studies across four domains: *clinical recovery* (e.g. psychiatric symptom measures, clinical measures of social functioning), *personal recovery* (e.g. hope, meaning, empowerment, self-esteem, confidence, self-efficacy, quality of life), *acute mental health service use* (e.g. number of hospital admissions, inpatient bed days), and *social outcomes* (e.g. employment, independent living, social support). Findings were broadly consistent with previous literature, suggesting that group PS may have the most beneficial effect on overall personal recovery, and a lesser impact on other outcomes. The authors, however, advised caution, pointing out the heterogeneity of studies and acknowledging that not enough quality research into group PS exists to justify routine implementation across mainstream mental health services. White et al. (2020) conducted a meta-analysis on eleven studies specifically examining individual PS. Despite this difference in focus, their findings echoed those of Lyons and colleagues - a modest effect of individual PS on self-reported recovery and empowerment (i.e.

[152] Mahlke et al. (2014); Murphy & Higgins (2018)
[153] Burke et al. (2018)
[154] Fuhr et al. (2014)
[155] Burke et al. (2018)

personal/psychosocial factors), and no effect on clinical outcomes. These authors also highlight issues around the heterogeneity, reporting bias, and overall quality of studies.

PS can also be delivered in person or digitally (e.g. peer-to-peer social media networks, PS interventions supported by smartphone apps). The adoption of digital PS is expanding the reach of services[156], and increasing their impact[157]. Although the field is in its early stages, studies that have examined the efficacy of digital PS have reported significant improvements in psychiatric and medical self-management skills, as well as reported levels of hope, quality of life, and empowerment[158]. Fortuna et al. (2020) reviewed thirty studies in order to examine the biomedical and psychosocial outcomes of digitally delivered initiatives, finding they demonstrated both feasibility and acceptability, as well as preliminary evidence of effectiveness in terms of functioning, symptom reduction, and improving programme utilisation. A relationship was also found between level of service engagement and active/consultative community engagement, suggesting that involving service users in the development of digital programmes may help to maximise their effectiveness by fostering a greater willingness to engage. In seeking to develop innovative solutions among a technologically literate and engaged profession, this may represent an area of interest for the *Danish Partnership for Sustainable Development in Music* to explore in greater detail. Again, however, the number of studies was low, with the authors highlighting not only a lack of longitudinal work – something which, regardless of intervention methods adopted, would be key to embed from the beginning of a service offering - but also the fact that no studies had attempted to formally unpack the specific mechanisms of digital PS that may bring particular benefit. Both these issues offer avenues for future work.

4.4. Challenges of Measurement and Factors of Success

Despite the broadly encouraging – if tentative - evidence regarding the efficacy of PS in certain contexts, particularly for personal/psychosocial recovery outcomes, widespread implementation remains limited[159]. Repper and Carter (2011), in their review, identified potential barriers to successful implementation, including concerns about PSW boundaries, power dynamics, stress, and *role clarity*. This final point is key, as it refers to the importance of having trained and qualified facilitators whose role(s) within the group are clear. Others have reported reservations among other health professionals around PS increasing workload[160]. The use of former service users as PSWs has also been met with resistance[161], while others have reported mental health stigma in Australia leading to the "professional isolation" of PSWs in that country[162]. Scepticism to PS has also been reported in Canada and Norway; however, as per our comments above, the authors foreground the importance of open practices of user evaluation, suggesting that: "evaluating to support continuous improvement can help turn resisters into supporters" [163]. Vanderwalle et al. (2016) identified barriers including cultural impediments, poor organisational arrangements, and inadequate mental health policies.

Other reviews have attempted to pinpoint the organisational and operational domains that may influence the success of PS implementation. A systematic review of 53 studies highlighted fourteen domains, within each of which the successful implementation of PS may

[156] Fortuna et al. (2019a)
[157] Fortuna et al. (2018)
[158] Fortuna et al. (2018; 2019b)
[159] Chinman et al. (2017); Farkas & Boevink (2018)
[160] Gillard & Holley (2014); Collins et al. (2016)
[161] Davidson et al. (2006)
[162] Byrne et al. (2019)
[163] Mulvale et al. (2019: 72)

be facilitated or hampered[164]. The most common included organisational culture, role support, and staff attitudes. Examples of a facilitator within the latter domain include acceptance, trusting relationships between PSWs and staff, and a sufficient level of support, while barriers may include a lack of contact between PSWs and staff, conflict, lack of respect from staff, and/or the emergence of traditional power dynamics i.e. hierarchies or competition within the group setting. Ibrahim and colleagues also suggested the interrelated nature of these phenomena, pointing out that they may act as modifiers, mediators, or links in a causal chain. Mutschler et al. (2022) used the five-domain Consolidated Framework for Implementation Research (CFIR)[165], which conceptualises implementation success as dependent on factors relating to i) the *intervention* itself, ii) the *outer (wider) setting*, iii) the *inner (organisational) setting*, iv) *individual characteristics*, and v) the *implementation process*. Important facilitators identified within these domains were a flexible organisational culture involving leadership and commitment, education for both PSWs and their colleagues – with studies highlighting that this was potentially important for obtaining buy-in from staff, as well as reducing stigma - and a clear definition of the PSW role. Barriers included a lack of recovery focus in the organisation, and a lack of role clarity.

Lastly, a narrative review by Mirbahaeddin and Chreim (2022) identified a three-level framework of influence[166]. At the *macro* level were socio-cultural (e.g. medical model discourses), regulatory/political (e.g. policy mandate), and economic factors. Variables identified at the *meso* level were organisational ones such as culture (e.g. level of role clarity vs. ambiguity), leadership and supervision of PSWs (e.g. organisational level of commitment), and human resource management policies, (e.g. PSW education, training, socialisation). *Micro* level factors included relationships with team members (e.g. understanding role boundaries, readiness for integration into mental health teams) and PSW wellbeing (e.g. level of emotional involvement and self-care). Again, the authors emphasised the related (i.e. intra- *and* inter-level influence) nature of these factors.

Despite the slightly differing approaches taken by these reviews, their findings – when taken together – suggest that variables influencing PS implementation success operate in a multi-layered, interconnected way, and that factors such as wider policy contexts, organisational culture, attitude of leadership/colleagues, and PSW training/credentials/role clarity are of paramount importance.

4.5. Conclusion

Peer reviewed research into the effectiveness of PS has – due to the lack of an agreed definition – used a range of outcome measures. Despite this, a number of reviews have offered evidence that it may be of more benefit for personal, or psychosocial, factors, than clinical ones, although studies are relatively few in number, and issues surrounding heterogeneity, bias, and overall quality have been highlighted. Work on variables influencing the success of PS implementation have highlighted factors including wider policy, organisational culture, and domains of influence, and that these factors likely operate in an interconnected way. Future work could focus on the specific mechanisms of PS that bring benefit, place greater emphasis on long term outcomes, and examine the effectiveness of particular types of PS for specific populations. Additionally, the effect of potentially

[164] Ibrahim et al. (2020)
[165] Damschroder et al. (2009)
[166] Mirbahaeddin & Chreim (2022)

confounding variables such as the life experiences of peer support workers (PSWs)[167] and the computability of PSWs with clients[168] could be examined. Specific interventions targeting the music and/or entertainment industry often comprise group delivery, but are, in the musicians' mental health service provisions landscape, relatively rare. While these services tend to emphasise a) the credentials of the therapists/professionals involved, b) the opportunity to interact with industry peers, and c) the facilitative, safe, and confidential environment provided, we found no peer-reviewed investigation into their effectiveness.

Synopsis of the Peer Support Model

- In the context of the existing mental health intervention landscape for musicians, the PS model is one of the least prevalent models of delivery.
- A number of characteristics have been suggested to impact the success of the PS model. One of these relates to those facilitating the sessions. Facilitators should have: (i) appropriate qualifications, (ii) shared lived experience with service users, and (iii) are clear about their role within the group setting.
- Peer reviewed evidence suggests that PS has greater benefit with regard to personal or psychosocial factors e.g. hope, meaning, empowerment, self-esteem, confidence, self-efficacy, quality of life, than it does for clinical mental health symptoms. For more severe cases of mental ill-health, other interventions may be needed.
- Whist evidence is still preliminary, the development of a PS service alongside, and in collaboration with, potential service users has been suggested to offer promising results in terms of willingness to engage.
- Facilitating a safe environment of trust and a positive organisational culture is seen as key to the effectiveness to PS.
- It is beneficial for any form of PS to establish a method of long-term evaluation to both ensure effectiveness and, if seen to do so, mitigate potential scepticism. There is no single, agreed method of evaluating effectiveness, so any service evaluation must be multi-faceted and adopt a range of measures. Indeed, many of the providers named here already do so e.g. Tonic Rider employs clinical and participant-led methodologies.

[167] Kent (2019)
[168] Fuhr et al. (2014); Jones et al. (2014)

Conclusion

The musicians' mental health service landscape has expanded greatly in recent years, and in undertaking a preliminary mapping of the range of interventions on offer we were able to identify four non-exclusive models of practice: helplines, approaches rooted in prevention foregrounding resilience, more traditional forms of therapy, and the peer support approach. Peer reviewed evidence for each of these areas relating to musicians is scarce, with only a handful of studies exploring these interventions (see Visser et al. 2022 for the first scoping review in this area). We have thus attempted to summarise more general literature on the efficacy of these models; predominantly meta-analyses, systematic reviews, and scoping reviews in order to offer the broadest possible overview, whilst acknowledging that our insights here are *not* an evaluation of any named service provider. We have examined how effectiveness in each of these domains have been understood in order to try and consider if, and when, interventions of these kinds are likely to prove most useful to musicians living and working in Denmark (and beyond). We have also sought to contextualise the literature discussed against our earlier survey findings on the mental health and wellbeing of Danish music creators. Our findings in this report should be understood as offering a complementary evidence base. We are also conducting interviews with Danish music-makers to better understand their subjective experiences of this service provision landscape, as well as their wants and needs going forward. Findings from these interviews will be presented in a future report.

Having synthesised an extremely rich and broad evidence base and having balanced these findings against the results of our earlier survey, we would suggest that, of the approaches considered, both therapeutic and peer support models appear to offer the most favourable evidence base. Resilience-based, preventative methods are potentially promising for musical performers at specific career stages and in certain demographics, although there is a lack of peer reviewed evidence to date. Helplines based on need in a crisis are, on balance, likely to offer less utility in the Danish context given our survey data.

It is critical to conclude by emphasising three points. Firstly, of all of the four models we have explored, none are likely to be sufficient in isolation, and instead a more holistic and multi-faceted approach is likely to yield the best results, as per many of the offerings outlined here which, as suggested, have been highlighted in many cases as examples of best practice. Secondly, it is crucial that any musicians' mental health intervention includes mechanisms in order to rigorously evaluate effectiveness amongst service users across different delivery modalities, time scales and demographics. Indeed, many of the service providers we have highlighted here already adopt excellent features of evaluation. Further, these findings should be shared among relevant stakeholders and service offerings adapted accordingly where needed. Finally, none of the models explored here change the structural realities of musicians' careers in Denmark or elsewhere – the economic precarity, limited live performance opportunities, limited availability of funding or other forms of revenue, etc., which open comments from our survey tell us are all sources of considerable anxiety for Danish musicians. Our view is that interventions such as these are likely to need combining with socio-political and structural change in order to ensure that they do not simply represent individualised 'sticking plasters' for the profound feelings of uncertainty and distress experienced by many music makers in the face of economic hardship, professional instability, and any other stressors they may face.

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