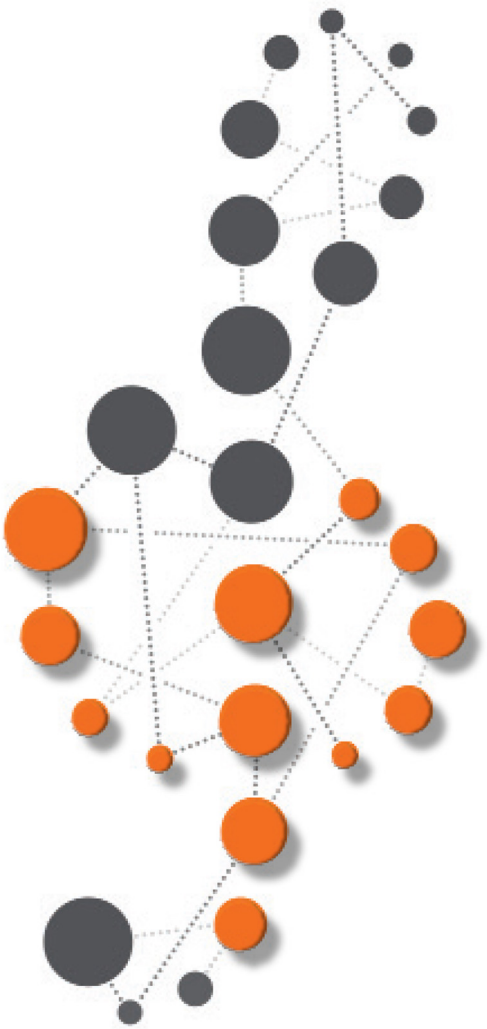
Psychological Perspectives on Musical Experiences and Skills

Research in the Western Balkans and Western Europe



Edited by
Blanka Bogunović,
Renee Timmers,
and Sanela Nikolić

https://www.openbookpublishers.com

ISBN Paperback: 978-1-80511-218-1

ISBN Hardback: 978-1-80511-219-8

ISBN Digital (PDF): 978-1-80511-220-4

ISBN Digital eBook (EPUB): 978-1-80511-221-1

ISBN HTML: 978-1-80511-223-5

DOI: 10.11647/OBP.0389

Cover image: Psychology & Music illustration/logo by Stefan Ignjatović, CC0 1.0
Cover design: Jeevanjot Kaur Nagpa

16. How do European and Western Balkans Conservatoires Help Music Students with their Health and Well-being?

Raluca Matei and Jane Ginsborg

Introduction

A large proportion of musicians, from students to professionals, experience problems with their psychological well-being and physical health. These include music performance anxiety (MPA) (see Chapter 15 in this volume), performance-related musculoskeletal disorders (PRMDs), noise-induced hearing loss (NIHL), and issues related to musicians' lifestyles. Problems such as these have been documented, investigated, discussed, and reported widely (e.g., Burin & Osório, 2016; Matei & Ginsborg, 2017, 2020; Rotter et al., 2020). The purpose of the present chapter is to consider the ways in which music higher education (MHE) institutions in Europe and the Western Balkans (WB) have begun to address musicians' health problems during their training so that they are able to prevent or at least mitigate them throughout their professional careers.

Like other schools, MHE institutions have the potential to be healthy settings, as defined by Dooris et al. (2010) and the World Health Organization (Wilkinson & Marmot, 2003). These settings (WHO, 2021) facilitate the implementation of policies and measures that respect social and cultural differences, and strive to improve the health of students, members of staff, families, and the community more widely. Furthermore, they provide health education and enhance health literacy, which enables individuals to obtain, interpret, and understand

 https://doi.org/10.11647/OBP.0389.16

health information and services, and develop the decision-making skills to make use of health information so as to improve or maintain their health (WHO, 2012).

By the middle of the first decade of the 21st century, health education programmes had begun to be introduced into MHE institutions (Manchester, 2007a,b,c). According to evaluations published in the peer-reviewed literature, such programmes have now been delivered to music students in Germany (Zander et al., 2010), Iceland (Árnason et al., 2018), the Netherlands (Baadjou et al., 2018), Spain (López & Martínez, 2013), the United Kingdom (Clark & Williamon, 2011; Matei et al., 2018; Matei & Ginsborg, 2022), Taiwan (Su et al., 2012), Canada (Barton & Feinberg, 2008), and the United States (Laursen & Chesky, 2014).

While courses varied in length, delivery, and the expertise of tutors involved, their content was generally broad, including information about the musculoskeletal system, risk factors and preventative strategies for PRMDs, healthy lifestyles, managing stress and anxiety, national guidelines, and reliable sources of health-related information. Somatic movement, the Alexander Technique, and the Feldenkrais Method were also taught. Preventing hearing loss was rarely addressed.

Aims

Given that it is likely that many other such courses are delivered without having been developed systematically, evaluated, or reported in peer-reviewed journals, we aimed to find out about these other courses in Europe and the WB and to compare them. We did so by administering two cross-sectional surveys consisting of an *ad hoc* questionnaire. We report the methods and results of the study and discuss its findings in the light of relevant published literature.

Method

Participants

Initially, the survey was administered to representatives of MHE institutions in 11 European countries. They were asked to respond with reference to health education-related initiatives that had been completed or were scheduled to take place in the academic year 2016–17. At the suggestion of the editors of this book, the survey was subsequently shared with representatives of MHE institutions in the WB, who were asked to respond with reference to similar initiatives completed or scheduled to take place in 2019–20. Representatives of MHE institutions included school administrators, course leaders, and other relevant personnel who reported having played a key role in designing, implementing, or evaluating a health education course.

Procedure

The original survey was created using Online Surveys (n.d.) and designed for distribution to the European Association of Conservatoires (AEC). Its members comprise 300 institutions in 57 countries (AEC, n.d.). The first author contacted 240 institutions in 38 countries within Europe via the AEC newsletter, individual emails sent to MHE institutions named on the AEC website between August and December 2017, and her own personal contacts. Ethical approval was granted by the Conservatoires UK Research Ethics Committee. The follow-up survey was administered in the form of a Word document. Respondents were recruited with the help of a researcher and music psychologist based in Serbia, who facilitated contact with 18 individuals at five institutions in Croatia, Serbia, and Slovenia. Ethical approval was granted by the Birkbeck Ethics Committee, University of London, UK.

Materials

The survey consisted of a preamble and 38 questions. It was designed to take 15–20 minutes to complete. It was explained in the preamble that health, in the context of the present study, referred to both mental

and physical health. Health education was defined as comprising 'consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health' (WHO, 1998, p. 4), and communicating information concerning the underlying social, economic, and environmental conditions impacting on health, as well as individual risk factors and behaviours, and use of the healthcare system.

In the survey itself, respondents were asked to provide demographic information; the name of the course; its aims and objectives; when it began and if it was continuing; whether and, if so, why it had been modified; if it was embedded in the curriculum; and whether it was compulsory. They were asked to nominate the stakeholders involved in the design of the course; list the theoretical assumptions on which it was based; identify its target audience; provide its duration and the frequency and size of classes. They were asked to describe the nature of the sessions; who delivered them and the topics covered; and to say how the course was assessed; whether it incorporated lectures and seminars; face-to-face and/or online; and the sources of information used in sessions. They were asked to report whether the course had been or was to be evaluated, and if so how and when; also, whether students' awareness, knowledge, perceived competency, and responsibility for health issues had been or was to be assessed. They were asked how qualitative and quantitative data were to be analysed and by whom; and how and to whom findings were to be disseminated. Response options included yes/no and multiple-choice answers, Likert-type scales and free text.

Respondents were asked to submit separate responses for each stand-alone or modified existing course, seminar, guest lecture, or other activity that was designed for educating music students and/or teachers about health and well-being as a primary strategy for promoting health, completed in or planned for 2016–17 (Europe) or 2019–20 (WB). The content of the data was analysed descriptively.

Results

Institutions

Twenty-one replies were received in response to the original survey (2016–17) from 17 European MHE institutions in 11 countries. Unless otherwise specified, one response was received from each of the following institutions: Austria: University of Music and Performing Arts Vienna; Belgium: Royal Conservatoire of Brussels; Royal Conservatoire, Antwerp; Finland: Turku Arts Academy; France: Pôle d'Enseignement Supérieur de la Musique et de la Danse Bordeaux, Aquitaine; École Supérieure Musique et Danse Nord de France, Lille; Germany: University of Music and Performing Arts Munich (two responses); University of Music, Drama, and Media, Hanover; University of Music Würzburg; Institute of Musicians' Medicine, University of Music Carl Maria von Weber, Dresden; Iceland: Iceland University of Arts, Reykjavik (two responses); Italy: Padua Conservatory of Music; Poland: The Grażyna and Kiejstut Bacewicz Academy of Music, Łódź; Sweden: Stockholms Musikpedagogiska Institut (two responses); Malmö Academy of Music; Switzerland: Zurich University of the Arts; Basel Academy of Music; and the Netherlands: Codarts, Rotterdam. Respondents at the Athens Conservatoire in Greece and Saint Louis College of Music in Rome, Italy, indicated that they did not offer any relevant programmes. Other respondents represented MHE institutions offering more than 20 programmes; they said it would be too time-consuming for an individual survey to be completed for each one, but did not reply when the first author offered a phone conversation instead.

Nine replies were received in response to the second survey (2019–20) from five institutions in three WB countries: Croatia: Academy of Music, University of Zagreb; Academy of Music, Juraj Dobrila University, Pula (three responses); Serbia: Faculty of Music, University of Arts in Belgrade (three responses); Academy of Arts, University of Novi Sad; and Slovenia: Academy of Music, University of Ljubljana. Of the 18 individuals contacted by the first author, six did not respond and four indicated that they did not have anything relevant to report. One response from Sarajevo was removed as it referred only to a course that had been delivered in 2018–19.

Course design

Their aims and objectives varied, but in both Europe (Survey 1) and the WB (Survey 2) courses aimed to raise awareness, help prevention, improve knowledge, prepare students for public performing, provide adequate training, and improve students' resilience. In Europe, courses had first been implemented between 1979 and 2017 (one in 1979, four between 1994 and 1998, and 14 between 2008 and 2017). Nineteen were ongoing and one had ended. In the WB, they had first been implemented between 2010 and 2019 (one each in 2010, 2015, 2016, and 2018, and three in 2019). Seven were ongoing and one was no longer being delivered.

In Europe, 17 courses had been modified while only the two implemented in 2014 and 2016 had not (two respondents did not know). Seven modifications involved providing opportunities for students to give feedback and evaluation; four involved introducing additional expertise from guest lecturers and course leaders; and three modifications concerned the use of current research. Two respondents also mentioned 'increased curriculum', and further modifications listed by individual respondents consisted of a new partnership between the conservatoire and the college of physiotherapy, the introduction of a stress-management course, a greater focus on prevention, 'increased emphasis on strength training', and [increased] 'resources available'. In the WB, three of the nine courses had been modified, in two cases to accommodate new research, and, according to three further individual respondents, to reflect students' needs, having to reduce the course, and the expertise of changing course leaders.

Seventeen of the 21 courses in Europe and eight of the nine courses in the WB were embedded in the school curriculum. Fourteen of the courses in Europe were compulsory, while the other seven were optional; two of the courses in the WB were compulsory, four were optional, and the remaining three were compulsory for some and optional for other groups of students. The first was compulsory only for students in the department of music pedagogy, the second was compulsory for students of music theory but not performance, and the third was compulsory for students of music theory, musicology, and music pedagogy but optional for students of vocal and instrumental performance, conducting, and composition.

In both Europe and the WB, representatives of three or four stakeholder groups contributed to the course design. In Europe, these included health professionals (17 responses); music teachers (16 responses); music students (12 responses); managerial staff (10 responses); researchers (eight responses); administrative staff (five responses); and a dance teacher (one response). One course had been designed exclusively by music teachers and another had been designed exclusively by music students. In the WB, stakeholders included health professionals (three responses); music teachers (two responses); music students (three responses); researchers (seven responses); and psychologists (three responses), but no members of the school's managerial or administrative staff.

Seventeen of the 21 respondents from MHE institutions in Europe and eight of the nine respondents in the WB agreed that the course was informed by explicit theoretical assumptions or a model. In Europe, two disagreed and two did not know, while in the WB only one disagreed. The numbers of responses to each category of assumptions and models listed are shown in Table 16.1. In Europe, individual respondents referred to the biopsychosocial model; the general salutogenesis approach combined with adaptations of models from the literature; current models of musicians' performance anxiety with reference to Kenny (2011) and literature on pain perception; and the Music in Health Settings model initiated by the European Research, Development and Innovation (ERDI) cooperation, 2011–13. Other sources of information (according to individual responses unless otherwise specified) included experience and knowledge from previous years (two responses); the course director or leader's expertise (two responses); the recommendations of the German Association for Music Physiology and Musicians' Medicine (DGfMM; two responses); team teaching; and the incorporation of sports medicine into the course on the assumption that musicians are comparable to athletes. In the WB, courses were designed according to the principles of Rational Emotive Behaviour Therapy (REBT) and Eric Berne's Transactional Analysis. Other sources of information included models of mental training for musicians (two responses); the professional experience of psychologists or course leaders working in specialist music schools (two responses); and research data.

Table 16.1 Theoretical assumptions and models informing course design

Theoretical assumptions	Europe $n = 17$	The WB $n = 9$
Somatic education models such as Alexander Technique, the Feldenkrais Method, or Body Mapping	10	2
Any set of assumptions based on published scientific articles on musicians' health and well-being	10	7
Any set of assumptions based on internal institutional data (e.g., surveys)	7	3
A known psychological model such as the Health Belief Model (or other similar models)	5	3
Recommendations made by the Health Promotion in Music Schools (HPMS)	4	0
Any set of assumptions based on opinions (of experts or not)	4	3
Any set of assumptions based on anecdotal evidence (i.e., evidence collected in an informal manner, based on personal testimony)	3	3
Other sources of information	9	2

Course delivery

In Europe, eight courses were offered to both undergraduate and postgraduate students, 18 only to undergraduate students, and 10 only to postgraduate students. Eighteen were offered to students of instrumental and vocal performance, and 17 to music education students. The longest courses took more than two years or lasted for one year (four responses each), although the majority lasted a term (five responses). Three single-day courses were reported, and one that took only an hour. Again, the majority of courses were delivered on a weekly basis (seven responses), every other week, once a month, or irregularly (two responses each), or once or twice a year. In the WB, four courses were offered to both undergraduate and postgraduate students, six only to undergraduate students, and five only to postgraduate students. Six were offered to all instrumentalists and nine to music education students. Although one course lasted a year, the majority took a term (six responses) and the other two consisted of a month-long course and a single event offered once during the year, respectively. The remaining seven courses were delivered weekly.

Six courses in Europe were delivered to small groups of up to 14 students, while five were delivered to larger groups, four to a

combination of small and large groups, and three, in addition to a combination of different-sized groups, to individual students. Twenty were delivered face-to-face while the other course included some online teaching as well. Delivery methods included lectures (six responses), seminars (two responses) and both (12 responses), together with other methods described as tutorials, demonstrations, and workshops. In 11 cases, courses were reported as including both theoretical and practical sessions. Eight were more practical than theoretical and four were purely practical. Of the nine courses in the WB, five were delivered to small and four to large groups; methods were described as lectures (four responses), seminars (one response), and both (four responses). Four courses were delivered face-to-face and five both face-to-face and online. Five were both theoretical and practical, two were more theoretical than practical, and two were purely theoretical.

In both Europe and the WB, courses were largely delivered by combinations of lecturers in different disciplines. In Europe, lecturers were described as musicians and/or music teachers (19 responses); physiotherapists (13 responses); health professionals (medical doctors, nurses, psychiatrists) (12 responses; other types of health professional listed in addition comprised an ear specialist, a medical doctor, a dietician, a speech and vocal therapist, a nursing lecturer, and a sports researcher); specialists in occupational and/or public health (10 responses; other specialists comprised a teacher of Dalcroze eurhythmics who specialised in ergonomics, a mental coach, a hearing specialist, a performance/presentation coach, a movement teacher/researcher, and teachers of Alexander Technique, Feldenkrais, breathing techniques, yoga, and Pilates/fitness conditioning); psychologists (seven responses); and researchers (six responses). One course was delivered only by music teachers and another by the Dalcroze teacher. In the WB, lecturers were described as musicians and/or music teachers (seven responses); psychologists (six responses); specialists in occupational and/or public health (four responses; others were described as a specialist in vibroacoustic therapy and a transactional analyst); health professionals (two responses; besides doctors, nurses, and psychiatrists, a music therapist, and trainer in Neuro-Linguistic Programming); and a physiotherapist. One course was delivered exclusively by music teachers and another exclusively by psychologists.

Course content

In both Europe and the WB courses covered a wide range of topics (see Table 16.2). The majority of courses in Europe covered anatomy and/or physiology, ergonomics, PRMDs, pre-performance routines, physical activity/exercise, mental skills, stress/stress management, performance anxiety and dealing with it, practice strategies and planning, and information on relevant health services within the institution, or within close geographical proximity. Most of the courses in the WB, however, only covered pre-performance routines, mental skills, stress/stress management, managing performance anxiety, practice strategies and planning, and mental health.

In Europe, course content relied primarily on staff knowledge and expertise (19 responses); textbooks or books, journal articles, and links to websites (13 responses each); and in one case, a compendium written by the teacher. In five cases, course content was derived exclusively from staff knowledge and expertise. In the WB, it was derived primarily from books (eight responses); journal articles (seven responses); staff knowledge and expertise, and links to websites (six responses each).

Table 16.2 Course topics

Course topics	Europe *n*	The WB *n*
Anatomy and/or physiology	17	2
Ergonomics	17	1
Performance-related musculoskeletal disorders (PRMDs) (including physical injury and the prevention and/or treatment of PRMDs)	15	4
Pre-performance routines	15	5
Physical activity/exercise	15	4
Mental skills	14	6
Stress and stress management	14	6
Performance anxiety and effective solutions for dealing with performance anxiety	13	7
Practice strategies and/or practice planning	12	7
Information on relevant health services within the institution, or within close geographical proximity	11	1
Mental health	10	5
Noise-induced hearing loss (NIHL) and use of hearing protection	10	1
Sleep	10	4
Nutrition	8	3
Memorisation techniques	8	4
Time management techniques	8	2
Alcohol abuse	7	4
Substance use	6	4
Smoking	5	4
Other	2	1

Course evaluation

The achievements of students on courses in Europe were assessed by written essays (seven responses); oral exams (five responses); both (three responses); and a range of other methods described in nine further responses: attendance, performance, multiple-choice tests, written health projects or examinations, questionnaires, and discussions with students. Student achievement in the WB was assessed by written essays (six responses); oral exams (five responses); both (four responses); and, in addition, a self-reflective diary and two book reviews ('very practical, [. . .] but not marked').

In Europe, 19 of the 21 respondents reported having collected or intending to collect student feedback via surveys and interviews to evaluate course effectiveness. Four reported administering questionnaires on behaviour change and health outcomes. Behaviour-change questionnaires, administered exclusively by two respondents, included the short-form 36-item (SF-36) health survey (Ware & Sherbourne, 1992) or were designed specifically for the course and/or as part of larger research projects. Health outcome questionnaires included the Pain Vigilance and Awareness Questionnaire (McCracken, 1997); Pain Catastrophizing Scale (Sullivan et al., 1995); Beck Depression Inventory (Beck et al., 1988); and an *ad hoc* questionnaire. In the WB, four respondents reported having collected or intending to collect student feedback via surveys (four responses) and interviews (two responses); none mentioned evaluating course effectiveness via questionnaires.

Table 16.3 displays the number of respondents in Europe and the WB that reported assessing students' perceived competency with respect to health risks associated with professional singing/playing an instrument; perceived responsibility for avoiding health risks associated with professional singing/playing an instrument; perceived awareness; and perceived/actual knowledge.

Table 16.3 Respondents' assessment of students' perception of various aspects of health risks behaviour

Students' perception — course outcome	EU *n*	How?	WB *n*	How?
Competency with respect to professional health risks	12	Via quality assurance, interviews and questionnaires, concerts and performances, seminar papers and personal feedback, and actual or planned research studies by the respondents or relevant staff.	1	Via exams, practical assignments, and seminars.
Responsibility for avoiding health risks	10	Via self-evaluations, interviews, feedback from instrumental teachers, reflective tasks, questionnaires, and scientific studies.	2	Via practical assignments and class discussions.
Risk awareness	10	Via students' resumés, observations and self-evaluations, questionnaires, reflective tasks, feedback from the students' council, and a research study on the effectiveness of the course.	4	Via the official university survey, discussions, and performance diaries.
Actual knowledge	9	Via quality assurance, questionnaires and seminar papers, observations, self-evaluations, seminar papers, and written tests.	6	Via examinations both oral and written, interviews, discussions on the practical application of techniques, and videos describing the individual music therapy sessions conducted.

Eleven of the 21 courses in Europe were (to be) evaluated when they finished; one course evaluation was in the process of being prepared for publication. The remainder were evaluated at different points in time, including before the course started and after it finished. Quantitative and qualitative data were analysed by members of the administrative staff in six cases, and by researchers in five; others involved in data

analysis included the faculty dean, vice-rector for didactic affairs, quality assurance officer, psychologists, teachers, and PhD students. Eighteen respondents reported that findings would be used to improve future courses, 13 that they would be disseminated to relevant stakeholders, and nine that they would be published. In the WB, five of the nine of the courses were evaluated when they finished, one throughout the course, and another through students' reflective diaries. Data were analysed in most cases by researchers and psychologists, but also by members of the administrative staff and PhD students. Again, seven respondents reported that findings would be used to improve future courses.

Discussion

While the 21 courses in Europe and nine in the WB had similar aims and objectives, focusing on raising awareness of health and prevention and improving knowledge, training, and resilience, they took various forms and were implemented with different degrees of rigour. It is notable that in the WB, courses on musical development, music therapy, and music pedagogy also included elements of health education.

Having been implemented earlier, courses in Europe were more likely to have been modified, but similar reasons for modification—new research, students' needs and feedback, and changes in course leaders and lecturers—were given in both regions. The vast majority of courses were embedded in the school curriculum. In Europe the majority were compulsory, but in the WB they tended to be optional. In both regions they were designed by several groups of stakeholders, but only in Europe did these include management and administrative staff. It may be particularly useful, when developing evidence-based initiatives for health education and promotion designed specifically for musicians, to take a multilevel approach involving an interdisciplinary team.

The design and content of most of the courses in both regions were based on psychological models, the findings of published research data, and in some cases internal institutional data. Somatic education models were reported by more respondents in Europe than in the WB, perhaps because practices such as the Alexander Technique, Feldenkrais Method and Body Mapping are more popular in Europe. In both regions, courses were designed largely for undergraduate

students of music performance and education, and delivered weekly over the course of a single term to different-sized classes, although some courses in Europe lasted one, two, or more years, perhaps because health promotion has been established there for longer than in the WB. While most courses in both regions were both theoretical and practical, there was an emphasis on the latter in several European, but not WB, courses. Particularly when initiatives are developed by non-musicians, it may be easier to rely on the published literature than to develop procedures for in-practice implementation of the research findings. In both regions, courses were delivered by a range of health professionals, occupational and public health specialists, psychologists, researchers, and musicians. More physiotherapists were involved in course delivery in Europe, while more psychologists were involved in course delivery in the WB. Perhaps as a result, course topics in Europe were more likely to include anatomy, physiology, ergonomics, NIHL and the use of hearing protection, while those in the WB focused on performance anxiety, stress management, mental skills, and strategies for practising and memorising. Local and institutional health services were also more likely to be mentioned in European courses, possibly because health education was introduced in the WB only relatively recently and some aspects of the wider infrastructure for health promotion (e.g., policies, services, and regulations) may be less well developed. In both regions, course content derived from books, journal articles, and website links, and was supported by staff knowledge and expertise.

Students' written essays and oral examinations were assessed, although they were also assessed on their attendance, contributions to discussion, and performances. Course effectiveness was largely evaluated using student surveys and interviews; only in Europe were questionnaires on behaviour change and health outcomes administered. Perceived or actual knowledge of health education outcomes was assessed at the end of most courses in the WB and in half of those in Europe; similarly, half of the European courses also evaluated students' perceived competency, responsibility, and awareness. Course evaluations were more likely to take place over time in Europe than in the WB. In both regions their findings were used to inform future improvements, but it was notable that they were more likely to be disseminated to relevant stakeholders, and also to be submitted for publication, in Europe.

Some limitations of the study should be acknowledged. The wide diversity of initiatives revealed by the survey data may be attributable to the invitation to respondents to refer to stand-alone or modified existing courses, seminars, guest lectures, or other relevant activities. Certain response options could have been specified more clearly; for instance, it could have been emphasised that 'links to websites' meant reliable sources of information only. Firm conclusions cannot be drawn as the response rate was low and there was a disparity between the numbers of respondents in the two regions. It will be interesting and useful to learn more about the MHE institution curricula more generally, for comparison with approaches to health education.

A division can nevertheless be observed, from the survey findings and respondents' informal comments, between the MHE institutions where health education programmes are well integrated into institutional approaches to music education and the curriculum, and those where they emerge from the intuitions of particular teachers. It would seem more responsible to develop 'best practice' on the basis of the available evidence, while recognising that this is often inconclusive or lacking.

Performing to the highest standards is essential for musicians' well-being, as well as that of their audiences; accordingly, musicians should be taught pre-performance routines, body awareness, relaxation techniques, and mental/psychological skills. It is also important to raise their awareness of NIHL and use of hearing protection, as well as health-related behaviour change techniques they can implement in their daily lives (Matei et al., 2018; Matei & Ginsborg, 2020). They should have opportunities to learn from role models and to discuss health-related topics. Music teachers should be trained in musicians' health and MHE institutions should be able to refer students to relevant health services such as counselling.

Given the complex nature of health education, the most effective strategies for designing programmes and curricula are likely to involve multidisciplinary networks discussing potential solutions and recommendations (Matei & Phillips, 2023a,b). Local resources are invaluable in the development and implementation of individual health education initiatives, but they should also make use of guidelines specifically designed for music MHE institutions that are sufficiently flexible for new ideas to be incorporated and experiments undertaken

so as to encourage health promotion in MHE institutions more broadly. One set of broad guidelines has already been developed; this is a list of consensus-based recommendations emerging from the Health Promotion in Schools of Music (HPSM) project in the US, which aimed to incorporate health promotion within the professional training of musicians. The recommendations included adopting a health promotion framework; developing and offering an undergraduate occupational health course for music majors; educating students about hearing loss as part of ensemble-based instruction; and assisting students to engage actively with health care resources (Chesky et al., 2006). More recently, Healthy Conservatoires in the UK has adopted the healthy settings approach (WHO, n.d.), aiming to adapt available best practice to the domain of the performing arts in the context of higher education (Healthy Conservatoires, n.d).

Conclusion

As in Europe, health education is increasingly being provided in music MHE institutions in the WB. This is encouraging. The enhanced development of a curriculum for health and well-being requires a multidisciplinary, multilevel approach, embedded in musicians' access to a network of services, healthcare professionals, and forms of prevention, mitigation, and treatment, where theory is combined with practical implementation and continued development. Such guidance will need to be multilingual, culturally sensitive, and offer long-term development.

References

Árnason, K., Briem, K., & Árnason, Á. (2018). Effects of an education and prevention course for university music students on their body awareness and attitude toward health and prevention. *Medical Problems of Performing Artists, 33*(2), 131–136. https://doi.org/10.21091/mppa.2018.2021

Association Européenne des Conservatoires, Académies de Musique et Musikhochschulen (AEC). (n.d.). *Our members*. https://aec-music.eu/members/our-members/

Baadjou, V.A.E., Verbunt, J.A.M.C.F., van Eijsden-Besseling, M.D.F., de Bie, R.A., Girard, O., Twisk, J.W.R., & Smeets, R.J.E.M. (2018). Preventing musculoskeletal complaints in music students: A randomized controlled trial. *Occupational Medicine, 68*(7), 469–477. https://doi.org/10.1093/occmed/kqy105

Barton, R., & Feinberg, J.R. (2008). Effectiveness of an educational program in health promotion and injury prevention for freshman music majors. *Medical Problems of Performing Artists, 23*(2), 47–53. https://doi.org/10.21091/mppa.2008.2010

Beck, A.T., Steer, R.A., & Garbin, M.G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8*(1), 77–100. https://doi.org/10.1016/0272-7358(88)90050-5

Burin, A.B., & Osório, F.L. (2016). Interventions for music performance anxiety: Results from a systematic literature review. *Archives of Clinical Psychiatry, 43*(5), 116–131. http://dx.doi.org/10.1590/0101-60830000000097

Chesky, K.S., Dawson, W.J., & Manchester, R. (2006). Health promotion in schools of music: Initial recommendations for schools of music. *Medical Problems of Performing Artists, 21*(3), 142–144. https://doi.org/10.21091/mppa.2006.3027

Clark, T., & Williamon, A. (2011). Evaluation of a mental skills training program for musicians. *Journal of Applied Sport Psychology, 23*(3), 342–359. https://doi.org/10.1080/10413200.2011.574676

Dooris, M., Cawood, J., Doherty, S., & Powell, S. (2010). *Healthy Universities: Concept, model and framework for applying the health settings approach within higher education in England. Final project report*. Healthy Universities. http://www.healthyuniversities.ac.uk/wp-content/uploads/2016/10/HU-Final_Report-FINAL_v21.pdf

Healthy Conservatoires. (n.d.). *Wellbeing framework*. https://healthyconservatoires.org/framework/

Kenny, D.T. (2011). *The psychology of music performance anxiety*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199586141.001.0001

Laursen, A., & Chesky, K. (2014). Addressing the NASM health and safety standard through curricular changes in a brass methods course: An outcome

study. *Medical Problems of Performing Artists, 29*(3), 136–143. https://doi.org/10.21091/mppa.2014.3029

López, T.M., & Martínez, J.F. (2013). Strategies to promote health and prevent musculoskeletal injuries in students from the High Conservatory of Music of Salamanca, Spain. *Medical Problems of Performing Artists, 28*(2), 100–106. https://doi.org/10.21091/mppa.2013.2018

Manchester, R.A. (2007a). Health promotion courses for music students: Part 1. *Medical Problems of Performing Artists, 22*(1), 26–29. https://doi.org/10.21091/mppa.2007.1006

Manchester, R.A. (2007b). Health promotion courses for music students: Part 2. *Medical Problems of Performing Artists, 22*(2), 80–81. https://doi.org/10.21091/mppa.2007.2017

Manchester, R.A. (2007c). Health promotion courses for music students: Part 3. *Medical Problems of Performing Artists, 22*(3), 116–119. https://doi.org/10.21091/mppa.2007.3025

Matei, R., Broad, S., Goldbart, J., & Ginsborg, J. (2018). Health education for musicians. *Frontiers in Psychology, 9*, Article 1137. https://doi.org/10.3389/fpsyg.2018.01137

Matei, R., & Ginsborg, J. (2017). Music performance anxiety in classical musicians—what we know about what works. *British Journal of Psychiatry International, 14*(2), 33–35. https://doi.org/10.1192/s2056474000001744

Matei, R., & Ginsborg, J. (2020). Physical activity, sedentary behavior, anxiety, and pain among musicians in the United Kingdom. *Frontiers in Psychology, 11*, Article 560026. https://doi.org/10.3389/fpsyg.2020.560026

Matei, R., & Ginsborg, J. (2022). Health education for musicians in the UK: A qualitative evaluation. *Health Promotion International, 37*(2), daab146. https://doi.org/10.1093/heapro/daab146

Matei, R., & Phillips, K. (2023a). Critical thinking in musicians' health education. Findings from four workshops with experts (Part I). *Health Promotion International, 38*(2), daac187. https://doi.org/10.1093/heapro/daac187

Matei, R., & Phillips, K. (2023b). Health education in conservatoires: what should it consist of? Findings from workshops with experts (Part II). *Health Promotion International, 38*(1), daac179. https://doi.org/10.1093/heapro/daac179

McCracken, L.M. (1997). 'Attention' to pain in persons with chronic pain: A behavioral approach. *Behavior Therapy, 28*(2), 271–284. https://doi.org/10.1016/S0005-7894(97)80047-0

Online Surveys. (n.d.). https://www.onlinesurveys.ac.uk/

Rotter, G., Noeres, K., Fernholz, I., Willich, S.N., Schmidt, A., & Berghöfer, A. (2020). Musculoskeletal disorders and complaints in professional musicians: A systematic review of prevalence, risk factors, and clinical treatment effects.

International Archives of Occupational and Environmental Health, 93, 149–187. https://doi.org/10.1007/s00420-019-01467-8

Su, Y.-H., Lin, Y.-J., Tang, H.-Y., Su, M.-J. & Chen, H.-S. (2012). Effectiveness of an e-learning curriculum on occupational health for music performers. *Telemedicine and e-Health, 18*(7), 538–543. https://doi.org/10.1089/tmj.2011.0215

Sullivan, M.J.L., Bishop, S.C., & Pivik, J. (1995). The Pain Catastrophizing Scale: Development and validation. *Psychological Assessment, 7*(4), 524–532. https://doi.org/10.1037/1040-3590.7.4.524

Ware, J.E.Jr., & Sherbourne, C.D. (1992). The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection. *Medical Care, 30*(6), 473–483. https://doi.org/10.1097/00005650-199206000-00002

Wilkinson, R., & Marmot, M. (eds). (2003). *Social determinants of health: The solid facts* (2nd ed.). World Health Organization. https://iris.who.int/bitstream/handle/10665/326568/9789289013710-eng.pdf?sequence=1&isAllowed=y

World Health Organization (WHO). (n.d.). *Healthy settings*. https://www.who.int/teams/health-promotion/enhanced-wellbeing/healthy-settings

World Health Organization (WHO). (1998). *Health promotion glossary.* https://www.who.int/publications/i/item/WHO-HPR-HEP-98.1

World Health Organization (WHO). (2021). *Health promotion glossary of terms 2021*. https://www.who.int/publications/i/item/9789240038349

Zander, M.F., Voltmer, E., & Spahn, C. (2010). Health promotion and prevention in higher music education: Results of a longitudinal study. *Medical Problems of Performing Artists, 25*(2), 54–65. https://doi.org/10.21091/mppa.2010.2012