

Musician Mental Health: Intersections of Poor Mental Health, Peer Support, and
Instrumental Conducting

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A dissertation

submitted in partial fulfillment of the
requirements for the degree of

Doctor of Musical Arts

University of Washington

2025

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Program Authorized to Offer Degree:

Music

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Abstract

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Introduction: The purpose of this dissertation is to contribute to emerging research and work in musician healthcare, and specifically musician mental health. It will review existing research on the mental health conditions that musicians face as a unique population, review existing research on the efficacy of peer recovery work as non-clinical mental health resource, and provide research and interview findings on existing peer support resources for classical musicians. Pedagogical and gestural implications for conductors will be introduced, as well as necessary further research study. Summaries of each topic listed above are provided below. Parts are not organized by any basis of importance or significance:

Part One: This literature review aims to aggregate major studies on the mental health of classical musicians as a unique population, relative to existing data from general population studies. The goal is to contextualize the field of musician mental health, demonstrating how musicians on a broad level are an at-risk population relative to conditions such as anxiety,

depression, stress, and life expectancy. The majority of the demographic focus is on student and professional classical musicians, though some relevant and important data on non-classical performing artists is also included. The paper will also provide implications for understanding the performance effects of poor mental health for musicians, as well as future research directions for overall well-being.

Part Two: The purpose of this second literature review is to introduce peer recovery work as a developing mental health resource for individuals experiencing poor mental health. It will define and specify foundational qualities of peer recovery work, and provide existing organizations, services, and resources as models of its use for varying populations and disciplines, such as undergraduate university students, medical students, and individuals experiencing substance abuse issues. The review will also present emerging evidence and research on the efficacy of peer recovery work on various metrics measuring mental health wellbeing, showing instances of its significant positive impact and improvement of mental health conditions. Lastly, I emphasize the need to explore and develop more mental health resources like peer recovery work to supplement existing clinical interventions, in the context of overall worsening mental health across general populations.

Part Three: In this final section, I will discuss existing wellness programs offering peer support services by trained peer support workers. The section will contain information gathered from personal research and various interviews with program directors, to present existing mental health resources for classical musicians. Implications of peer support principles for the conductor will be covered, with a focus on the pedagogical and gestural

elements of the conductor/director role. Further directions for research and development for peer support and classical musicians will also be discussed.

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INTRODUCTION

The journey of being a classical musician is one full of ups and downs. Like many professions in which the lines between career, hobby, and passion are blurry, life as a musician can be difficult to compartmentalize. Music is often a personal endeavor, with significant meaning and influence on our self-views and our identities. Its inherent emotional elements often impact us on intimate levels – we often describe music as resonating with us and becoming a part of us. Music’s ability to reach performers and audiences in this deeply fundamental way can make it a very intense experience, which can sometimes lead to difficulty separating it from our sense of being and existence. Musicians often report devoting immense amounts of time and effort toward perfecting their craft, at the cost of time spent better understanding their lives and personalities outside of any musical context. Music becomes all we know and the only medium through which we interact with the world outside us. The boundaries between who we identify as and our interaction with music easily become blurred.

For this reason, our relationship with our art can often become strained and lead to negative health outcomes. Inherent stress and challenge will always exist in any activity that involves failure, learning, and growth; this expected amount of stress in combination with the challenges unique to engaging in music has led to mental health significantly worsening in classical musicians when compared to the mental well-being of the general population. Research continues to show that on mental health factors like anxiety, depression, and stress, classical musicians consistently score more negatively than the general population. When considering unplanned stressors that nonetheless tend to occur,

the mental health situation is even more dire. Examples of “unplanned” stressors include unhealthy and/or abusive relationships with instructors or other persons in positions of power; burnout from being overworked based on factors like technical ability, time, inappropriate expectations; or lack of opportunities for healthy social interactions and community building.

Mounting evidence demonstrates that classical musicians are an at-risk demographic for poor mental health, but resources to support classical musicians are not available or being developed to match this rate of discovery. While non-profit organizations and other communities are slowly being developed to provide some element of musician-specific support, conservatories and schools of music across the United States are moving even more slowly. On this issue, however, both the general population and classical musicians relate; the need for more varied and robust mental health resources continues to outpace the development of new resources, a trend seen across all populations. Events like the COVID-19 pandemic have exacerbated this pattern (Curtin 2020).

One developing resource that has shown promising results is peer support. While it may take a variety of different names and labels such as peer counseling, peer coaching, or peer recovery work, its foundational focus on peer-to-peer interaction remains consistent. Peer recovery work (PRW) is utilized in programs like Alcoholics Anonymous and other topic-specific programs sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), with a growing body of research demonstrating its efficacy and effectiveness in improving participant mental health. While still in its early stages of crystallization into a defined practice, PRW may be a promising avenue to provide

complimentary mental health services for unique populations and demographics, such as classical musicians.

As a conductor, my training and personal study primarily focus on gestural development, musical, score-centered study, and pedagogy, But, in practice, this role encapsulates an immense amount more. As many have suggested, the role of a conductor is in reality a constant switching of “hats” – given the context, you may be an educator, a conductor, a fundraiser, a promoter, and sometimes a pseudo-school counselor. For this reason, the goal is hardly ever as simple as just rehearsing the ensemble to perform music at a high level. It is my belief that a classical conductor’s development should involve a basic awareness and understanding of classical musician mental health, as it may have impacts on the performance of music at a high level, but at the very least for the sake of the well-being of the musicians entrusted to our care and attention.

Thus, the purpose of this dissertation is to synthesize existing literature on classical musician mental health and the growing research on the efficacy of PRW, to propose for the continued adaptation of PRW for classical musicians. It will elaborate on existing resources, as well as discuss how elements of peer support can intersect with instrumental conducting.. This dissertation will also aggregate existing practices that current music programs utilize to improve the mental well-being of their musicians. An emergent theme out of the topics discussed is the importance of classical musicians’ mental well-being and the conductor’s role in it. The dissertation will close by discussing implications for theoretical exploration of this relationship between musician mental health and conductor.

PART ONE

An Exploratory Review of Existing Research on Musician Mental Health and Musicians as a Unique Population for Increased Mental Distress

There is little doubt that the road to success for most classical musicians is one laden with constant performances, rigorous and consistent training, and of course, hours and hours of practice. This is by no means an exhaustive list; a career in classical music necessitates non-musical demands like public relations skills, self-promotion and networking skills, effective pedagogical practices, and sometimes even an ability to navigate unique tax codes and health insurance plans. While the focus during musical education today primarily lies in the improvement of individual musical knowledge and performance skills, a professional musical career often extends past the classroom (Zhukov 2022). It is a broadly understood concept that a career in classical music necessitates many musical and non-musical skills.

Of course, the associated stress coming from the many challenges in both musical training and a professional music career can be understood as being a “normal” part of the journey – we can expect that spending hours in the practice room or budgeting travel finances to take multiple auditions involves an anticipated amount of stress and difficulty. The associated kind of stress coming from these anticipated challenges presents itself as eustress, or a short-term kind of stress that can lead to improved performance, feelings of resiliency, and positive growth when the stressors are overcome. This process is not unique to music and can be seen at play during the learning process of any kind of skill, craft, or art – different pastimes have different challenges, and overcoming these challenges leads to

learning, improvement, and sometimes self-confidence. Whether it be improving one's ability to shoot a basketball at consistently high percentages or to effectively cue an off-beat entrance through clear and consistent gesture, the challenge and eustress associated with either of these skills is anticipated, "normal", and an opportunity to build resilience and self-confidence.

There is also very little doubt, however, that the road to success for a classical musician rarely follows an anticipated and predictable plan. On top of the challenges and stressors we expect to face, classical musicians often find themselves confronted by a slew of other challenges, demands, and issues that can take us by surprise. Without proper care, neuromusculoskeletal issues can arise and end careers (Heming 2004). The many relationships that can exist in a classical musician's professional and personal life may be sources of fulfillment and enrichment, or sometimes be a source of unhealthy stress and trauma (Musgrave 2023). Whether it be our relationships with our peers in a section of a symphony orchestra, the more intimate relationship with our peers in a chamber ensemble, or often long-standing relationships with our private instructors, a lack of effective social skills and understanding on both sides can lead to these relationships feeling burdensome, stressful, and in the worse cases, damaging.

We may categorize this second kind of stress as distress, or stress that is overwhelming and has a negative impact on our well-being. Non-competitive and non-livable wages and compensation, labor strikes against unfair labor practices imposed by administrations, sexual assault, hazing, and bullying behavior leading to toxic work environments are all examples of distressful occurrences that have been well documented

and observed in the classical music profession (Seliger 2018, Lewis 2018, Baker 2019, Johnston 2017). In a broad sense, the differences between what constitutes an “inherent” vs. an “unanticipated” stress of any profession are fluid and always changing based on the perspective taken. Nevertheless, eustress and distress both always exist, though the consistency of the experience considered distressful or eustressful may be more subjective and change. This too is not unique to being a classical musician.

What does seem to differentiate classical musicians from the general population are a reported higher level of mental distress on a variety of different clinical factors, including feelings of depression, anxiety, stress, and optimism for a successful future. A growing amount of research studies including those referenced here measuring different elements of musician mental well-being continue to demonstrate classical musicians as a unique demographic exhibiting deteriorated mental health, particularly when compared to metrics of mental well-being of general populations. Research studies also vary in the categorization of musician they study, from professional classical musicians to music majors in schools of music and conservatories across the United States, and to other genres of professional musicians including pop, rock, hip hop, and heavy metal in the US and across the European continent as well. Much of this research is in its early stages and requires validation, but patterns from the current literature point towards classical musicians as an at-risk demographic for diminished mental well-being and increased vulnerability to mental distress.

Mental Health and General Well-Being of Musicians: Populations outside the U.S.

The majority of existing, peer-reviewed research on the mental well-being and health of musicians has been conducted within the 21st century. While writing does exist by educators, medical professionals, and other musicians on the topic of mental health in performing musicians before the 2000s, they do not involve validated research designs focusing on the measurement of specific factors of mental well-being in classical musicians. Salmon's work introducing and defining the concept of Musical Performance Anxiety in 1990 is one of the earliest publications specifically elaborating on a mental condition unique to performing musicians. Today, research continues to evolve and ranges from self-reported survey studies to more rigorous longitudinal research tracing the development of specific samples, using a variety of validated medical surveys measuring feelings of anxiety, depression, stress, etc. Interestingly, a significant portion of existing research centers around and cites the impact of the Covid-19 pandemic on musician mental health – consistent with general population studies also demonstrating an overall poorer mental well-being post-Covid-19 pandemic (Curtin 2020).

In 2004, researchers at the University of Freiburg in Germany, in collaboration with researchers at Würzburg University of Music, conducted a survey-based study comparing the psychological and physical health problems of music students in comparison to other student populations. The study sought to measure differences in well-being between music students and psychology, medical, and sports students, along with their subject-related attitudes toward health at large. Results showed that music students reported significantly higher on depression and anxiety scales than the other majors, placing them

in the borderline or elevated range on both factors (Spahn et al. 2004, 29). As one of the earliest studies to compare metrics of well-being between musicians and other non-musician samples, the framework of this study has since been expanded to comparisons between many different research groupings in comparison to musicians. This study serves as one of the first substantial research designs to demonstrate that the musician population shows a higher prevalence of health problems, as well as the importance of musician-specific prevention and health promotion measures to address their specific need.

Voltmer and his team's work, in collaboration with Spahn and the Freiburg Institute for Musicians' Medicine, recategorized the scope of comparison between musician and control populations. In their 2012 study, 429 professional opera and/or concert orchestra musicians were given the Short Form-12 general health questionnaire. Data was compared with three other reference samples given the same survey: general population samples, a sample of physicians, and a sample of aircraft manufacturers. Results showed that professional musicians scored on average higher on physical health scores compared to all three reference samples, and lower on mental health scores compared to the general population (Voltmer et al. 2012, 11). Mental health scores between musicians, physicians, and aircraft manufacturers did not differ significantly. Between concert and opera orchestra musicians, there was also no significant difference in either physical and mental health scores, and female musicians scored lower both in physical and mental health compared to male musicians (Voltmer et al. 2012, 13). The authors theorize that professional musicians may have higher perceptions of their physical well-being due to the

normalization of various neuromusculoskeletal, playing-related symptoms that musicians report – they may be experiencing physical maladies that they understand as being inherent parts of musicianship and therefore not reportable as signs of poorer physical health. Voltmer and team’s study focuses on the experience of professional musicians compared to Spahn et al.’s focus on student musicians, but more recent research will conclude and reconfirm similar results for both categories of musicians.

At the Leiden University Medical Center from the Department of Psychiatry in the Netherlands, researchers van Fenema and van Geel sought to determine if music students were an at-risk population for mental problems compared to medical students, another population perceived to have a predisposition for high stress and other mental health issues. Their 2014 study saw a group of first-year conservatory students and first-year medical students take the Symptom Questionnaire (SQ48) and the Standardized Assessment of Personality-Abbreviated Scale (SAPAS) to compare symptoms and characteristics between both groups. Results demonstrated both conservatory and medical students trending towards more psychological issues compared to the general population, with no significant differences between each other (van Fenema and van Geel 2014, 113). The SAPAS showed that both a majority of conservatory and medical students considered themselves perfectionists (87.9% and 79.1% respectively), as well as worrying a lot (63.6% and 65.1% respectively). van Fenema and van Geel’s research saw similar results to Spahn et al.’s work comparing music students to other students, demonstrating student musicians in two different countries and cultural environments simultaneously reporting poorer mental health.

Dianna Kenny is known for her work expanding, illuminating, and deepening the widespread experience of Music Performance Anxiety (MPA) as a musician-specific phenomenon, which as of today is listed as a social anxiety disorder in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Kenny and a team of researchers in the University of Sydney's Public Health, Music, and Biomedical Science departments engaged in research studying the differences in physical and mental well-being between professional Australian orchestral musicians on stage, in pit orchestras, and a combination of both on stage and in pit orchestra musicians. The sample of 380 full-time orchestral musicians were drawn from the eight major state orchestras in Australia, including the Australian Opera and Ballet Orchestra, Sydney Symphony, Melbourne Symphony Orchestra, and the Queensland Symphony Orchestra. Musicians completed physical assessments including evaluations for performance-related musculoskeletal disorders (PRMD) and perceived exertion and psychological health during performance. They also completed mental assessments including surveys for MPA, work-place satisfaction, and experiences with bullying in the work-place. Compilation of results showed that pit musicians demonstrated higher psychological vulnerability in factors like MPA and lower work-place satisfaction compared to the two other comparison groups, with no significant differences in physical characteristics between all three groups (Kenny et al. 2016, 6). The two-fold nature of this study's results demonstrate not only the prevalence of particular physical (PRMDs) and psychological issues that these professional musicians face, but also that differences in severity of physical and psychological issues exist within professional orchestral musicians. These results in combination with musician-

to-general population comparison studies continue to elucidate the depth and severity of issues that musicians in different contexts encounter as part of their craft, and the need for further research and resources to support their unique experiences.

One 2020 study with the largest epidemiological data sets involving musician well-being relative to a general population is Detari, Egermann, Bjerkeset, and Vaag's work applying the unique concept of psychosocial work environment among working Norwegian musicians and the general workforce in Norway. These researchers, working in the University of York Department of Music in York, UK and the Faculty of Nursing and Health Sciences at Nord University in Bodø, Norway, underscore the value of examining musician psychosocial work environments. The authors define psychosocial work environment as the interaction between the individuals' personal experiences and the characteristics of the workplace, stressing its contributions to personal well-being and health and the need for its application for working musicians. Using the Norwegian Surveys of Level of Living (NSLL) measurement, researchers gathered data from 1,607 professional musicians drawing from the Norwegian Musician's Union, as well as 12,255 participants who constituted the general workforce sample for this study. These general workforce participants were currently employed and held an International Standard Classification of Occupations certification to verify their employment status. Seven variables were the focus of the NSLL: job control, job demands, social support, effort-reward-salary, effort-reward-acknowledgment, work-family conflict, and job motivation. Sex, age, musician role (soloist, orchestra, band, etc.), and genre type were also collected.

Findings indicated that musicians in comparison to the general workforce felt less supported and acknowledged, had more work-family conflicts and less motivation in work, perceived their work as more demanding, but reported more control over their work and experience fewer disturbances (Detari et al. 2020, 3). Overall, musician psychosocial work environments significantly contrasted the general work force in all psychosocial aspects measured, with a trend towards worse overall psychosocial work environments according to Detari et al.

Music genre classifications also revealed differences in perceived experiences of the psychosocial work environment variables studied. Classical musicians on average reported the least amount of control, high family conflict, and low job motivation compared to other genre averages (Detari et al. 2020, 4). Interestingly, classical musicians also reported less demands and high effort-reward through salary than other genres, though it is important to note that musicians as an entire category reported higher demands and lower effort-reward through salary compared to the general workforce.

While research continues to be conducted studying the individual and subjective experience of musicians to measure their well-being relative to their profession, this research by Detari et al. differs in its focus on the environment as the potential source of overall worsening mental well-being in musicians. It serves as complimentary research to demonstrate the environment's effect on musician well-being, along with any predispositions that individuals may bring in their engagement with music during their preprofessional and professional careers. Its use of a large data set and a relevant and important construct (psychosocial work environment) across two populations furthers the

importance of acknowledging the role of the environment in all populations' general well-being. At the same time, it establishes the differentiating impact of specific environments relative to others, starting with its comparison between musicians and the general workforce, but going on to analyze sub genres and categories within the musician population as well. The authors emphasize the need for both individual and population/environmental interventions to better support laborer mental and physical well-being. As research begins to look at the specific reasons classical musicians report contributing to their low mental health, Detari et. al and their research serve as some of the most specific information we have to potential causes for low mental health.

On a smaller scale but with important implications, researchers from Codarts Rotterdam University of the Arts performed a study investigating the role of PRMDs (as referenced and studied by both Spahn and Kenny) in classical music conservatory students and their mental health and general health. Researchers sought to determine if students with PRMDs would vary significantly in their reported mental and general health, relative to students without reported PRMDs. Results in this study demonstrated low reports of PRMD in this population relative to other research on the prevalence of PRMDs, but a high prevalence of mental health issues was demonstrated unexpectedly. From a sample size of 46, 17.8% reported a PRMD, while almost half (45.7%) of participants reported poor mental health. No significant differences existed in mental health scores between participants with or without PRMDs, but students with PRMDs reported significantly lower self-rated general health compared to students without PRMDs (Steemers et al. 2020, 217). Important implications are made by researchers: could the

large difference between reported mental health and physical health stem from attitudes accepting physical problems as inherent parts of musicianship (seen in adages like ‘no pain, no gain’)? How do existing resources musicians have access to influence the difference seen in reported physical and mental health? Given the small sample size, further research is necessary in understanding the role of PRMDs in affecting musician mental and general health. Nonetheless, the additive, compounding effects of poor health for musicians, particularly categorized between physical and mental health, is an important experience to be better understood, implying the need for a psychosomatic or multisystem research lens on musician health.

Kegelaers and researchers at the Vrije Universiteit Brussel, Vrije Universiteit Amsterdam, the Conservatorium van Amsterdam, and the Amsterdam University of Applied Sciences published a unique study in 2021 studying resilience, general physical health, and mental health issues as variables compared between third year undergraduate and first year masters level music majors, and professional musicians. Kegelaers and his team used the 12-item version of the General Health Questionnaire (GHQ-12) to measure symptoms of both depression and anxiety in participants, as a measure of mental health. The GHQ-12 was selected from other depression and anxiety-based surveys due to focus on the impact of depression and anxiety symptoms in the general functioning of an individual, rather than a survey tool to clinically diagnose anxiety and depression. To measure capacity for resilience in participants, researchers used the Connor-Davidson Resilience Scale 10 (CD-RISC-10), which measures an individual’s ability to use protective resources to combat and adapt to adversity and stress at large. The CD-RISC-10 is a

condensed version of the CD-RISC, and is most used as a tool measuring resilience within the general population, with demonstrated reliability and validity. Finally, general physical health was measured using a 5-point Likert scale attached to four statements assessing general physical health, chronic pain, sleep quality, and eating habits. This four-statement survey was developed by the researchers themselves.

In total, 64 participants completed the survey in its entirety, with 36 music students and 28 music professionals. Results indicated that based on the GHQ-12, prevalence of symptoms of anxiety and depression, the mental health variable in this study, were high for both groups, consistent with existing research conclusions. On the GHQ-12, general populations report prevalence rates varying between 10% and 20%, while this study displayed an average of 51.6% for student and professional musicians. Between student and professional musicians, student musicians reported significantly higher than professional musicians on the GHQ-12, indicating music education settings contribute to a higher prevalence of mental illness for musicians (Kegelaers et al. 2021, 1279). Female-identifying musicians also reported higher on the GHQ-12 compared to male and other gender identifications, indicating a higher level of psychological distress.

Psychological resilience and general physical health both demonstrated an inverse relationship with mental health issues as defined in this study. Participants who scored higher on the resilience measurement as well as scoring higher on general physical health self-reporting tended to score lower on the GHQ-12. The researchers point to the value of developing resilience skills and habits for the improvement of physical health as effective interventions for poorer mental health (Kegelaers et al. 2021, 1280), consistent with other

researchers cited on the direct relationship between physical health and mental health. Much like Steemers et al., researchers in this study promote the importance of a multisystem approach to musician well-being. Improvements in physical health are shown to correlate with better mental health – further research may be valuable in determining if the opposite is also true. Lastly, Kegelaers’ team emphasizes the lack of research on resilience and musicians and cites sports psychological studies that provide specific perspectives of resilience in sports performance. Research linking sports psychology and musician psychology under the umbrella of ‘performance psychology’ continues to be championed and developed by researchers like Dr. Noa Kageyama at The Julliard School, but further research and development on the possible similarities seems likely to prove fruitful as well.

Mental Health and General Well-Being of Musicians: Populations within the U.S.

Studies on American classical musician populations are less common despite the large number of classical musicians, departments of music, conservatories of music, and classical music institutions in the country. A number of collegiate music departments have more recently developed music-major specific resources to support their overall health and well-being, along with a growing list of organizations seeking to support professional musicians and their wellness as well. These organizations will be discussed in the third chapter of this dissertation.

Koops and Kuebel’s research in 2021 is one of the first large-scale studies focused on the self-reported mental health state of US music majors across the country. Researchers designed a survey that included a questionnaire polling mental health literacy

and experiences with mental wellness in the university setting, paired also with the short form of the Depression Anxiety Stress Scale (DASS-21). The survey was disseminated across 11 private and public universities, conservatories, and liberal arts programs spanning the six regions identified by the National Association for Music Education (NAfME), for a total of 252 completed surveys. Survey responses were categorized by year in school, implicating that all responses were undergraduate students.

Notable results of the 226 responses showed about 33.6% of music majors in the 'normal' category of depression, leaving 66.4% of music majors in 'mild', 'moderate', 'extreme', or 'very extreme' categories of depression. On anxiety levels, 23% were in the 'normal' category, with the remaining 77% in 'mild' to 'very extreme' categories. On overall stress levels, 26.9% classified as 'normal', leaving 73.1% within 'mild' to 'very extreme' categories.

Open-response questions yielded patterns as well. Researchers asked music majors about the availability of resources in their particular collegiate settings – 117 out of 187 comments mentioned low or no cost university counseling services, though accessibility and practicality of these services varied. Another notable theme found among all responses was the difficulty in managing criticism from figures like studio professors and ensemble directors, and how criticisms from these parties “varied in how supportive it was for their mental wellbeing” (Koops and Kuebel 2021, 137). Because of the perceived emotional connection between music-making, self-expression, and identity, certain critique by teachers was noted as leading to perfectionist mindsets, furthering poor mental well-being. The psychosocial concept termed “imposter syndrome” stemming from the

comparative nature of music-making was another consistent experience music majors across all campuses reported. In all, Koops and Kuebel note that a majority of the descriptive language found in the open-response questions was “emotionally charged, extreme, and desperate language” (Koops and Kuebel 2021, 138). This language was expressed consistently enough on all responses to warrant its own categorization by the authors, under ‘Code Red’ responses or language. Comparing the aggregate DASS-21 data with these open-response questions responses seems to validate the idea that most music majors are experience poor mental health to varying but nonetheless concerning degrees.

Danni Gilbert’s comparative study between undergraduate music majors and non-music majors on self-reported depression and anxiety levels was also published in 2021. Similar to Spahn, van Fenema, and van Geel’s work comparing music students to non-music students, Gilbert’s participants were also undergraduate students but at a private liberal arts university in the American Midwest. All participants of the study completed a form comprised of both the Burns Anxiety Inventory (BAI) and the Burns Depression Checklist (BDC) combined together into one questionnaire. Both the BAI and BDC are validated self-reporting instruments developed by David Burns to serve as tools for determining an individual’s anxiety and depression levels. Participant pools were relatively small – out of 30 total music majors, 25 students completed the study questionnaire, and out of a General Studies course of 30 non-music majors, 22 students completed the study questionnaire. Non-music majors were not classified further by their specific majors. Similarly to the DASS-21 used in Koops and Kuebel’s study surveying music majors across the US, the BAI/BDC used in Gilbert’s study categorizes participants’ aggregated responses

into descriptive groupings, including ‘minimal or no anxiety’, ‘mild anxiety’, to ‘extreme anxiety or panic’ (BAI). The BDC descriptive groupings range from ‘no depression’ to ‘extreme depression’, with four different categories in-between. Participant pool size in Gilbert’s study is smaller than that found in Koops and Kuebel’s, but results are similar nonetheless.

Results show that on the anxiety variable as measured by the BAI, music majors tested on average at the ‘severe anxiety’ category, while non-music majors were in the ‘mild anxiety’ category on average. On the depression variable as measured by the BDC, music majors tested on average at the ‘moderate depression’ category, while non-music majors were in the ‘mild depression’ category on average. On both anxiety and depression, music majors tested one category higher. Percentage analysis shows that 8% of music majors were in the minimal or no anxiety or borderline anxiety categories, leaving the remaining 92% in-between mild to extreme anxiety or panic. In the non-music major sample, 45% were in the minimal or no anxiety or borderline anxiety categories, with the remaining 55% in-between mild to extreme anxiety or panic. On the depression variable, the percentage breakdowns were the same – 8% of music majors classified in the ‘no depression’ or ‘normal but unhappy’ categories, with 92% in ‘mild’ to ‘extreme’ categories, and 45% of non-music majors in the ‘no depression’ or ‘normal but unhappy’ categories, with 55% in ‘mild’ to ‘extreme’ categories (Gilbert 2021, 76). The limitations of this study are thoroughly addressed by Gilbert, including the small sample size and the potency of self-reporting bias in relatively smaller sample sizes, though placed in the context of other research conducted with larger sample sizes, the results trend toward the same conclusion.

Gilbert also provides important implications for music educators, calling for more effective and thorough training for music educators to lessen the pressure of perfectionism, help reframe stress, develop specific self-care strategies, and overall better support their students through their collegiate music careers. Finally, an important secondary finding from this research confirms that not only do undergraduate music majors trend toward poorer mental health as a unique demographic, but undergraduate students at large score highly on different measures of mental illness as well. Support and resources must be developed for all students in the college level, as the need is there regardless of major.

Music Performance Anxiety (MPA)

Music Performance Anxiety (MPA) as a unique experience to performing musicians has been the focus of much research and development beginning with the work of Dr. Paul G. Salmon at the University of Louisville Department of Psychology. Salmon's work in 1990 titled "A Psychological Perspective on Musical Performance Anxiety: A Review of the Literature" is one of the earliest resources contextualizing and defining MPA. Salmon proposes MPA as a more appropriate term than terms like stage fright to characterize the generalized psychological distress that musicians report before and during musical performances. He defines MPA as: "the experience of persisting, distressful apprehension about and/or actual impairment of, performance skills in a public context, to a degree unwarranted given the individual's musical aptitude, training, and level of preparation" (Salmon 1990, 3). Importantly, MPA necessitates that the distressful feelings about a musician's performance ability do not match the musician's actual performance ability,

demonstrated in some shape or form in other performance and non-performance contexts like practice sessions and rehearsals. Salmon further specifies that MPA is a complex phenomenon that involves interactions of physiological, behavioral, and cognitive variables. Each variable presents differently: physiological variables present mostly in variations of the experience of physical arousal, behavioral variables in avoidance behaviors, and cognitive variables in fear-based predictions of future consequences/threat of failure, negative self-perception, and unrealistic expectations and beliefs (Salmon 1990, 5-7). Salmon suggests that interventions aimed specifically at each variable produce better results for overcoming MPA, rather than trying to address overall anxiety.

Dianna Kenny, referenced earlier for her work in Australia with pit and stage orchestra musicians, is also a major contributor to the development of our understanding of MPA, as seen in both of her works, “The Psychology of Music Performance Anxiety” and “Music Performance Anxiety: Theory, Assessment and Treat: Selected papers on music performance anxiety”. Kenny’s earlier publication written in 2006 entitled “Music performance anxiety, Origins, phenomenology, assessment, and treatment” provides an introductory lens to understanding necessary factors that lead to the development of MPA. Similarly to Salmon’s proposition of MPA being generated by an interaction of key variables, Kenny identifies the combination of these variables as responsible for MPA’s appearance particularly in early childhood: innate anxious temperament, inherent development of cognitive capacity and self-reflective functioning from childhood through adolescence, specific parental/interpersonal experiences in which consequences for poor performance are imposed, the individual’s interpretation and perception of the world, the individual’s

technical skill and mastery, and specific performance experiences with either positive or negative outcomes (Kenny 2006, 52). Kenny further describes an all-too-familiar experience for young musicians as an example of these variables at play: a home environment with low support for achieving excellence and high expectations of achieving excellence, and competitive environments in which frequent and early evaluations and self-evaluations of performances occur along with the individual's possible cognitive predisposition to anxiety. As these situations may be analyzed as a kind of social phobia, which also has roots in performance anxiety at large, MPA has as of 2013 been added to the fifth edition of the Diagnostic and Statistical Manual of Mental Illnesses (DSM-5) as a social phobia. Kenny further elaborates that researchers differ in their agreement as to the interaction of these variables; some researchers believe that performance anxiety is primarily a psychophysiological event rooted in the autonomic nervous system, while others maintain that symptoms of MPA are activated in majority by cognitive negative self-perception (Kenny 2006, 54). In all, while different researchers vary in their appraisal of the main contributors to the development of MPA, the existence of a variety of variables that seem to interact is agreed upon.

Given the similarities in stress environments that all performers face, it is no surprise that any demographic of musical performer can suffer from MPA. Kenny elaborates on the different ways that MPA can present in different categories of musicians, including child musicians, adolescent musicians, orchestral, and even operatic chorus artists – some demographics of musicians receive more or less support for their symptoms, different degrees of support and attention, and different presentations and

consequential effects based on the generalized differences between categories. For example, the socio-cognitive differences in development between child and adolescent musicians means that MPA leads to different behavioral patterns seen between children and adolescents (Kenny 2006, 57). This concept of demographic variability at large can be understood as the central premise for this study, and it is clear that continued research continues to demonstrate the significant differences between enclosed or nested demographics within musicians. In other words, musicians as a unique demographic is only one level of analysis, and continued demographic variability within the musician demographic seems important for further research. The more significant differences we find in experiences between nested demographics of the 'musician' category, the more targeted interventions may need to be developed.

Interventions and treatments for MPA for all demographics require considerable development and evaluation. Kenny provides a list of practices and their associated degrees of research depth and needs for validity: cognitive, behavioral, and cognitive-behavioral interventions, Alexander Technique, biofeedback, music therapy, hypnotherapy, meditation, beta-blockers, and medication. Cognitive-behavioral interventions, particularly in the form of cognitive behavioral therapy (CBT), currently show the most consistent positive effect on the treatment of MPA, though two caveats exist: out of all interventions listed, CBT has the most amount of research and practice for validity as an intervention for mental illnesses at large, and the scope/research parameters for each intervention listed varies to great degree (Kenny 2006, 64). Ultimately, all interventions listed would benefit greatly from further research.

Mental Health and Instrumental Conductors

To date, very little research has been conducted on the subcategory of instrumental music conductors, their mental health, and the impacts of poor mental health on their experiences as conductors. One research study in 2015 led by Victoria Jaque and her team sought to study the psychophysiological effects of performance of orchestral conductors; in it, researchers investigated the experience of two professional orchestral conductors. Utilizing self-report tests on experiences like anxiety, dissociation, shame, and fantasy proneness, and ambulatory physiological monitoring during a rehearsal and public performance, authors concluded that both mental and physical health are influenced in the engagement of musical conducting. High cardiovascular demands as well as high levels of anxiety were observed, along with a “hard” classification of work intensity based on physiological demands (higher than the classification of work intensity of walking up stairs). One conductor exhibited elevated anxiety and dissociative absorption, and both conductors had moderate levels of fantasy-proneness as well as high flow responses. As the authors state, this study cannot be generalized due largely to factors like small sample size, and replication of this kind of research design must be made to better understand both physiological and psychological conditions of instrumental conductors. Other than this study by Jaque with a very small sample size, there is no other research on conductor mental health.

Subcategories within the broader musician grouping are seen in some studies, such as Detari’s research on musicians of various genres, or Kenny’s classification of pit musicians vs. on-stage orchestral musicians. These kinds of studies demonstrate unique

challenges and stressors that subcategories of musicians face, such as oral health concerns and tooth movement of professional wind instrument performers (Czech 2024). There is high potential that researching the subcategory of instrumental conductors would do the same, given the unique experience instrumental conductors have relative to their sound-producing peers, and their distinct lack of an “instrument”. Due to the increased points of social contact that the role of the conductor entails, research on the psychosocial health of a conductor may be particularly salient and relevant. It stands to follow that if a conductor exhibits symptoms of poor mental health, they may experience direct impacts to their ability to engage in the psychosocial aspects of conducting, both socially and gesturally. Part three of this dissertation will discuss the foundational social elements that together with physical/gestural elements define the field of instrumental conducting.

Conclusion

The majority of published research on the mental health of classical musicians as a unique demographic with unique degrees and varieties of mental health issues has been completed within the 21st century. Research varies in both the categorization of classical musician studied (e.g. professional, student, conservatory, and pit orchestra musician), and the comparison group (e.g. general workforce, student to professional, physicians, medical students). The research does not seek to establish the classical musician category as having more mental health issues than other specific professions, but it does establish that when compared to the general workforce at large, classical musicians consistently score as having lower mental well-being. The depth of differences is multi-faceted and varied dependent on the categorization at hand – whether it be classical musicians at large,

orchestra musicians, adolescent musicians, professional Norwegian classical musicians, or child classical musicians, each category presents unique experiences and needs.

Music performance anxiety has been researched more extensively as a consistent experience across different musician categories, now included in broadly accepted medical referential material such as the DSM-5.

As research continues to be conducted and validated, our understanding of the type of negative mental health experiences classical musicians face will continue to grow. The mental well-being of musicians should be of concern to classical musicians themselves, but also for their teachers, families, educational administrators, mentors, and audiences, as all constituents are affected in some shape or form. For the overall well-being of these individuals, it is of utmost importance that further research continues and that accompanying interventions also are given serious attention.

PART TWO

Efficacy of Peer Recovery Work or Peer Support as a Mental Health Resource

The task of capturing the state of mental health among any population can be a daunting task, but a few key organizations and initiatives have conducted longitudinal research to help us better understand how trends on different mental health factors have changed over time. Mental health and mental wellness as concepts are broad categories that can be comprised of many different metrics, but organizations like the World Health Organization (WHO), the National Institute of Health (NIH), and the U.S. Department of Health and Human Services (HHS) have used some specific factors as indicators for mental well-being. These include suicidality, substance-use disorders, hospitalization rates, psychiatric visits to emergency departments, reported persistent feelings of sadness or hopelessness, Major Depressive Episodes (MDE), Adverse Childhood Experiences (ACE), and even the amount of time between the onset of mental health symptoms and treatment and delayed treatment.

Based on these metrics, a variety of existing longitudinal research has altogether shown a downward trend in mental well-being at large between 2007 and 2023, exacerbated by the global 2020 COVID-19 pandemic. According to one such longitudinal study by the National Vital Statistics System, a part of the Center for Disease Control and Prevention, national suicide rates among adolescents and young adults aged 10 to 24 in the United States significantly increased by 57.4% between 2007 and 2018 (Curtin 2020, 3). According to the CDC's Youth Risk Behavior Surveillance Data Summary and Trends Report covering 2013 - 2023, trends show a significant increase in percentage of youth who

seriously considered suicide, attempted suicide, or made a suicide plan, with an increase of 13% from 2019. Almost all indicators of health and well-being used in this report worsened significantly as well, including indicators like protective sexual behaviors, mental health, experiences of violence, and suicidal thoughts and behaviors (CDC 2024, 1). These concerning outcomes have prompted action by institutions like the U.S. Surgeon General Vivek Murthy, the World Health Organization, and the United Nations to make a number of different advisories, testimonies, and calls to action to address worsening mental health and diversify available resources for mental well-being and recovery. One such resource that has been specifically highlighted is peer support services, as seen in President Biden's recent 2023 State of the Union (White House 2023).

The different responses to recent calls to action by these notable agencies and organizations have led to increases in available resources for people in need of mental health services, with the peer support model receiving increasing amounts of attention, development, and even investment. According to Gagne, peer recovery coaching, as it is currently deployed in substance use treatment programs did not formally begin until the early 2000s, while formal peer support in mental health began in the 1980s in the form of drop-in centers and other consumer-run organizations (Gagne 2018, 259). A variety of iterations of peer support continue to become available, with equally varying levels of consensus as to what defines peer support. For this reason, programs and resources may look drastically different; thankfully, there is existing and growing research on the importance of defining and solidifying what peer support is, and what it is not.

Peer Support – Definitions, Boundaries, Parameters

Peer support goes by many names, including peer counseling, peer coaching, peer-to-peer work, and peer recovery work (PRW, as used in this dissertation). All focus on utilizing social learning theory and social support theory to increase feelings of self-efficacy, empowerment, engagement, feelings of hope, and confidence for healing. Often referred to as paraprofessionals, these peer support workers provide distinctly non-clinical services, and work most effectively in conjunction with other medical interventions that provide health and wellness resources. On college campuses and universities, peer recovery work exists in many different forms and shapes, including peer mentorship and peer advising. They can tackle broad issues like alcohol and substance use, sexual health, and continued college retention; nevertheless, these programs often do not qualify as peer support based on factors like lack of training and certification. In college music programs, very few peer recovery systems exist – the third chapter of this dissertation will aggregate collegiate programs offering health and wellness programming, including the only two programs that offer peer support services for music students specifically. For the purposes of consistency, this dissertation will continue to use the term “peer recovery work”, or PRW, interchangeably with “peer support” to denote the same thing.

Given that PRW utilizes the positive impacts of broad concepts like social learning and social support found in many different formal and informal practices, it can sometimes be hard to understand what constitutes PRW versus practices like therapy, friendship, family support, counseling, and even team-based competitive sports and athletics, all of which can involve social support and social learning. All peer recovery work necessitates

social support and social learning, among other key concepts to be discussed, but not all experiences that include social support and social learning can be defined as peer recovery work. However, the added complication that peer recovery models do not all abide and adhere to the same standards has made it more difficult and complicated to define boundaries, and therefore to initiate scientifically sound and valid research for its efficacy. Many universities offer services for undergraduate students that are labeled as “peer counseling”, but the degree to which these programs agree to elements like the rigor of required training varies significantly. Reputable organizations like SAMHSA and the WHO offer guidelines for best practices in PRW, but due to its relatively novel emergence, more research, practice, and iteration is necessary for consistent definitions to be accepted.

Definitions

Mutual support groups such as Alcoholics Anonymous and Narcotics Anonymous are commonly referenced examples of peer-led resources, where individuals with shared experiences with substance abuse gather, share, and discuss experiences and coping strategies. These support groups vary in subject matter, but all share the peer element – they are centered around individuals with a shared experience gathering to support each other.

SAMHSA, an agency within HHS, provides resources for different support groups including Alcoholics Anonymous; though they are not officially affiliated, their mutual mission of supporting individuals with substance abuse issues has set a precedent for how support groups can form and operate. Alcoholics Anonymous is sometimes thought of as a predecessor for modern peer support, but collaboration with SAMHSA has led to clearer

definitions of PRW that differentiates it from substance-focused support programs.

According to SAMHSA, peer recovery work are services that offer and receive help, based on shared understanding, respect and mutual empowerment between people in similar situations. Peer recovery workers “help people become and stay engaged in the recovery process and reduce the likelihood of relapse”; they “extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.” (SAMHSA 2024). Two foundational aspects of PRW mentioned are the peer element, and the recovery process – individuals with shared experience help each other experience sustained recovery.

Dr. Phyllis Solomon, Associate Dean of Research at the University of Pennsylvania School of Social Policy, defines PRW as “social emotional support, frequently coupled with instrumental support, that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change” (Solomon 2004, 393). Support includes facilitation of self-awareness, self-reflection, as well as promotion of self-efficacy over one’s life.

Solomon elaborates on five underlying psychosocial processes that further characterize PRW: social support, experiential knowledge, the helper-therapy principle, social learning theory, and social comparison theory. A distinct lack of testing for these psychosocial processes within peer support groups makes it difficult to substantiate them as consistent processes across the board – further research is suggested by Solomon. Nonetheless, these processes are inferred and observed informally from practicing peer support groups;

while they are not unique to peer support, the occurrence of all of these processes consistently characterize peer support.

Social support

Social support refers to the availability of people who can be relied on for positive emotional support and care – they are individuals who are willing and able to assist with resource and psychosocial needs (Solomon 2004, 394). These individuals offer emotional, informational, and instrumental support. According to Solomon, the presence of social support has been shown to contribute to “positive adjustment and to buffer against stressors and adversities, including medical as well as psychiatric problems”. The availability of PRW and peer support groups can provide individuals social support through its accessibility and reliability of peers. Social relationships in general function largely as sources of social support, and PRW may be thought of as a structured system of a process otherwise organically achieved. The reliability of having established peer workers dedicated to providing an individual support constitutes social support. Unlike informal relationships like platonic friendships where the availability of social support is unstructured, peer workers are available in a consistent manner.

Experiential knowledge

Experiential knowledge refers to the unique and specialized perspectives and information obtained by individuals who live through distressing experiences, psychological or not – this information allows individuals to offer validation and further foster choice and self-determination through the sharing of this unique knowledge (Solomon 2004, 394). Through the sharing of this experiential knowledge, a passive attitude

towards self-recovery that can develop in traditional clinical services can be counteracted, especially in clinical services with established hierarchical social structures. In the traditional clinical structure, doctors are sometimes seen as experts who work with patients who receive healthcare services – patients are seen deficient and in need of the expertise of someone like a doctor who holds the keys to their recovery. In peer support, individuals who interact with others with experiential knowledge feel empowered to play a more active role in their choices towards recovery. When individuals receive validation from peers, they feel more inclined to act upon shared specialized perspectives, or even to develop and discover their own experiential knowledge.

Helper-therapy principle

The helper-therapy principle refers to the idea that personal benefits are derived from effectively helping others; when positive feedback is received, helpers also become more experienced in effective strategies to help others, and receive an enhanced sense of self from the “social approval received for those helped” (Solomon 2004, 395). In practice, peer recovery workers are observed to experience feelings of increased self-confidence when they are successful in providing positive benefits to the peers they work with. The peer element of shared experiential knowledge extends to feelings of interpersonal competence as well; both the peer worker and the individual seeking peer support obtain a positive gain when PRW is successfully practiced.

Social learning theory

Similar to experiential knowledge, social learning theory (in the context of peer support) refers to the principle in which interactions with peers who are successfully

coping with illnesses and adversity are more likely to result in positive behavioral change for the individuals seeking support (Solomon 2004, 395). This occurs due to the perception of peer workers as more credible role models, because of their shared experience, perspectives, and knowledge. This positive interaction leads to an enhanced sense of self-efficacy in dealing with illness and adversity, along with the treatment system at large. Social learning theory tells us that people are more likely to experience positive benefits and recovery when they interact with others who they see themselves in, due to some element of shared experience. When individuals see themselves in peers who are successfully coping with their illnesses and adversity, they see a model of the possibility of positive change for themselves, leading to feelings of self-confidence.

Social comparison theory

Lastly, social comparison theory refers to the idea that individuals generally gravitate towards others who share commonalities with themselves – this inherent attraction establishes a sense of normalcy of the illnesses, adversities, or general experiences in question (Solomon 2004, 395). This process of attraction can happen both “upwards” or “downwards”; individuals may see their peers as models for growth, or they may see them as models for how bad things could be, both of which are useful for the recovery process. The feeling of normalcy that can occur can provide an open environment in which peers feel safe and willing to explore all aspects of their experience, thereby helping eliminate negative stigma towards certain illnesses or issues. This sense of normalcy gained from peer interactions can lead to a greater understanding of an

individual's experiences, as their experiences are no longer understood as taboo or associated as shameful.

Defining characteristics by practitioners

In 2018, researchers led by corresponding author Eilish Burke from the Institute of Mental Health in Nottingham, UK sought to gain the perspective of practicing peer support workers across the UK for definitions of peer support. Using a Delphi method to develop consensus, Burke's team conducted multiple rounds of questionnaire surveys populated by statements pertaining to defining elements of peer support, as generated from literature reviews and consultation with experienced peer support workers. Questionnaires were distributed in each round to UK peer support workers who gave ratings towards the validity of each statement, ultimately leading to consensus based on quantity of consistent rating per statement. Statements with observed consensus were grouped thematically as follows: acquiring and sharing knowledge, developing peer practice, empowering peers, encouragement and active support, meeting organizational requirements, modelling self-care and recovery, non-specific therapeutic competencies, prioritizing unique aspects of being a peer, promoting peer work values, and having role clarity and supervision. Consensus was also achieved regarding the benefits of PRW including improvement of well-being; however, no consensus was reached regarding any statements on personal costs to working in peer support (Burke 2018, 810).

These categorizations differ semantically to definitions provided by Solomon and SAMHSA, but similarities and agreement can be inferred. All three sources prioritize the peer element as a key definition of PRW such as sharing of experiential knowledge, social

learning theory and modelling self-care and recovery, social support and encouragement and active support, and the helper-therapy principle and improvement of well-being. Between SAMHSA and Burke's study, recovery and promoting values underpinning peer support both prioritize a person-centered approach to healthcare.

Burke's study also demonstrates the disparity between the large scope of work, skills, and competencies peer workers do, and the scope of work that definitions put forth by SAMHSA and researchers like Solomon produce – without a clear consensus between all participants in peer support, clear guidelines will continue to be difficult to develop and enforce on the field. The difficulty in differentiating between counseling/therapy vs. peer support work may be a result of the lack of clear consensus in research and practice as well, particularly when considering the consensus on non-specific therapeutic competencies that peer support workers in Burke's study signaled. Specifically on themes of personal cost, organizations may reference Burke's study to better understand the barriers towards developing peer support structures from the perspective of practitioners. All in all, a continued collaboration between peer support researchers and practitioners to “zero in” on what defines and separates PRW from other clinical and non-clinical practices is encouraged and needed. Clear, consistent, and agreed-upon guidelines will be pivotal in setting appropriate and achievable goals, assessing efficacy based on those goals, and setting clear expectations for what PRW should and should not entail.

Efficacy of PRW, and Research Limitations

Peer support's relative novelty as well as its fluid definitions have resulted in a predictably early stage of efficacy and outcome research. Most studies have taken place in

the last 25 years, and research studies continue to be designed and implemented to better capture the effects of implementing PRW. Given the massive depth of individualized experiences possible when considering the effects of poor mental health, PRW efficacy research has a long way to go in establishing any reliably consistent patterns of outcomes it can produce. This is not unique to PRW efficacy research, but to any clinical intervention efficacy research. Nonetheless, research continues to be published at high rates, and points to different observed positive outcomes when PRW is implemented. Research on limitations of existing efficacy research also exist and are presented here, signaling a strong awareness in the field for clear definitions and clear outcomes.

Engagement or "buy-in" to treatment services is an issue that health services across the board have and will continue to wrestle with as different interventions, services, and treatments are developed and introduced. Treatment effectiveness is separate from whether or not individuals are willing to engage in or sustain said treatments to begin with – a growing issue as the desire for quick, instant "magic pill" solutions becomes more and more persistent and pervasive. While many efforts have been successfully made on the national level to support healthcare parity and access, a low level of engagement due to negative perceptions about behavioral health conditions still remains (Gagne 2018, 259). In this issue specifically, PRW demonstrates early evidence for positive outcomes in both recovery and engagement in the recovery process.

Gagne's examination of different kinds of PRW integration in clinical or rehabilitation settings presents promising examples of the value of PRW on the issue of parity and "buy-in". Gagne elaborates on six distinct settings and the effect of integrating peer workers to

the service provided: integrated healthcare teams, crisis service teams, medication-assisted treatment for people with opioid use disorders, criminal justice settings, supported employment programs, and Assertive Community Treatment teams.

In integrated healthcare teams, peer workers often are found delivering wellness coaching services themselves or connecting patients as well as other team members to other health or community resources (as 'peer navigators') – their work contributes to the development and growth of the network of healthcare systems available in a specific area. Because integrated healthcare teams are often based in a physical location such as healthcare clinics, peer workers are often valued for their ability to expand accessibility outside of this physical environment (Gagne 2018, 260). When peer workers are successfully integrated in these healthcare teams, treatment and recovery can be experienced outside of clinical settings, thereby further improving recovery for individuals to more aspects of their lives outside of the hospital or clinic; recovery becomes more normalized and continuous.

Crisis service teams also employ peer workers to provide services for people with urgent behavioral health needs. While these peer workers alone do not provide clinical or medical care, they work together with nurses, social workers, therapists, psychiatrists, and other specialists to prevent or ameliorate behavioral health crises. The support provided by peer workers for individuals needing urgent care in cases like opioid overdose allows these crisis service teams mobility – bringing services bound to the hospital out to the community (Gagne 2018, 261). This portability that peer workers provide can bring services even to a person's home.

For people with opioid use disorders engaged in medication-assisted treatment, peer workers have been employed by medical providers to provide additional individual coaching and support. These peer workers also conduct support groups and develop educational content, leading to an increased effectiveness of medication-assisted treatments administered (Gagne 2018, 261). Gagne states that, through PRW, individuals engaging in medication-assisted treatment have been observed to better adhere to their treatments, as well as regain valued roles in their communities.

In criminal justice settings, peer workers serve as mentors and coaches for people with behavioral health needs, and particularly in helping people exiting jail or prison as they transition to community life – they provide support and accountability in setting and achieving goals for re-entry to life outside of prison (Gagne 2018, 261). These peer workers are often known as forensic peer specialists, and after receiving training, work in mental health courts, drug courts, veteran treatment courts, and other specialty courts that once again extend recovery and engagement to the immediate environment outside of clinics and hospitals for people with behavioral health needs.

Supported Employment Programs were developed in the 1990s to help individuals with mental health disorders (with or without substance use disorders) both acquire and retain employment, with individualized placement and support (IPS) programs as the most common model. IPSs have demonstrated a high level of research evidence for positive outcomes, including higher rates of competitive employment, fewer days to the first competitive job, more hours and weeks worked, and higher wages (Gagne 2018, 261). Individuals providing these employment programs are often trained peer workers

themselves; in conjunction with other team members, peer workers have demonstrated high levels of efficacy in research and practice.

Lastly, one of the earliest spaces in which PRW has demonstrated efficacy are Assertive Community Treatment teams. As defined by Gagne, "Assertive Community Treatment is an evidence-based practice that provides intensive services in the environments where people with severe mental illness live". These teams and this practice specifically focus on bringing treatment directly to individuals needing care, once again contributing to the decoupling of treatment and the physical space of a clinic or hospital. The integration of peer workers in these teams has led to an increase in outreach, engagement, and connecting people with severe mental illnesses to other resources in the community.

Gagne's work provides concrete examples of practicing mental health services that have integrated PRW, and resulted in concrete, associated benefits of this integration. Across these clinical/rehabilitation settings, peer workers seem to consistently extend the accessibility and engagement of services, leading to an increase in engagement in the self-recovery process when recovery is no longer understood as a clinic-specific process. Through PRW, peer workers effectively normalize the recovery process and contribute to increasing agency for individuals engaged in treatment, largely by bringing treatment and recovery to individuals directly. The many issues of healthcare access, often gatekept by factors like insurance, high costs, high demand and low supply, can therefore begin to be solved by models like peer support. PRW cannot replace clinical treatment, but through

effective integration, can improve access to, quality of, and recovery after treatment under the right circumstances.

Other researchers have also contributed to efforts in better understanding the impact of PRW – Matthew Chinman, professor of medicine at the University of Pittsburgh, clinical/community psychologist and research scientist within the Center for Health Equity Research and Promotion (a branch of the US Department of Veterans Affairs) has engaged in multiple research studies on the efficacy of peer support work. In one of his earliest studies, Chinman, Davidson, and colleagues' 1999 review of existing evidence for the impact of peer support concluded that PRW has shown effectiveness in: reduced inpatient service use, improved relationship with providers, better engagement with treatment, increased levels of empowerment and patient activation, as well as higher levels of hope for recovery. Another review of existing evidence by Chinman and another team of colleagues in 2014 concluded that the level of evidence of efficacy for different types of peer support was moderate, and that persistent methodological shortcomings existed necessitating further research and consensus on parameters for what defines peer support. Nonetheless, the review also noted that peer support workers were observed as better able to reduce inpatient use and improve a range of recovery outcomes when compared to professional staff (Chinman 2014, 434, 436). Other existing research on the perceived impact of peer support integration on various populations and settings include:

- a significant reduction of risk of relapse and improvements in community affiliation and supportive behaviors for clients recovering from substance addictions and homelessness (Boisvert 2008, 211-212)

- an average psychiatric hospital discharge time of 116 days earlier for individuals with chronic mental illness, and a significant decrease in hospital costs (Forchuk 2005, 561)
- lowered rates of Medicaid-funded hospitalizations, crisis respite use, and other health expenditures resulting in decreased hospital costs (Bouchery 2018, 1072)
- for people who experience serious and persistent mental illness, significantly greater improvement in ‘patient activation’ (or a patient’s ability to manage their overall health and recovery through their own knowledge, skills, and confidence), as well as some observed advantages in physical health related quality of life metrics such as physical activity and medication adherence (Druss 2010, 265-267)
- for a population of adults with serious mental illness who use alcohol, drugs, and a criminal justice history, a significant reduction of alcohol use over time as compared to a control group – for both the experimental group and the control group, drug use and criminal justice charges decreased significantly (Rowe 2007, 958-959)
- for individuals using hospital diversion services, a decrease in feelings of stigma due to mental illness, satisfaction or high satisfaction with quality of life, increased social activity and involvement, and feelings of more personalized and accessible mental healthcare (Bologna 2011, 278-282)

Regarding the rigor of scientific research on the efficacy and fidelity of peer support, Chimman reiterates in 2017 the importance of establishing a consistent research agenda to better understand the role and impact of PRW. Peer workers vary widely in the roles and

settings they are employed in, and qualitative descriptions of PRW lack grounding in established implementation science frameworks. Specific research agendas including a focus on empirical testing, more rigorous outcome studies, and replicable randomized control trial studies can help verify otherwise observed peer support fidelity and efficacy (Chinman 2017, 956-957). Other issues that arise include small sample sizes, inability to substantiate improvement of mental health on the peer support factor over other existing factors in a client's mental health improvement, social desirability bias, bias due to lack of blind studies, substantial variation between peer support structure study to study, and heterogeneity of disease based on factors like genetics, comorbidities, age, sex, and gender. As Lloyd-Evans Brynmor, professor of mental health and social inclusion at the University College London's Division of Psychiatry, outlines in his 2014 research review, continued research with more sound methodology is necessary, and peer support work must be implemented within the context of high-quality research parameters. Research continues to demonstrate positive health outcomes when different peer support systems are implemented, but these positive outcomes must be validated by robust and evidence-based research methodology.

In all efficacy research cited in this chapter, all researchers acknowledge Chinman and Brynmor's same concerns – a variety of significant limitations exist in peer support research and results must be further validated and replicated. As noted earlier, largely due to the novel nature of PRW, a lack of consensus remains that limits the application of rigorous scientific methodology. Without a clear agreement of what peer support is and is not, researchers cannot validate whether or not peer support works if peer support looks

so different case by case, demographic to demographic. It is worth noting, however, that efforts continue to be made to reach consensus and establish precise research parameters. As different PRW structures continue to be created and deployed, an accompanying amount of research on efficacy and fidelity must also be done for peer support to be validated as an effective mental health resource.

PART THREE

PEER SUPPORT IN MUSICAL PRACTICE: STUDENT HEALTH AND WELLNESS PROGRAMS, PEDAGOGICAL CONSIDERATIONS, AND IMPACTS FOR THE CONDUCTOR

The developing pool of research on musician mental health and well-being has thus far suggested that performing musicians, and particularly performing classical musicians, experience a higher amount of mental distress compared to the general population. The increased amount of mental health issues musicians face have been linked to several aspects of classical musicianship, including stressors in musical training and education, social challenges in the musical workplace, lack of support, and negative feelings towards career viability and success. Research continues to elucidate the specific sources and causes of reported observations of lowered mental well-being for classical musicians – as we learn more about what elements of classical musicianship may lead to worse mental health, we can be more and more specific with the appropriate and validated resource best suited to help. Nonetheless, a majority of the research currently focuses on establishing the outcome of poor mental health, rather than the causes. In the case that no established resources exist for a given mental issue, we may develop new resources altogether or seek other emerging modalities and systems to adapt for musicians, such as the peer support/peer recovery model. Peer support at large has gained increased attention and traction due to recent advocating by reputable entities internationally like the President of the United States, the U.S. Surgeon General, the WHO, the NIH, and HHS (as of the writing of this document before the Trump administration’s second tenure) - due to the widespread deterioration of mental (and physical) health as a result of the COVID-19 pandemic, an

increased effort has been made by nations worldwide for diversification of resources, interventions, and practices.

As referenced in part 2, PRW has only more recently been perceived as its own unique mental health resource with unique practices and desired outcomes despite its established uses and practices. Elements of modern definitions of PRW have been utilized throughout history in different ways, informally and formally, while programs with PRW as their core continue to be created, adjusted, and developed. Just like our understanding of musician mental health, continued research is required to further specify what PRW is and PRW isn't, in order for its practices to gain scientific validity for the positive outcomes observed. Consensus on what PRW in practice is, as well as what PRW seeks to achieve is pivotal for peer support programs to establish themselves as reliable and evidence-based practices.

Both musician mental wellbeing and peer support are therefore in relatively early stages in development and research. Nevertheless, the potential for peer support to lead to consistent positive outcomes for musicians as a unique demographic is clear and has been capitalized on in the United States by a few collegiate music programs. Peer support has shown effectiveness in creating a sense of community and normalcy of one's experiences, along with extending healthcare practices outside of the clinical space. Through its utilization of the 'peer' element, it also provides a resource for building recovery-based skills – skills, practices, and experiential knowledge to recover from specific adversities and issues. Meanwhile, classical musicians consistently report higher feelings of anxiety, depression, and stress compared to the general population, making

them a unique demographic with unique needs. Peer support's focus on the 'peer' element to normalize, destigmatize, and create community for demographics with unique needs could therefore be an effective resource. Peer support's ability to form communities based on shared experience may help with feelings of isolation that classical musicians can feel, and that likely contribute to elevated reporting of feelings of anxiety, depression, and stress. In the same way peer support has demonstrated success in improving recovery through community for groups like those dealing with substance abuse, technology addiction, and criminal activity, peer support may also prove effective for classical musicians.

It follows that classical musician, a population already perceived as being at greater risk for worse mental health, may be "first in line" to benefit from the development of new wellbeing programs and practices such as peer support. This chapter will outline a few ways that select music programs have already utilized peer support to address the mental wellbeing of classical musicians, as well as intersections between elements of peer support and instrumental conducting.

Peer Support and Music: Programs Offering Trained Peer Support Programming

The University of Michigan and its School of Music, Theatre, and Dance (SMTD) offers a Wellness Program that is currently in its 9th year of operation; it is one of the earliest programs in general to offer wellness resources for classical musicians. Piano faculty Dr. Paola Savvidou is the founder of the SMTD's Wellness Program – among her other duties as adjunct lecturer in piano and pedagogy, she serves as Wellness Initiative program manager. The following details were shared and discussed in a personal interview with Dr. Savvidou.

SMTD's Wellness Program's goals are to provide injury and mental health prevention services on-site within SMTD for students, staff, as well as faculty. Resources include a variety of programming, educational resources, accredited courses, screenings, asynchronous services, coachings, as well as a peer support network program. Wellness topics include hearing health, nutrition, neuromusculoskeletal health, as well as mental health wellness and through collaboration with departments such as the University of Michigan Medical School, Savvidou's work aims to localize and embed resources for the SMTD specifically. SMTD's on-site triage clinic includes a hand specialist, physical therapist, a certified wellness coach, as well as an embedded licensed counselor with experience in music. As these professionals are a part of the SMTD, students, faculty, and staff do not need to coordinate with the university's broader medical services; the on-site triage clinic provides its services specifically for performing artists. SMTD's Wellness Program is also engaging in policy development and research, providing systematic reviews on various physical and mental health topics and offering insights in various programs and wellness-related courses.

The SMTD Wellness Program's Peer-to-Peer Support Network provides networking opportunities where students meet individually to discuss different challenges and topics in their experiences as musicians. Students are paired with one another based by year, but from different departments, and receive free training from the University of Michigan's Eisenberg Family Depression Center on active listening, empathy skills, and existing wellness resources at the University of Michigan. These trained peer students meet at minimum twice per term, with optional larger gatherings for all participants to meet.

Students taking a wellness course (Wellness, Alexander Technique, or Yoga) are required to join the Peer-to-Peer Support Network.

The Peer-to-Peer Support Network program is in its third year since creation in 2021, which was largely in response to the effects of the COVID-19 pandemic. The program has grown each year, with its average currently at 25 to 30 students per semester. While students are required to meet at minimum twice per term, number of meetings average between 2 to 4 meetings per semester. A form currently exists as a way to gather feedback and data, though response rate is inconsistent – more formalized data retrieval methods are currently in development. According to Savvidou, responses and feedback for the program have been positive – participants report that having a peer supporter feels like an effective way to make new friends. Other reported effects include:

- a dedicated space to talk about wellness topics and the struggles and experiences of being in a collegiate program
- building a sense of reliable community and social networking
- opportunity to meet peers one would not normally meet, and a strong feeling of relating to each other's experiences

Topics that peers have shared as conversation points include: gender and sexual identity, imposter syndrome, loneliness, new environments and how to adapt, various stressors of pursuing a career in the performing arts, and stressors/strategies for practicing and performing. SMTD's peer support program places both individuals as each others'

trained peer support, rather than having a dedicated peer support specialist who meets with multiple individuals seeking peer support.

At Indiana University Bloomington's Jacobs School of Music, the Office of Wellness and Arts Health Initiatives (OWAHI) also offers a variety of resources to support the physical and mental well-being of its students. Based on data offered on their website, OWAHI aims to foster a reliable community of wellbeing tailored specifically for classical musicians, by cultivating partnerships with various organizations both within and outside of IU to bring to Jacobs School of Music students. Programming includes community drop-in sessions and events, a Speaker Series with experts providing workshops and presentations on various aspects of musician health and wellbeing, hearing health resources, financial wellness group coaching sessions, and peer-trained wellness coaching in individual and group settings. OWAHI also participates in outreach through performances in both local elderly communities and local hospital settings including the IU Health Bloomington Hospital. Current partners of OWAHI include the Office of Entrepreneurship & Career Development at IU, the Health and Wellness Committee within the Jacobs School of Music, Jacobs Performing Arts Medicine, and the IU School of Social Work.

Associate Professor of Music Education Dr. Frank M. Diaz serves as OWAHI Coordinator, as well as a member of the Health and Wellness Committee at Jacobs from which OWAHI was produced. The following data was discussed and shared in a personal interview with Dr. Diaz.

Founded as a response to the significant increase in student reported stress levels after the COVID-19 pandemic, OWAHI was proposed as an experiment to provide an alternative to outsourcing resources for music students or sending music students to departments outside of Jacobs. OWAHI's mission continues to be to create embedded wellness programs and practices so that students do not have to chase outside resources and compete for resources that are not aimed specifically for their experiences as music students. Through its various events and programs, OWAHI has engaged with about 800 students in the Fall 2024 semester. Through its partnerships and outreach work, OWAHI has become fully funded by outside donors.

OWAHI's peer support resource is its Wellness Coaching program, through partnership with the IU School of Social Work. Wellness Coaching provides individual coaching by trained senior undergraduate and graduate-level peers from the School of Social Work, addressing 8 broad dimensions of wellbeing: emotional, spiritual, intellectual, physical, environmental, financial, occupational, and social elements of overall well-being. Through this partnership, peer counselors gain practicum hours as part of their requirements from the School of Social Work. Peer counselors students of the School of Social Work and not music majors themselves, though all peer counselors are integrated in the variety of programming that OWAHI provides – they serve as coaches, and also provide community workshops and events, tabling events, and other outreach services for OWAHI. The Wellness Coaching program is currently in its 2nd year.

First sessions with OWAHI peer coaches involve an intake assessment to determine pertinent skills to work on, alongside any concepts that clients wish to discuss themselves.

Goals are set between peer coach and client to achieve for the following session, which typically occurs on a weekly basis. Clients determine how many sessions they want to commit to – one to four sessions per semester is the average session length. Peer coaches are available all semester for as many sessions as clients need. All sessions are free of charge to the client. Topics most often discussed include: social well-being and how to connect with others, emotional wellness and stress management, improving communication skills and relationship-building skills, and for international students, cultural differences and integration to the U.S. particularly in relation to community engagement.

Although no formal data collection currently exists, OWAHI has recently received approval for development of its research lab, intended specifically to investigate outcomes for various musician mental wellness resources like its Wellness Coaching program. The research lab, with plans to open officially in the 2025 academic year, will gather feedback on OWAHI program impact, understanding what makes students return to OWAHI programming, and what kind of students engage with OWAHI. According to Diaz, anecdotal feedback describes Wellness Coaching as making a positive and observable difference in clients seeking peer support. The continued dramatic increase in engagement with OWAHI at large seems to corroborate its success. Peer coaches report finding great value and satisfaction in their integration to the school of music as peers, as well as the convenience of being able to fulfill practicum hour requirements through OWAHI Wellness coaching.

At the Manhattan School of Music (MSM), the Student Affairs department offers a similar program in its International Peer Advisor that provides individual consultations from

a trained peer student for incoming international students. These peer students are current MSM students who receive a 3-hour training through the Student Affairs office and assist incoming international students to acclimate and familiarize themselves with MSM and New York City at large. As a part of a student leadership team, the international peer advisor corresponds with incoming students on a timeline through e-mail, providing pertinent information and programmed resources, along with meeting with incoming students virtually before their arrival. This data was gathered from MSM's public website.

The University of Oklahoma School of Music houses a student wellness initiative called "Breathe OUt" – like other wellness programs it offers resources, workshops, and events while outsourcing its mental health interventions to departments outside of the School of Music, including OU's Academic Life Coaching for all OU students. Within Breathe OUt, "Find a Music Buddy" and "Catlett Buddies" programs help connect peers with each other through informal mentorship and networking between new students and upper-level students, though evidence for training for peer mentors cannot be identified. Breathe OUt is led by Dr. Melissa Baughman, program coordinator and associate professor of music education (vocal). As noted in chapter 2 of this dissertation, the informal nature of training as peer support workers makes it difficult to validate the methodology and outcomes of their work. Nonetheless, programs such as Breathe OUt exist with the aim to support classical musicians and are continuing to grow and develop. A lack of formal training does not preclude a program from making positive impacts for a community of classical musicians. Breathe OUt's Catlett Buddies program also grew out of the perception of social isolation post-COVID-19 pandemic, and much of its feedback speaks

on the value of community it has built after the social impact the COVID-19 pandemic on OU School of Music community. This information was gathered from both the University of Oklahoma School of Music website, as well as the “Breathe OUT” facebook page.

Abroad in the UK, four foundational organizations in musician mental wellbeing exist: Tonic Music for Mental Health (and specifically its Tonic Rider program), Music Mind Matters, Music & Mind, and Help Musicians. While none of these organizations specialize in classical musician mental health exclusively, they all offer a variety of resources for any individuals working in the UK music industry, with a slight focus on professional popular musicians. These four organizations often collaborate with each other with their programming and resources, with practitioners and experts from each group leading different programs cross-organizationally. The following data was gathered from a personal interview and discussion with Dr. Adam Ficek and Jeordie Shenton, who both work in various capacities at Tonic Music.

Tonic Music for Mental Health, and its Tonic Rider program aimed for professionals in the music industry, offers peer support groups for free to any involved in the music industry. Led by Dr. Adam Ficek, a practicing musician and certified psychotherapist, these peer support groups are formed based on affiliation; currently, 5 groups exist including women in music, music producers, musicians with ADHD, Musicians’ Union members who are parents or carers, and an open group for all music industry professionals where the most diversity in music industry category exists. In 2023, a peer support group for classical musicians specifically operated but does not appear to be supported currently. However, each group category has included some classical musicians as participants, as none of the

groups are exclusive based on type of music practiced. These peer support group sessions are distinctly classified as non-clinical. Tonic Rider's peer support group is one of four levels of support that Tonic Music offers; the remaining three programs are therapeutic sessions, preventative workshops led by facilitators with experience in the music industry and mental health on topics such as substance-use awareness, acceptance commitment therapy skills, music performance anxiety, and emotional resilience, and training courses on topics like mental health, first aid, and suicide prevention.

Tonic Music peer support groups meet weekly for 6 weeks and are made up of 12 participants maximum. Interested participants are given a consultation appointment that serves as a screening process for their eligibility and fit for the peer support group program – along with a robust triage system designed by a team with a deep understanding of the UK's primary healthcare service provider the National Health Service (NHS), Tonic Music is able to direct participants to resources most appropriate for their needs. Healthcare provider systems at large in the UK do not contend with concepts like state-specific therapeutic practice guidelines and health insurance policies, allowing Tonic Music staff to more effectively and efficiently refer individuals to proper resources. Once participants are matched into the peer support group program, they take a survey at the beginning and end of the program as a form of data collection. Gathering specific psychometric data is not generally the focus; instead, feedback forms allow Tonic Music researchers to focus on the broad livelihood of participants during as well as after their time in the peer support groups. This form of data collection focuses less on whether or not peer support groups specifically lead to change within 6 weeks, and more on tracking the overall fluctuations of mental well-

being as participants report them, across all 4 levels of mental health support provided by Tonic Music. Once participants complete 4 sessions, they are able to join the open group for all music professionals, which runs indefinitely. Groups do not adhere to specific curricula; topics discussed emerge organically based on the composition of the group and what they decide to cover week to week. This allows each iteration to be unique and flexible. The peer support group program has been active for 2 years, with some individuals participating since the program's inception. In each iteration cycle, the program has been filled to capacity with the number and kinds of groups varying cycle to cycle. In accordance with Tonic Music's broader goals, many groups continue to meet outside of Tonic Music, extending their mental health work outside of the organization exclusively.

Some topics and positive outcomes that Tonic Music has observed include the building of a safe space supported by music industry professionals with equally robust healthcare experience. Safety due to contained relationships of the peer support groups is also reported – participants meet with other individuals they share experiences with, but do not have to interact with the same individuals outside of the groups. Participants feel they are able to leave all of their conversations in the group, and do not have to continue to contend with these issues in their working lives when they finish a session. The variety of participants that constitute each group also leads to an effective balance of relating to each other as music industry practitioners, while learning from the differences in each participant's more unique personal and musical backgrounds. The focus becomes the musician identity rather than the individual differences in musical genres, industries, or positions. Participants also have shared that peer support groups serve as a space to

negotiate industry-specific challenges that the general public do not understand – what Solomon may label as the social comparison theory active in practice.

Dr. Adam Ficek is also the founder of Music & Mind, an independent team of mental health professionals with personal experience in the music industry as performers, managers, stage production, etc. They offer independent consultation, coaching, content planning, research, continuing professional development, and educational support resources. Music & Mind also does not specialize in any particular genre of musician and does not offer peer support – though Dr. Ficek often partners with other leading organizations to provide peer support group sessions.

Music Minds Matter, a sister charity to Help Musicians, also provides resources for musician wellbeing and mental health. Its platform connects individuals to Help Musicians’ peer support groups, which are free and meet once a week for six weeks. These sessions are facilitated by individuals like Dr. Adam Ficek and other mental health professionals, though they are not intended to be clinical or therapeutic. They serve as open spaces for music industry professionals to meet and discuss their experiences. Music Minds Matter also offers a confidential help line that works to connect individuals to a counselor for further assistance. Lastly, Music Minds Matters engages in large-scale research and has focused on musician mental well-being research as well.

Discussion: Pedagogy, Conducting, Mental Health, and Peer Support

The University of Michigan’s SMTD and Indiana University’s OWAHI at Jacobs are two of the most developed and robust classical musician wellness programs that exist, and the only two programs found with trained peer support services. MSM’s International Peer

Advisor position also offers a type of peer support with a trained individual. As these programs continue to operate and iterate, it is pivotal that they also develop formal data collection methodology. The positive outcomes on musician mental well-being they are observing can be better validated and peer-reviewed with data retrieval methods that meet established scientific rigor. If programs like these can legitimize their outcomes through the same metrics that other peer support groups outside of classical music use, the case for peer support for classical musicians may gain even more traction as a positive and effective intervention for the worsening mental health of classical musicians internationally.

It seems pivotal nonetheless that more programs invest in the mental wellbeing of their constituents simultaneously with the development of formalized, peer-reviewed research methodology in the peer support space. A combination of “on-the-ground”, informed and monitored practice of peer support models with a commitment to staying current on peer support research literature can allow programs to continue their support for classical musicians in immediate need of help. The concurrent development of both fronts is key to developing an effective, reliable, and safe resource.

In regards to music pedagogy and conducting, the specific PRW models like ones employed at SMTD and Jacobs School of Music may not apply directly to rehearsal and performance spaces; maintaining clear boundaries between peer support work and musical performance is important for the value of both activities, and the blending of boundaries can introduce issues with conflicts of interest. However, drawing from specific elements of PRW to inform musical pedagogical practices may yield similar positive

outcomes towards the mental health and performance skills of an ensemble/musician. While the primary goal of a rehearsal may be to practice music as an ensemble, social interactions, cooperation, collaboration, etc. occur nonetheless, much in the same way as social interaction acts as a basis of peer support. Music-making in an ensemble setting is at its core a social act, and conductors as individuals with authority in an ensemble can utilize the social nature of their work to better mental wellbeing and even music-making itself. One 2024 qualitative, questionnaire-based survey study by Biasutti et al. exists in which 34 Italian choir conductors answered questions about their conducting experience in 2020 and 2021 during the COVID-19 pandemic and lockdown periods. In it, the theme of worsening mental health for conductors due to the loss of social interaction between conductors and choir appears anecdotally, demonstrating the inherent social element and value that conductors have in their roles (Biasutti 2024, 547). Otherwise, no research could be found specifically on the relationship between poor musician mental well-being and/or peer support and instrumental conducting, either from the perspective of the conductor or ensemble musicians; further research is necessary to corroborate what is otherwise a very common anecdotal connection.

An important core perspective that informs this capacity for principles of peer support and conducting to intersect is that the field of instrumental conducting involves a lot more than the traditional focus on gestural technique. The intention is not to devalue or replace the importance of gestural technical development, but rather to expand the general consideration of what instrumental conducting entails for its success, including elements like the social relationships a conductor has with their ensembles. Some research and

writing exists that seeks to specify different categorizations of instrumental conductors beyond just the gestural: Gustems, Calderón, and Oriola propose a link between leadership skills and musical conducting, citing skills such as personal dimensions, verbal level, legitimacy, emotional self-awareness, social awareness, social skills, and self-management as relevant for the musical conductor (Gustems et al. 2015). Chaffin writes in 2011 on the general experience of conducting as a multitask phenomenon – he explains the necessity of a conductor to be able to perform multiple tasks such as gesture, focus on mechanical elements like tempo, engage and connect with musicians, and analyze produced sounds relative to mental audio imagery of the score, concurrently. By reviewing relevant existing literature on cognitive psychological optimization of other multitask operations like airplane piloting and vehicle driving, Chaffin broadens the scope of what conductors do, beyond that of gestural technique. Alan Gumm’s work in 2012 categorizing conducting into six discrete functions is another perspective into how instrumental conducting extends beyond physical gesture, including distinctly social elements of conducting in the motivational and psychosocial functions he describes. Ultimately, these non-gestural elements are not intended to replace or supersede the pivotal nature of effective gestural technique. The research that does exist specifying what instrumental conducting entails already focuses on gestural technique – more research is necessary to validate everything else that affects and defines instrumental conducting.

A Conductor's Role Relative to Musician Mental Health and Peer Support Principles

Given my unique experience as a practicing instrumental conductor and certified peer recovery specialist, my perspective on what conducting entails in its full practice has widened considerably since I began my work in peer support. The technical, gestural aspects that occur on the podium are a large focus in conducting pedagogy, but the actual practice of conducting extends far beyond this physical element. As referenced in the introduction and by writers like Chaffin (2011), being a conductor is a switching of many different roles, with the gestural element one of many different duties a conductor performs. At the heart of being a conductor are elements of leadership, social influence, direction, and even administration, implying both power and responsibility over the ensembles we conduct. Because conductors have an increased number of points of contact with musicians within and outside of the rehearsal hall, it is incumbent on us to be informed and aware of the mental health of the individuals we are leading. Conductors must be proficient in the field of research regarding musician mental health and the unique experiences musicians face as an at-risk population, as they can have direct influences on musician mental well-being in positive and/or negative ways.

Conductors may be the best positioned to be advocates for the mental well-being of the musicians they work with. The unique peer position conductors hold between performing musicians and arts administrators allows them to serve as a medium between the two. They work directly with performing musicians and, as performers themselves, also engage with other directors, deans, administrative staff, and other non-performance centered leadership roles in ways that a performing ensemble member may not have

access to. Drawing from the concept of peerness and experiential knowledge, conductors can be understood as having a unique peer relationship with both musicians and administrators directly – they have unique experiential knowledge gained by working in both spheres and thus can advocate and educate either group to the other. Given this variable position, conductors have an opportunity that is relatively rare; the potential ability to contribute to the improvement of musician mental well-being. It is imperative that conductors utilize the kinds of privileges this unique peer relationship allows.

In organizational and administrative roles, conductors can be a positive resource for struggling musicians by advocating on their behalf. They can advocate for the development of more population-specific resources such as the peer support services found at the University of Michigan SMTD and Indiana University’s Jacobs School of Music. Both have demonstrated positive outcomes for student musicians struggling with mental health issues. Through research and outreach, conductors can act as stewards for their students and departments at large when collaborating with external mental health resources to bring services to students and peers, including organizations like Tonic Music and Music Minds Matter. Conductors can also support musician mental health by exploring peer support education to learn valuable evidence-based intervention skills and peer support perspectives. Conductors can serve as models for open communication through the utilization of peer support skills, ultimately educating and developing important communication skills for students. Other important actions conductors can initiate include collaboration with mental health organizations or university departments; seeking grants and other funding sources to support and develop novel peer support or mental health

programs; or engaging in research, advocacy, education, and promotion of better mental well-being in classical music. A conductor in any administrative leadership position can do much to support the well-being of classical musicians and can be particularly well equipped when informed by the research on musician mental health.

Social learning theory, as drawn from peer support, can also be utilized by conductors. Social learning theory, which refers to the idea that individuals are more likely to experience positive outcomes and change when interacting with others who have demonstrated and experienced that positive change themselves, is a vital consideration for directors of classical music programs in which individuals hold leadership positions, such as section leaders, concertmasters, and administrators. If a conductor has the authority to select leadership, social learning theory would assist in the selection of individuals with experience overcoming certain stressors in classical music, such as mastering difficult repertoire, instrument-specific technical challenges, balancing personal practice time with ensemble rehearsal time, performance skills like tuning as a section, and high technical ability as well. Many directors and conductors already formally and informally utilize social learning theory in their consideration of leadership; however, a more direct, informed, and intentional use of social learning theory may lead to even more effective leadership within an ensemble. If musicians have peers serving as leaders in whom they relate, trust, and share experiences with both socially and musically, their own wellbeing and musical experiences may improve. The opposite may be true as well – if selected leadership does not have any experiences with social or musical adversity, they may be less able to provide personally-informed support to the musicians they work with. Poor or ineffective

leadership may lead to an increase in feelings of stress or not feeling supported, leading to worsening mental health. Given the common practice of assigning leadership based on musical auditions, it is of great importance that conductors consider leadership assignment through the lens of mental health-conscious perspectives like peer support. Leadership studies exist demonstrating these concepts of socially informed leadership appointment leading to better musical and overall experiences in music (Warfield 2013, Cumberledge et al. 2024), but a peer support-oriented perspective can help conductors/directors maximize this principle.

Knowledge of musician mental health as well as peer support skills and concepts can also inform pedagogical practices. A conductor equipped with the knowledge that the musicians they are conducting may be suffering from symptoms of depression, anxiety, and high stress should adjust their pedagogical approach so as not to exacerbate the performer's mental health issues. For example, many students from the Husky Marching Band enroll in the University of Washington Campus Band during the winter quarters following the football season in the fall. These students are looking for continued opportunities to make music together during winter term, but also tend to be very worn out and stressed after having to set aside other personal and academic responsibilities in an effort to accommodate a demanding football season of repeated rehearsals, performances, and away games. With this unique knowledge drawn from my peer experience as a graduate assistant director of the Husky Marching Band, I saw great value in adjusting my pedagogical approach so as not to demand more or overwhelm these students, even if the musical settings were entirely different. In practice, this presented

itself as a greater attempt at more careful programming choice based on my perceived level of effort required given specific pieces, as well as cultivating rehearsal social dynamics that were less demanding and intense, and more encouraging and motivating based on where they felt they could give their limited effort and energy. Finding an effective balance of artistic integrity, performance eustress, and fulfillment in programming was and continues to be an important facet of conducting informed by peer support and awareness of musician mental well-being.

Through peer support skills like active listening and motivational interviewing, I was able to gauge how the ensemble was feeling, and adjust rehearsal intensity as well as rehearsal schedules, frequency, assignments, and practice expectations. As an educator and conductor, it was important to me to use my peer support skills to better understand the mental state of the ensemble and use that information to guide and inform my pedagogical, administrative, and even gestural practices. Through these practices, I observed that musicians seemed to feel more at ease during rehearsals, allowing greater flexibility to different pedagogical techniques, musical demands, and challenging repertoire. Their continued enrollment in UW Campus Band in the following quarters as well as the increase in membership altogether may have indicated they found value in their experiences with the ensemble, though more substantiated data retrieval would have better validated the positive effect that these peer support skills aimed to achieve. When considering research like Koops and Kuebel's 2021 study in which the theme of difficulty managing criticism from ensemble directors emerged as a consistent contributor to feelings of anxiety, depression, and stress among music students, it becomes even clearer

that conductors must be aware of the influence they have over their students' well-being. As leaders and role models, our choice of words, public-facing actions, demeanors and attitudes in interactions with others can have direct impacts on student mental health, a responsibility that must be informed through careful understanding of students' mental well-being. In these ways, the lens of peer support and knowledge of musician mental well-being are important skills that conductors must be familiar with to be even more effective leaders and educators for the ensembles they are responsible for.

Drawing from Gumm's work categorizing conducting into six distinct functions, a conductor can utilize the motivational and unrestrained tone functions in conjunction with an awareness of a musician's state of mental well-being to directly support a musician and their musical performance. Gumm describes the motivational function of conducting as the type of gesture that helps musicians "stay alert and responsive to the conductor at any point in the music... [by raising] the enthusiasm of gestures and facial expressions for no reason but to mentally engage musicians" (Gumm 2012, 45). While this descriptor implies a dynamic in which an expectation is placed on the musician to "pay attention" to the conductor, this function may be could alternatively be considered the responsibility of the conductor to engage with a musician to achieve the same goal – a direct connection from conductor to player to support and motivate them. A conductor with an awareness of the anxiety and stress that players may be experiencing when performing can engage in motivational gestures to help players feel safe, supported, and positively encouraged through sustained eye-contact, smiling, genuine and encouraging facial gestures to signify affirmation and support for the performer. This kind of positive motivation can help

performers feel less alone during practice and performance, giving them a stronger chance at feeling confident in the technical execution of a piece of music.

The unrestrained tone function of conducting can operate in a similar way. This function is defined as gestures “that lift, rise, float, hover, circulate, draw up, and round out... to counteract the restrictive downward pressure elicited by downbeats, the narrowing constraint of a dictated tempo, the inward closing off of a pinched cutoff, and other restrictive results of traditional gestures” (Gumm 2012, 46). In practice, this can look like drastically minimizing all gestures and giving musicians the freedom to engage with each other, rather than centralizing control on the conductor as the arbiter of time keeping, musical expression, or ensemble blend. By demonstrating relaxation, ease, and freedom with smooth, floating, and relaxed movements, conductors can model a sense of ease to counteract inherent feelings of anxiety and stress that can arise from a mindset of perfect technical execution of music. This kind of mindset can restrain musicians from producing characteristic sounds due to the expectation of having to “sound good” at all times – a burden that translates to stress and anxiety, and a decrease in mental well-being. Music at large can start to develop an association of perfection and negative consequences or punishments for not achieving perfection, which have been directly associated as symptoms of musical performance anxiety (Kenny 2006). These are direct instances where an informed mindset that considers a musician’s mental well-being can be addressed by thoughtful gestural choice. Ultimately, gesture on its own will not and cannot be relied on as a resource to improve musician well-being, but can be impacted and optimized by being aware of musician well-being.

The mental health of conductors is also a subcategory of musicians that may benefit greatly from peer support. Research in peer support efficacy has resulted in observed positive outcomes for unique populations through the optimization of peerness or shared experience in a social setting. It stands to reason that conductors as a unique population with unique experiences, stressors, and challenges would also benefit from a peer support group structure catered towards building a specialized community to share, discuss, and validate each other's struggles. As demonstrated by groups like Tonic Rider and Alcoholics Anonymous, a peer support group for conductors could help assist in gaining a feeling of normalcy of their struggles and even provide a space for learning and discovery from experiences shared by peers. A lack of research on conductor mental health also provides a strong impetus to develop peer support resources, which could provide relevant data to justify the need for more research and support for conductors altogether. Resources like peer support groups may help conductors overcome some of the mental challenges of conducting that much like other performing musicians, can hinder their well-being as well as musical performance.

These examples represent some of many possible ways a strong understanding of the values of peer support and musician mental health relate to instrumental conducting, in the variety of roles and responsibilities conductors accrue. As long as ensembles involve social interaction between peers, principles found in peer support will remain relevant and useful; as long as the conductor/director of an ensemble holds responsibilities over the well-being of the ensemble, they may find value in looking to peer support to address and contribute a positive influence towards musician mental health. Nonetheless, it is

important to note that asking conductors to become practicing peer support specialists for their musicians is not suggested– instead, utilizing some of the driving social principles and skills found in peer support structures to the social elements of rehearsal can help with declining musician wellbeing and effective musical performance.

Conductors can and should use their influence as leaders and directors to advocate for the development of resources for declining musician mental well-being, for which they have direct points of contact with. More research is necessary to substantiate and clarify the potential value of peer support elements for the conductor, both in relation to the field of instrumental conducting itself and for musician mental well-being at large. Qualitative survey studies assessing conductor’s experiences on the impact of poor mental health may also help set a foundation for the need for research, as it currently does not exist. At the very least, conductors should become more aware of and pay closer attention to the impacts and potential influence they have on the mental well-being of the musicians they interact in repeated and unique ways, as they have the capacity to be both a negative influence or a great support.

CONCLUSION

Currently, a few wellness programs exist with formalized peer support programs for classical musicians involving trained peer counselors. In the US, existing peer support programs are found primarily in collegiate music programs, as a part of a larger wellness department offering a variety of resources for student musicians. The University of Michigan's SMTD and Indiana University's Jacobs School of Music OWAHI both are on the forefront of structured PRW for classical musicians as an at-risk demographic. Other programs exist, both in the US and abroad, with a variety of training expectations, formats, and targeted demographics – these include programs like Tonic Music and Music Mind Matters in the UK who provide peer support groups for professionals in the UK music industry.

Classical musicians as a demographic with unique needs and experiences relative to their mental wellbeing must continue to be understood as a unique population. The pool of research is growing regarding the health issues that classical musicians face. However, the majority of existing research focuses on neuromusculoskeletal morbidity with a continued need for more robust, detailed, and structured study regarding classical musician psychological morbidity. The research that does exist continues to support the claim that classical musicians score lower on metrics of mental wellbeing, when compared to general population scores. As this field continues to grow, research aimed at understanding potential causes of these low mental wellbeing metrics may help healthcare practitioners and educators to design targeted interventions and resources for

these causes. The more unique to classical musicking the cause, the more unique of an intervention/resource/practice must be developed.

Peer support and PRW are also in early stages of development, especially in the grand scheme of wellness research. While a variety of research has been published demonstrating positive outcomes of peer support and positive correlations between peer support and improved mental health, research rigor and validity must be further developed. Definitions of what peer support is and is not must be agreed upon in order to work towards consistency and reliability in peer support efficacy research. Nevertheless, a combination of an urgent need for diversification of mental wellness resources for all, along with some preliminary research demonstrating promising improvements in mental well-being, have catapulted the peer support model closer to center stage in the landscape of wellness programming. More scientifically-sound research must be conducted concurrently with reiterations and executions of different peer support practices that already suggest their efficacy and relevance.

Conductors are not serving as mental health professionals, and thus are not directly responsible for the well-being of their musicians. Clinical and non-clinical mental health professionals should continue to bear this responsibility, but a greater understanding of mental health principles as they affect classical musicians is nonetheless pivotal for the conductor, given that they hold a unique position as directors with influence as well as performing musicians themselves. Adopting a lens of mental health, a conductor may better understand both their students and themselves, leading to more effective pedagogy and gesture, as well as positive mental health impact for the musicians they interact with.

The interplay of mental wellbeing and musicianship remains largely unstudied yet can be seen clearly when considering all-too-common experiences like music performance anxiety; research on measurable effects of poor mental health for musicians is likely a fruitful next step for a field that is nonetheless in its early phases. While it may be easy to take instrumental conducting and mental wellbeing as discrete concepts, they can and should be understood as being intimately connected – an element of instrumental conducting that also sorely needs further research and consideration.

The intention of this dissertation is to provide a foundational framework of information and a consolidation of research as a “launching point” for more study on the musical and health-related outcomes of poor mental well-being in conductors, much in the same way as peer support requires concurrent iteration and efficacy research. As long as a conductor is simultaneously an educator and/or leader, it behooves the conductor to become more proficient in understanding the mental health of their musicians, both for the sake of the musicians themselves, as well as the artistic value of the music itself.

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