Research Symposium

Every year this event brings together academics and researchers studying areas relevant to the work of STARTTS to ensure it is informed and guided by the latest developments in the field of refugee trauma, ranging from advances in neuroscience to new findings in clinical implications, interventions and outcomes. This year BONNIE McCONNELL, author and senior lecturer in Ethnomusicology at the Australian National University's School of Music, spoke about the positive effects of music on mood, social connectedness, sense of belonging, health and wellbeing of refugees. Deakin University sociologist, author and Professor ANGELA DEW, delivered a presentation on four conceptual frameworks used in her research about the experience of disability over time and place in people fleeing traumatic conflict situations, illustrated by two case studies.

The role of music engagement in supporting refugee health and wellbeing

McConnell: First I will provide an overview of research on music in the context of refugee trauma and the migration experience; then I will talk about the findings from our current research on music and perinatal mental health – on how music can improve the mental health of migrant and refugee women during pregnancy and after childbirth.

The Musical Care International Network brings together researchers and practitioners from various disciplines and cultural contexts, to focus on the role music plays in supporting developmental or health needs in the course of a life. I will discuss how music works as a form of care, as well as some interdisciplinary and intercultural perspectives on musical care.

There is a substantial body of research investigating the role music plays in the experience of displacement and resettlement of refugees and asylum seekers. It shows music can be really important in allowing people to maintain a sense of continuity, a sense of identity and social connection as they transition to a new place of residence.

From a broader perspective in the life histories that people tell, music can sometimes be a lifeline. Refugees are not able to bring many material possessions with them, but they can bring aspects of intangible culture, music in particular. Research has demonstrated music can provide a way to express aspects of the migration experience that may not easily be expressed in words. It can also provide a space to integrate different cultural elements in new ways, to negotiate the identity shifts that can accompany migration.

In this presentation, "music" refers to a range of different cultures and styles of music-making as well as different modes of engaging with sound as an expressive practice. A systematic review conducted by Gabriella Bernard and Abbie Dvorak in 2023 showed the benefits that result from engagement with formal music programs in the healing process; this included community-based music making, individual music-making or simply listening. It is not a one-size-fits-all approach. The terms music can refer to all types of engagement. It may be facilitated by a trained therapist, perhaps a trained music therapist with special skills, by a teacher or other professional, by refugees themselves within communities, families or individuals.

An important point is that it's not a top-down approach, but rather it is already a part of the culture, an accessible resource for people to draw on when they experience challenges. What are the potential benefits for refugee health and wellbeing? What are the outcomes? What is the evidence?

A systematic review conducted by D. Henderson and colleagues published in 2017 identified four thematic areas for outcomes of music participation for at-risk migrants and refugees. The first was social wellbeing. Research shows music can trigger a positive sense of social identity and pride, as well as connection with others. The second area was stress reduction, which has multiple aspects – the review discusses it primarily in relation to communication and the way music can support the development of language skills and at the same time provide an alternative non-verbal form of expression. The latter can be really important when people are learning an unfamiliar language or may not be able to express themselves fluently. Enhancing mental health was third. This is a strong theme in the literature. The review connects this to the way music can increase self-esteem, self-confidence and facilitate empowerment. The final theme, improving emotional health, was also widely discussed, but the review's specific focus was on the way music can support the expression of grief and help participants to negotiate and cope with challenging emotions.

Narrowing the focus specifically to refugee trauma, a systematic the review by Bernard and Davojak that I mentioned identified both the psychological and behavioural outcomes of music engagement: the former included improved coping strategies, wellbeing, sleep, and decreased trauma symptoms, and among the latter were improved emotional expression, interactions with others and decreased behavioural difficulties, hyperactivity and weeping.

As an example of the ways in which refugees may use music in their own lives, a study conducted by Kathryn Marsh examined the role of musical play for refugee children in Australia, in the UK and US. Her work has examined structured music programs for refugee young people as well as informal musical play, such as might happen on playgrounds or outside structured sessions. This research shows music provides a bridge between old and new forms of belonging. It can connect

to children's home cultures, or to the culture of their new homes, or it may allow them to experiment bringing the two together. The flexibility and adaptability in music is an important aspect of this kind of play, enabling children to navigate changes in their lives.

A contrasting example and an unusual one in the research literature comes from K. Boswall and Al Akash, who worked with Syrian refugees in Jordan, examining the way women's informal, self-administered music listening provided a means of emotional expression. They write that the process of listening to the songs on the women's mobile phones stimulated emotional conversations, triggered memories and provoked storytelling, and much laughter and tears. Many explained they would feel better after listening to the songs and recordings. "They make us sad, but then afterwards, it's as if the sadness is lifted for a while," one said. Such examples show that music is used in varied ways by refugees themselves and by program facilitators to improve health and wellbeing.

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What principles should inform facilitation of music-making with migrant and refugee individuals and communities? The following are based on my long-term research with reference to the literature as well as principles of trauma-informed care.

The first principle is using a strengths-based approach, one of the overarching values that underpin this work, where music engagement and facilitation are based on an understanding of the individual's inherent musicality and strengths, rather than imposing a predetermined idea of what music should sound like, what is excellent music, or what music is worth engaging in.

The second point is cultural humility, which means it is essential to recognise, appreciate and understand cultural diversity in music and to enable participants to be active agents rather than passive recipients of a musical intervention, collaboration and reciprocity.

This links in with the strengths-based approach. Musical care should be approached as an activity done with and not to other people, but with a ground-up rather than a top-down approach.

Cultural and historical understanding: Musical genres and practices have particular cultural and historical associations that will shape how people hear them, how they respond to them and how they experience the music they are participating in. It is important to understand not just the sounds themselves and how to create music, but the context behind those sounds and what meanings are attached to them in the place of origin.

The next point is about gender and power. Musical styles and instruments are often highly gendered. This means they may have a strong association with masculinity or femininity, with performances only by men or only by women. Some participants may feel included, others excluded, so it is important to consider the dynamics of gender and power to understand who feels comfortable engaging in the particular form of music making. This may not always be spoken or openly acknowledged. Yet such dynamics are not fixed. In some cases, people may want to take on musical practices that have historically been associated with a different gender from their own.

Empowerment, voice and choice constitute another principle which, aligns again with the strengths-based approach and is an important principle in trauma-informed care more broadly. Music facilitation should empower participants to express themselves and have agency in their musical and cultural lives. Finally, we must recognise that not all music helps. There are examples of music interventions that can cause harm, particularly when they are imposed without adequate cultural understanding or without adequate protections to ensure the safety of participants. There are cases of music facilitation being profoundly disempowering if it is based on culturally-specific ideas about musical expertise and excellence, with the unintended impact of making people feel less able to be musical in their lives. This is another connection to the need for a strengths-based approach and starting from an understanding of participants' inherent musicality and cultural agency.

The CHIME Project (Community Health Intervention through Music Engagement) for perinatal mental health is inspired by my work in The Gambia

and South Africa, where I worked for a number of years. Tailored to the Australian context, its aim is to improve the perinatal wellbeing of migrant and refugee women in Australia through community-led music engagement to improve mental health in pregnancy and after the birth of the child.

The perinatal period is a critical time for health issues for the mother, her child, her family and the wider community. One in five mothers in Australia experiences perinatal depression or anxiety, with higher rates among mothers from refugee backgrounds. Research conducted by J. Rees and colleagues in 2019 found that pregnant refugee women have higher rates of major depressive disorder – 32.5 per cent, against 14.5 per cent of Australian-born women.

Our policy brief from the Multicultural Centre for Women's Health, released in 2022, states that there is an urgent need to create more gendered, culturally-appropriate and equitable perinatal mental health services for migrant and refugee women. It says the compounding effects of displacement- related trauma, resettlement processes and greater social and economic disadvantage have negative impacts on perinatal mental health outcomes among migrant women. This aligns with the findings of our research that suggest there is a gap in support – organisations focused on supporting perinatal mental health are not always effective in engaging with migrant and refugee parents, whereas organisations that support migrant and refugee families do not always have tailored perinatal programs.

The CHIME project aims to improve perinatal wellbeing of migrant and refugee women in Australia, using a co-design approach to program development emphasising the importance of culture and context. It is based both on an understanding that music is, very often, an integral part of the culture around pregnancy and parenthood and on research evidence showing that music can be effective in building strong social connections, in lifting mood and in communicating information.

The project was initially developed in The Gambia through a co-design process with health workers and women's music groups. The intervention involved group singing sessions with pregnant women for a trial of one hour a week over six weeks. The results showed that the sessions were effective in reducing symptoms

of anxiety and depression in participants.

In the Australian context, we are taking a qualitative approach in these research methods that include interviews, focus group discussion, and a co-design workshop with 30 participants comprising migrant and refugee women and service providers.

Our research identified factors contributing to mental distress during the perinatal period for migrant and refugee women. Among key factors, the first is the lack of social support and social isolation. Social support is reduced because of the migration process and the separation from friends, family and networks. Social support is also reduced because services are not always well designed to support migrant and refugee women. They may be culturally inappropriate, with no interpreters or not readily available, or information does not reach the people who need it. Social isolation may be exacerbated in the case of parents with limited English proficiency or precarious immigration status, which can also inhibit their access to essential care for family violence support. About one in four migrant women experiences intimate partner abuse in the first 12 months postpartum.

And the final principle is the cultural gap that women experience is important for our research in particular and emerged as a key theme in the responses more generally. First there is a lack of culturally-responsive interventions; second, the sense of separation from their own cultural practices of pregnancy and parenthood, and a lack of community celebration of a new baby.

Feedback from our interviews illustrates the challenges that migrant and refugee women experienced during the perinatal period. One participant talked about her experience after the birth of her third child. She had two children in her country of origin, and then she had her third child in Australia. She explained: "I did not see my husband very often, and I had three children. I was supposed to take care of them without any help. So I think I found myself depressed without even realising I was depressed. I was thinking of running away and leaving the children by themselves because it was too much to handle." This feeling of lack of support and being overwhelmed was identified by many participants.

In addition, participants talked about the absence of cultural celebration and cultural recognition during the perinatal period and the way this intersected with the wider sense of social isolation and lack of support. One explained: "I had a huge celebration back home, and when I came here, I didn't have any. And that's how I realised how important your family could be when they are around you, how important it is when you have somebody to help you during this time, the pregnancy term, and especially when you have to raise your child when it's born."

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The cultural gap presents a challenge for new parents. The ceremonies, celebrations and social support that women often had experienced in their home communities was absent, much reduced or changed in the context of resettlement. The CHIME approach responds to this gap, recognising the ways music is already very often an important cultural element when babies are welcomed into the family and into the community.

Research has shown musical practices such as naming ceremonies, baby shower songs, singing of lullabies and other rituals associated with pregnancy and birth, work as a kind of rite of passage, whether becoming a new parent or welcoming a new baby into the family. They can also promote infant caregiver bonding and wellbeing at the same time as the above quote indicates. They're an important way that the wider family and community show support to new parents.

The co-design group had eight participants; six came from a migrant or refugee background, the others had experience working with migrant and refugee parents in the community in Canberra. The

co-design process started with empathy mapping –an activity designed to develop a deeper understanding of migrant and refugee mothers' experiences and needs and how it feels to be a parent in a new country.

Next, we included a theory of change exercise, involving a participatory process. We had identified the lasting social change we wanted to contribute to in promoting perinatal wellbeing, as well as the near-term objectives to achieve that social change. Then the co-design group identified the shifts and outcomes that we wanted from our program. The final stage involved prototyping, trying out potential program designs then refining the themes resulting from the empathy maps – which align quite closely with the themes I had identified already through the thematic analysis of the interview and discussion data.

And through the co-design group, one of the questions that arose was whether and how to engage women's partners in our program. There was no clear agreement about the best approach. Some participants felt it was important to involve partners to promote family bonding connection and to prevent domestic violence; others noted that in mixed gender settings, some women would feel less comfortable sharing their experiences of pregnancy and childbirth. Issues of cultural difference and power relating to gender roles could make mixed gender program less effective. We decided to have separate sessions for partners in an effort to involve male community leaders, while maintaining some sessions specifically for women. This could be adapted depending on the preference of the target community and context.

Another question to address from our discussions was whether programs should be tailored to a specific cultural or language community, or whether participants would prefer a multicultural program that included people from different cultures. Here again, the results were mixed – a multicultural program was seen as beneficial because it could build English language skills, the ability to communicate across cultures and allow women to feel part of a wider community by building those bridges. Others noted that a culturally-specific program could allow a deeper level of cultural understanding, musical and social connections.

The takeaway from our work: both approaches are possible and can be beneficial, when tailored to the preferences of the particular community and context. Once the theory of change was identified, we had the social change that we wanted to contribute to in order to improve the perinatal wellbeing of migrant and refugee women.

The co-design project outcomes developed, both near-term and enduring, included: increased social connection and support for parents to feel a sense of belonging, with a strong network of peers to lean on for advice; improved emotional support and friendship, enhanced emotional wellbeing and stress relief. By engaging in uplifting musical and singing activities, mothers will experience improved mood, stress relief, emotional balance, cultural connection and celebration. Mothers also will reconnect with their cultural roots through shared musical experiences, fostering a sense of pride and celebration of their identities. They will be better informed about the mental health resources and support available to them in Australia, in a safe, multicultural environment that combats discrimination.

The program aims to create a space where diverse cultures are respected, celebrated and empowered, actively working against racism and discrimination. Finally, Empowerment through knowledge sharing, mothers will feel empowered by gaining practical advice, discussing experiences and solutions with one another, fostering a sense of autonomy and agency in navigating parenthood.

The co-design group identified conditions for success, primarily maintaining the focus on singing and dancing to create a joyful and uplifting atmosphere while delivering key messages clearly and gently and not overwhelming participants with too much information.

In terms of coverage: ensuring diverse participation by reaching out to women from various cultural backgrounds; recruiting culturally-aware facilitators who understand the needs and experiences of the particular group of participants; and providing language support or using music as a way to overcome language barriers.

And logistically: choosing a venue that is accessible, comfortable and culturally appropriate; ensuring diverse participation; reaching out to women from various cultural backgrounds, recruiting culturally-aware facilitators who understand the needs and experiences of the particular target group of participants, and providing language support or using music as a way to overcome language barriers.

Avoid overwhelming participants with too much information, focusing on delivering key messages clearly and gently, and creating a respectful and inclusive space for all participants ensuring a child and baby friendly environment; and providing transport or choosing venues accessible by public transport.

We are currently preparing to facilitate the program and we are aiming to run a longer series in 2025. ℟