An Open-Group Music Therapy Program Design for Asylum-Seeking Prenatal Women

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ABSTRACT

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Asako M. Kando

Asylum-seeking prenatal women (ASPW) are an emerging vulnerable population worldwide, facing unique physiological and psychological challenges within a dual context of being asylum-seekers who are pregnant. Given their multifaceted needs during precarious resettlement periods, a broader context-based approach, rather than the current medical approach, could provide much more comprehensive support. While the literature indicates that music therapy can be used to promote health and wellbeing, no research has been conducted to date on how music therapy may help ASPW. Using an adapted intervention research methodology, this study examined how an open-group music therapy program can be designed to address the needs of ASPW during their resettlement period. A directed qualitative content analysis of related literature in music therapy and other relevant fields revealed that the main challenges of ASPW during their resettlement were poor health and absence of perceived feelings of wellbeing. Poor health was described as a lack of three dimensions of health: (a) absence of disease, (b) positive personal experience in one's life, and (c) quality in the relationship between a person and their surroundings. The analysis also revealed multiple risk and protective factors, as well as potential malleable mediators inherent to the wellbeing of ASPW during the period of their resettlement. These findings combined with relevant music therapy literature and the researcher's perspectives (based on her clinical experience), resulted in a proposed action strategy and theory of change that informed the development of an open-group music therapy program design for ASPW that was conceptualized within a Community Music Therapy approach. Limitations of the research are presented along with implications for practice and future research.

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Chapter 1. Introduction

Asylum-seeking prenatal women (ASPW) are an emerging vulnerable population in various areas of the world. Their numbers have been increasing dramatically since 2015 (United Nations High Commissioner for Refugees [UNHCR], 2016). For example, the civil war crisis in Syria forced an estimated 80,500 pregnant women to seek refuge in neighboring countries within 5 years, including 34,320 who claimed asylum in Turkey (United Nations Population Fund [UNFPA], 2016). Unlike refugees (whose claims for asylum are officially evaluated by government authorities prior to the arrival), asylum-seekers remain in an unsecured status for an undetermined amount of time with minimal legal and social rights in host societies while they await a decision on their refugee status claim (Drožđek & Bolwerk, 2010; McColl, McKenzie, & Bhui, 2008; Nickerson, Steel, Bryant, Brooks & Silove, 2011). As a result of this long asylum process, ASPW face continuous stress before and after migration (Morgan, Melluish & Welham, 2017), in addition to physiological and psychological challenges that may occur during pregnancy, even under the best of circumstances. These challenges may include malaise, insomnia, anxiety, and depression (Bozorgmehr, Biddle, Preussler, Mueller, & Szecsenyi, 2018; Dennis, Merry, & Gagnon, 2017; Heslehurst, Brown, Pemu, Coleman, & Rankin, 2018). Although asylum-seekers and residents in some countries have equal legal access to health care, research indicates that ASPW have a higher risk of overall ante- and post-natal obstetric issues, abortive outcomes, stillbirths (Bozorgmehr et al., 2018; Goosen, Uitenbroek, Wijsen, & Stronks, 2009; Van Hanegem, Miltenburg, Zwart, Bloemenkamp, & Roosmalen, 2011), and perinatal mental illness (Dennis et at., 2017; Gagnon et al., 2013; Heslehurst et al., 2018).

Literature that explores how these challenges have or have not been addressed will be explored in more detail in Chapter Three. Overall however, literature suggests that conventional medical approaches have generally failed to adequately address the full range of needs of ASPW as they center on psychopathology and individually focused solutions (Brown-Bowers, McShane, Wilson-Mitchell, & Gurevich, 2015; Vukich, 2015). A broader context-based approach that encompasses both individual and communal levels of care could provide more comprehensive support to address multi-dimensional needs of this population (Brown-Bowers et al., 2015; Fassetta, Da Lomba, & Quinn, 2016; McCarthy & Haith-Cooper, 2013).

"Music therapy is a professional discipline in which a credentialed music therapist (Music Therapist Accredited [MTA] in Canada) uses music purposefully within a therapeutic relationship to address clients' physical, emotional, cognitive, communicative, musical, social, and spiritual needs" (Canadian Association of Music Therapists, 2016, about music therapy). Some literature exists on the use of receptive and active music therapy techniques in prenatal contexts for antenatal-related stress management (e.g., Bauer, Victorson, Rosenbloom, Brocas, & Silver, 2010; Liebman & MacLaren, 1991; Short, 1993) and preparation for childbirth (e.g., Barbieri, 2015; Browning, 2000, 2001). Other literature explores the use of music therapy to address issues related to pre-migration trauma and post-traumatic stress disorders (PTSD; e.g., Ahonen & Mongillo Desideri, 2014; Alanne, 2010; Baker & Jones, 2006; Beck, Messel, Meyer, Cordtz, Søgaard, Simonsen, & Moe, 2017; Choi, 2010; Orth, 1998, 2005) However, these publications do not indicate how music therapy might be used to address the multi-faceted and unique needs of ASPW.

Although music therapy sessions for individual clients can address a variety of needs, the current paper is focused on proposing how a group music therapy program may serve as an integral component of community-based perinatal support provided to ASPW. Having worked in short-term housing center for newly arrived asylum-seekers during my music therapy internship and beyond (further described below), I came to believe that an open-group music therapy approach (i.e., a drop-in format) was more feasible in this type of setting rather than closed group or individual sessions (i.e., formats where established therapeutic goals are dependent upon regular and predictable attendance). Given the need for flexibility and the needs of ASPW, it also seemed appropriate to conceptualize a group music therapy program within a Community Music Therapy (CoMT) approach. CoMT can be generally described as the facilitation of music therapy experiences that "are context-sensitive and resource-oriented, focusing on collaborative music making and attending to the voices of disadvantaged people" (Stige, 2015, p. 233). Philosophically, CoMT views musicing [1] as an engaged social and cultural practice and as a natural agent of health promotion (Ansdell, 2002, 2004). A CoMT framework provides the

[1] Musicing (Elliott, 1995) or musicking (Small, 1998) is a concept developed independently both by David Elliot and Christopher Small (music scholars), which is often referred to in music therapy contexts. It describes music making as the creation and performance of relationships among people and things within social and cultural context (Ansdell, 2002; 2004).

flexibility needed to address the multi-dimensional and ever-changing needs that ASPW experience throughout their resettlement period as they emerge in context and in real-time.

Personal Relationship with the Topic

As a partial requirement to complete both my Graduate Diploma and Master's degree in Music Therapy, I completed a total duration of 11 months of practicum (one semester during my pre-professional music therapy training and two semesters during my Master's degree) at a short-term housing center in Canada for newly arrived asylum-seekers (various ages). For eight months, I worked specifically with prenatal women in a weekly open-group community-based pilot project where various helping professionals worked collaboratively to address the emotional needs of the participants and promote feelings of wellbeing and empowerment. Music therapy was one of the two options offered, alongside psycho-education. The center offered open rather than closed groups since most participants can typically only attend one or two sessions because of complex immigration processes and rapidly changing conditions related to their resettlement. Due to a wide range of cultural diversity as well as a wide range of unique and unpredictable challenges faced by each participant, I initially struggled with knowing how to structure sessions and facilitate relevant music therapy experiences. Furthermore, I usually had little background information on each participant (only name, age, and country of origin), as social workers were often still collecting that information. As noted above, my literature search revealed a lack of information on how music therapy might be utilized with this population. While participating in supervision, I tried various music therapy experiences and activities adopting approaches that I had used in previous practicum/internship settings that took place in multicultural contexts (e.g., a multicultural in-patient psychiatry unit in India and a day center in Canada for elderly people many of whom were immigrants). Upon completion of my internship, I was hired as a professional music therapist to continue my work at the Centre, which was ongoing at the time of writing this thesis.

Throughout this time, I have witnessed how an ongoing open music therapy group can be beneficial for these ASPW during this difficult period of transition. Some benefits that I observed or that were reported by participants included: use of breathing techniques learned in music therapy during stressful medical examinations; feelings of empowerment and connection experienced during group instrumental and/or vocal improvisations; and recognition that the

group had been a place where they felt validated, experienced a sense of community, and could share resources (feedback shared when they returned to the group to visit following re-settlement). Given my experiences and this feedback, I felt motivated to try and create a more refined program structure, via my research thesis, one where clear connections could be made with theory and literature, and one that other music therapists would be able to adapt for use in their work with this population.

It is also important to note that my passion for this population and my motivation to conduct this research also stemmed from my own experiences of multiple transitions among different countries as a visible minority. I am a cis-gendered, colored, able-bodied Japanese woman who has resided in Italy, Egypt, and India over extended periods of time, sometimes as a musician, and sometimes as a music therapist, after completing my undergraduate education. During my stay in Egypt, I experienced two emergency displacements with my children due to the Arab Spring (2011) and subsequent coup d'état(2013),[2] which has influenced my perspectives on asylum-seekers and their families. I understand how hard it is to cut off all ties with what you have built up and rebuild new lives in a new place, while at the same time dealing with the traumatic events that you experienced. Additionally, I have witnessed the struggles of my Syrian friends who were forced to leave their own countries and resettle in new places where they felt forcibly unvoiced and dehumanized by being labelled as 'Syrian refugees' without receiving sufficient support. I feel that these personal experiences have helped me to better understand some of what my participants (i.e., ASPW) were going through and subsequently motivated me to design a music therapy program that could actually meet their unique needs in context.

Statement of Purpose

Given all of the above factors, the purpose of this study was to design a framework for a flexible open-group music therapy program, situated within a CoMT philosophical orientation, to addresses the needs of ASPW during their resettlement period. It was my hope that the results of this study would provide music therapists and other helping professionals, with practical information and new understandings that could help them to work in constructive and supportive

[2] The Arab Spring was a series of pro-democracy protests and uprisings that spread across the Middle East and North Africa beginning in 2010 and 2011, challenging some of the region's entrenched authoritarian regimes. In Egypt, popular uprising forced the region's leader, Hosni Mubarak, to resign from power in 2011. In 2013, Mohammed Morsi, Egypt's first democratically elected president was removed from power by a coup d'état led by army chief Abdel Fattahl el Sisi (Encyclopedia Britannica, 2020, Egypt uprising of 2011; Housden, 2013).

ways with this population, even in circumstances that may be considered as less than ideal or non-traditional (i.e., not a typical therapy context). I also hoped that this research would provide a basis for additional related inquiries, especially given the identified gap in the literature.

Research Questions

The primary research question for this study was: How can an open-group Community Music Therapy (CoMT) program be designed to address the needs of ASPW during their resettlement period? The subsidiary research questions were: What are the needs of ASPW during their resettlement period?; What music therapy experiences might meet these needs in an open-group CoMT setting and why?; and What is the overarching structure of the proposed program?

Definitions of Key Terms

The key terms in this study are defined as follows:

Asylum-seekers. Individuals who decide to seek protection across borders and await legal recognition as refugees in order to find safety for themselves and their families (UNHCR, 2014).

Prenatal women. Women who are in the period of pregnancy in which fetuses develop inside their wombs (The American College of Obstetricians and Gynecologists, 2015).

Resettlement period. The period of transfer from the home country to another country or state that has agreed to admit asylum-seekers until obtaining the permission of permanent settlement there. Legal and physical protection, including access to civil, political, economic, social and cultural rights similar to those given to nationals are provided during this period (UNHCR, 2019).

Migration. The movement of persons who leave their habitual place of residence and across an international border to a country of which they are not nationals (International Organization for Migration [IOM], 2019).

Music therapy experiences. There are four types of music therapy experiences that serve as the primary methods of music therapy: listening, improvising, re-creating, and composing. There are multiple variations of these experiences which may be used alone or in combination for a range of therapeutic purposes. “Every music [therapy] experience minimally involves a person,

a specific musical process, a product of some kind, and a context or environment" (Bruscia, 2014, p. 41).

Open-group. An open-group has an undefined number of group members with new people coming and going on a regular basis. It can be ongoing or limited in duration (Schopler & Galinsky, 1984).

Community Music Therapy (CoMT). CoMT practice focuses on "the contextual manifestation of music and health… [and is] especially mindful of the political and ethical" (Wood, 2016, p. 5). See also above description of CoMT.

Chapters Outline

Following this chapter, which outlines the need and significance for the present study, Chapter Two outlines the intervention research methodology used for this study. Chapter Three reviews literature on topics relevant to the present study. These include: healthcare literature on asylum-seekers and on ASPW; music therapy literature on refugee populations including asylum-seeking individuals; literature on music and health pertinent to pregnant women; and relevant literature on CoMT. This review was also an integral part of the data analysis process, wherein key components of the research problem, malleable mediators, change strategies, and potential outcomes could be identified. In Chapter Four, results of the data analysis are presented, including the proposed open-group music therapy program design. Chapter Five discusses implications of the findings and outlines limitations of the study, as well as recommendations for future research.

Chapter 2. Methodology

Research Design

The present study employed a modified intervention research methodology developed by Fraser, Richman, Galinsky, and Day (2009). This methodology allows researchers to define a problem to be changed, generate interventions for targeted agents with clearly defined outcome, and refinement of the program through continuous implementation and evaluation. According to Fraser et al. (2009), intervention research consists of five steps: "1. Specify the problem and develop a program theory; 2. Create and revise program materials; 3. Refine and confirm program components; 4. Assess effectiveness in a variety of settings and circumstances; 5. Disseminate findings and program materials" (p. 36).

The first phase of step 1 centers on defining the problem (including incidence and prevalence) and identifying mechanisms that produce (i.e., risk factors) or suppress/reduce (i.e., protective factors) the problem (Fraser et al., 2009). The second phase of step 1 is to build a program theory. Here, malleable mediators that could be "responsive to intervention and influential in affecting distal outcomes" (Fraser et al., 2009, p. 185) are identified. These are then matched to evidence-based change strategies that target expected outcomes. A theory of change for intended outcomes is constructed using various elements of intervention including levels, settings, agents, objectives, and outcomes (Fraser et al., 2009). The first phase of step 2 focuses on developing the program content/materials. The second phase involves evaluating these materials through testing the proposed program (e.g., a pilot project) and then revising/refining the program materials accordingly. The present study was delimited to step 1 and the first part of step 2, meaning that the proposed program in this study was not tested.

Materials

Data collected from the literature and my personal journal was stored on my password-protected personal computer and backed up on a USB flash drive.

Data Collection and Analysis Procedures

Sources of data in this study included: (a) information gleaned from relevant literature, and (b) my personal perspectives and reflections gathered in a journal throughout the data collection and data analysis process.

Literature. In order to identify and gather relevant literature, I searched databases available through the Concordia University library such as ProQuest, PsycInfo, PubMed, and RILM. Key search terms included: *music therapy; music; community music therapy; asylum-seekers; refugee; refugee claimants; prenatal/pregnant women; prenatal/perinatal/maternal health; prenatal/perinatal/maternal care; maternity; drop-in/open group.* Since the literature relevant to the topic was scattered throughout various field of healthcare, materials were searched in music therapy, obstetrics, psychology, psychiatry, and midwifery. This resulted in 117 articles, twelve book chapters, six books, and three dissertations. Literature was removed if it did not appear to have direct relevance to the purpose of the present study (i.e., did not fit within predetermined categories presented via the subsidiary research questions and the intervention methodology design). Final total counts of literature used as data in a directed content analysis procedure are listed below:

1. Twenty peer-reviewed research articles and two books from various relevant fields including obstetrics, psychology, psychiatry, and midwifery, published from 2008 to 2019, were used to identify the needs of ASPW.
2. Fifteen peer-reviewed articles, one dissertation, one published presentation document, two book chapters, and one book, published from 1998 to 2018, were used to examine the use of music therapy for asylum-seeking individuals. Given that the most of existing music therapy literature does not differentiate between individuals in asylum and individuals in refugee status, the literature on refugee populations at large were included. To be included as data with direct relevance to the present study, a study had to report findings on refugee individuals of reproductive age (WHO, 2006)[3] or had to include separate analyses on those of reproductive age. However, literature regarding male and gender-unspecified refugees was included due to the limited number of studies on refugee populations relevant to the present study.
3. Nine peer-reviewed research articles, two dissertations, and one book in music therapy, published from 1991 to 2016, were used to examine the use of music therapy for pregnant women. Ten peer-reviewed research articles in obstetrics, psychology, and midwifery,

[3] While the definition of the reproductive age varies depending on countries and surveys, this study refers to the World Health Organization (WHO) which defines the reproductive age of women as those aged 15-49 years (WHO, 2006).

published from 1998 to 2015, were added to further understand the use of music during pregnancy outside of music therapy contexts.

4. Three peer-reviewed research articles, seven book chapters, and two books, published from 2002 to 2016, were used to examine and inform the application of CoMT for ASPW.

I reviewed all of this literature and organized it in such a way so as to facilitate a directed content analysis process (see Chapter Three). First, I summarized the identified needs of ASPW. I then summarized how music therapy has been used to address the needs of asylum seekers and how music/music therapy has been used to address the needs of prenatal woman. It is important to note that I found no literature on how music therapy might be used to address the needs of ASPW. Finally, I reviewed CoMT literature to identify and summarize an example of a program that addressed needs similar to those that could be addressed in a program for ASPW (i.e., a CoMT program designed for another client population).

Intervention research step 1-1: specify the problem. A directed qualitative content analysis of the literature (Hsieh & Shannon, 2005) was utilized to identify the *problem(s)* as well as identifying potential *risk* and *protective factors* inherent to the wellbeing of ASPW during the period of their resettlement. Overarching summaries of these predetermined categories were then created.

Intervention research step 1-2: develop a program theory. By reviewing the risk and protective factors identified in the first step, *malleable mediators* were identified. These were then matched with *music therapy change strategies* conceptualized within a CoMT approach that targeted a range of desired outcomes and was organized according to levels, settings, agents, objectives and outcomes (Fraser et al., 2009). Material from my journal also helped to inform the conceptualization of these change strategies and helped me to envision how they could be realized in real world practice.

Intervention research step 2-1: create program structures and processes. Based on the problem and program theory generated, an open-group music therapy program design for ASPW was created and conceptualized within a CoMT approach.

Chapter 3. Related Literature

As noted in Chapter Two, the purpose of the Chapter Three was to review literature relevant to the present study and organize it in such a way so as to facilitate a directed content analysis process. First, the identified needs of ASPW are summarized. This is followed by a summary of how music therapy has been used to address the needs of asylum seekers and how music/music therapy has been used to address the needs of prenatal woman. Finally, this chapter concludes with a select example of a CoMT program described in the literature that had relevance for the present study as the needs addressed in this program were similar to the identified needs of ASPW. At the time of this writing, I found no literature that examined or described music therapy with ASPW.

Needs of Asylum-Seeking Individuals During Their Resettlement Period

Introduction. The context of asylum includes experiences both before and after arrival to host countries (Gagnon et al., 2013). Prior to arrival, asylum-seekers may be exposed to traumatic events associated with violence, deprivation, and losses (Signorelli & Coello, 2011). After arrival, they may face the "seven Ds" (McColl et al., 2008, p. 454) due to the policies applied in host countries during the wait for an asylum outcome. These include: discrimination, detention, dispersal, destitution, denial of the right to work, denial of health care, and delayed decisions on asylum applications (McColl et al., 2008).

Unlike refugees, whose citizenships become valid on arrival, asylum-seekers remain in their host countries in unsecured status for an undetermined amount of time with minimal legal and social rights (McColl et al., 2008; Nickerson et al., 2011; Ryan, Kelly, & Kelly, 2009; Steel, Silove, Brooks, Momartin, Alzuhairi, & Susljik, 2006). Studies found that asylum-seekers have poorer health outcomes overall than refugees and local residents (Bogic, Njoku, & Priebe, 2015; Hadgkiss & Renzaho, 2014; Li, Liddell, & Nickerson, 2016; Ryan et al., 2009). The predominant focus on treating pre-migration trauma has recently been criticized, stating this focus underestimates the impact of challenging post-migrative conditions, as well as homogenizing the population as "traumatized victim[s] at risk" without considering individuals' multifaceted experiences (Drožđek & Bolwerk, 2010; Jin, 2016; Morgan et al., 2017; Silove, Ventevogel, & Rees, 2017). Recent studies suggest that pre- and post- migration challenges should be

considered as interactive factors that together form a negative impact on asylum-seekers' health and wellbeing (Gagnon et al, 2013; Li et al., 2016; Morgan et al., 2017).

Overarching needs. The needs of asylum-seekers most often cited in the literature can be identified according to socioeconomic-cultural and psychological-emotional needs in contexts.

Socioeconomic-cultural needs in context. The right to seek asylum is protected by international law. However, this right does not protect asylum-seekers from an imposed legal/social status that can result in a "toxic social environment" (Rian et al., 2009, p.107) in which their basic human needs are not met (Fassetta et al, 2016). Overall security related to hygiene, food, and privacy can be threatened by long-lasting poor social conditions including low-standard accommodations, unemployment, financial strain, and limited access to adequate healthcare and social services (Cleveland & Rousseau, 2013; Drožđek & Bolwerk, 2010). Forced dispersal every one or two months may limit asylum-seekers' opportunities to connect with an ethnic, cultural, or neighborhood community and may place these individuals in situations of isolation (McColl et al., 2008; Nickerson et al., 2010; Steel et al., 2006). Prolonged asylum procedures can create language and cultural barriers as well as ongoing exposure to societal discrimination (e.g., racism, bias, and stigma), which in turn, can cause feelings of acculturative stress, loss of identity, and loss of connection to host countries (Bogic et al., 2015; Drožđek & Bolwerk, 2010; McColl et al., 2008; Steel et al., 2006). Although providing asylum-seekers with supportive environments may help diminish negative impacts of asylum procedures (Hadgkiss & Renzaho, 2014), the literature also indicates that language, social and cultural needs are rarely addressed and prioritized for this population (Ryan, 2009).

Psychological-emotional needs in context. Pre- and post-migrative challenges faced by asylum-seekers have a longitudinal impact on their mental health. Much research links the high rates of pre-migration trauma exposure to elevated rates of higher psychiatric symptoms including depression, anxiety, and PTSD in asylum-seekers (Drožđek & Bolwerk, 2010; Morgan et al., 2017; Nickerson et al., 2010; Steel et al., 2006). Other research also connected imposed socio-economic conditions in post-migration with an elevated rate of psychiatric symptoms including somatization, depression, anxiety, and PTSD in asylum- seekers (Bogic et al., 2015; Hadgikiss & Renzaho, 2014, Li et al., 2016; Ryan et al., 2009).

After their arrival, asylum-seekers may experience feelings of guilt and loss, as well as worries about the safety of family members left behind (McColl et al., 2008; Morgan et al., 2017; Steel et al., 2006). Fears of unsuccessful claims and subsequent deportation and/or family separation, in addition to feelings of insecurity and uncertainty, may hamper asylum-seekers' feelings of agency until their asylum claims are determined (Nickerson et al., 2010; Ryan et al., 2009; Steel et al., 2006). They may blame themselves for their inability to achieve social status similar to what they had in their country of origin, which may lead to feelings of inferiority, humiliation, anger, and despair (Centre for Addiction and Mental Health [CAMH], 2012). Studies find that the change of legal status from temporary to permanent resident is associated with significant improvements in PTSD, depression, and overall mental health (Nickerson et al., 2011; Silove et al., 2007). This indicates that longer periods of asylum could put asylum-seekers' mental health at risk.

Unique needs of ASPW. From the relevant literature, common needs of ASPW (i.e., those that exist notwithstanding differences between various countries with regard to societal and healthcare systems) were identified according to socioeconomic-cultural and physiological-psychological needs in contexts.

Socioeconomic-cultural needs in context. Basic human needs during pregnancy, including security in hygiene, food, clothing and privacy and personal safety, are all compromised by poor social conditions associated with asylum status (Denice et al., 2017; Gewalt, Berger, Ziegler, Szwcsenyi, & Bozorgmehr, 2018). Studies highlight that ASPW receive significantly less social support than resident pregnant women, who have access to more support from family, friends and government (Denice et al., 2017; Fassetta et al., 2016; Gagnon et al., 2013). Many ASPW give birth and are discharged from hospital without anyone to help them (Fassetta et al., 2016; Lephard & Haith-Cooper, 2015). They are also heavily dependent on charitable and third-sector support for substantial resources (Fassetta et al., 2016; Feldman, 2014).

ASPW also face challenges in accessing perinatal care (Cignacco et al., 2018; Denice et al., 2017; Feldman, 2014; Gagnon et al., 2013; Heslehurst et al., 2018; Lephard & Haith-Cooper, 2015). Multiple relocations, lack of sufficient insurance coverage, and lack of access to support services (including transportation, childcare, language assistance, and medical documentation), may hamper ASPW from receiving continuous and adequate treatment (including assessment and

referral) in a timely manner from regular providers over the perinatal period (Feldman, 2014; Heslehurst et al., 2018; Lephard & Haith-Cooper, 2015; McCarthy & Haith-Cooper, 2013).

Relationships with healthcare and social service providers also impact ASPW's experience of healthcare (Cignacco et al., 2018; Fassetta et al., 2016; Heslehurst et al., 2018; Lephard & Haith-Cooper, 2015). Providers' lack of knowledge regarding the unique needs of ASPW, the services they are entitled to, and the differing values or understandings about health, may result in insufficient explanations of care, lack of discussion regarding options, inadequacy of service provision leading to delayed care, and negative communication experiences (Haith-Cooper & Bradshaw, 2013; Kurth, Jaeger, Zemp, Tschudin, & Bischoff, 2010). Experiences of racism, discrimination, and stigma in encounters with healthcare service providers may promote ASPW's mistrust of the healthcare system in host countries (Fassetta et al., 2016; Lephard & Haith-Cooper, 2015). Due to fears of being misunderstood and of negative impacts on their asylum claims, ASPW sometimes will not share crucial personal information, such as experiences of trauma, FGM (Female Genital Mutilation), or gender-based violence, with healthcare providers. (Fassetta et al., 2016; Gagnon et al., 2013). Difficulties in navigating differing cultural, religious, and spiritual values in healthcare (e.g., needing female practitioners due to cultural practices, do's and don'ts during pregnancy) without social support may create barriers and gaps in overall care (Brown-Bowers et al., 2015; Heslehurst et al., 2018; Kurth, et al., 2010).

Physiological-psychological needs in context. Along with common pregnancy-related physiological challenges including decreased physical mobility, changes to appetite, malaise, fatigue, muscular tension, sleep disturbance, and troubled breathing (Bozorgmehr et al., 2018), ASPW are at higher risk of overall ante/post-natal obstetric issues, abortive outcomes, and/or stillbirths than pregnant refugees and resident pregnant women (Bozorgmehr et al., 2018; Cignacco et al., 2018; Goosen et al., 2009; Heslehurst et al., 2018; Kurth, et al., 2010; Van Hanegem et al, 2011). Untreated underlying illnesses including HIV also impact ASPW's health outcomes (Haith-Cooper & Bradshaw, 2013; Van Hanegem et al, 2011).

ASPW have particular psychological needs related to pre- and post-migration experiences. Research has found a statistically significant association between perinatal anxiety and the number of traumatic events experienced or witnessed by refugee women including those in

asylum (Matthey, Silove, Barnett, Fitzgerald, & Mitchell, 1999; Bjerke et al., 2008). Studies have also indicated that ASPW experience a higher incidence of sexual assault, more unwanted pregnancies, and a higher induced- abortion-to-live-birth ratio when compared with resident pregnant women (Goosen, 2009; Kurths et al., 2010; Stewart, Gagnon, Merry, & Dennis, 2012). Moreover, those ASPW who have experienced gender-based violence are found to be at increased risk of violence during pregnancy if they lived without a partner, delayed access to prenatal healthcare, miscarriage, and postpartum mental health concerns (Stewart et al., 2012).

Although antepartum mental health among ASPW has not been fully examined, extant studies find that they are more likely to experience anxiety and psychosomatic symptoms postpartum, and that their incidence of postpartum depression is triple to quintuple as compared with resident pregnant women of host countries (Collins, Zimmerman, & Howard, 2011; Dennis et al., 2017; Gagnon et al., 2013). Given the correlations between antenatal mental health issues and poorer pregnancy, obstetric, and postnatal health outcomes including increased risk of postpartum depression (Alder, Fink, Bitzer, Hösli, & Holzgreve, 2007; Bansil et al., 2010; Biaggi, Conroy, Pawlby, & Pariante, 2016), antenatal mental health among ASPW is assumed to be at high risk (Dennis et al., 2017; Gagnon et al., 2013; Heslehurst et al., 2018).

Prolonged, precarious immigration status can also affect the emotional wellbeing of ASPW. Gagnon et al. (2013) stated that mothers' fear of separation from their infants (as infants are guaranteed permanent residency at birth), as a consequence of unsuccessful asylum, recurs over the perinatal period (Gagnon et al., 2013). Guilt stemming from ASPW's belief that they are unable to ensure their child's future (although their motivation for seeking asylum is for the safety and wellbeing of their child) may last (Signorelli & Coello, 2011). The stigma of being labelled "healthcare and residency scroungers" may result in ASPW feeling denied and lost in their identities and roles (Brown-Bowers et al., 2015; Lephard & Haith-Cooper, 2015). Limited opportunities to connect with childbearing communities, which could compensate for the lack of provision of public support over the perinatal period, may promote ASPW's feelings of isolation and lack of belonging in their host countries (Fassetta et al., 2016; Feldman, 2014). Repeated experiences of not being heard may affect self-confidence and sense of agency, which in turn may negatively impact childbirth and parenting experiences (Brown-Bowers et al., 2015; Fassetta et al., 2016; Lephard & Haith-Cooper, 2015).

These socioeconomic-cultural and/or physiological-psychological needs of ASPW may not be fully or holistically addressed in current healthcare systems, since they are beyond the scope of conventional medical approaches which center on pathology and individually focused solutions (Brown-Bowers et al., 2015; Fassetta et al., 2016; McCarthy & Haith-Cooper, 2013). In the present study, this issue will be further explicated via the development of a problem theory in Chapter Four. The following section reviews literature that explores how the needs of ASPW have been addressed/examined in music and health contexts.

Relevant Literature on Music and Health

Although the literature indicates that music and music therapy intervention can be used to promote health and wellbeing (e.g., MacDonald, Kreutz, & Mitchell, 2012), no literature was found regarding the use of music therapy to address the needs of ASPW. However, a small amount of literature exists on the use of music therapy with refugee populations and on the use of music/music therapy with prenatal women. Cumulatively, these two areas of literature may provide some guidance for conceptualizing a music therapy program tailored to meet the needs of ASPW.

Music therapy with asylum-seeking individuals. It is important to note that most of the existing music therapy literature does not differentiate between individuals in asylum and those in refugee status. Therefore, literature on refugee populations at large was included. While music therapy is practiced in diverse settings, two main focuses of practice were identified: trauma-informed and sociocultural-focused.

Trauma-informed music therapy practices. The use of music therapy with refugee populations has been discussed within the clinical context of trauma treatment since the 1990s（e.g., Orth & Verburgt, 1998）. This has included various approaches/theoretical orientations such as: psychodynamic (Ahonen & Mongillo Desideri, 2014; Alanne, 2010; Beck et al., 2017; Metzer, Verhey, Braak, & Hots, 2018; Orth, 2001, 2005; Orth & Verburgt, 1998) and cognitive behavioral (Baker & Jones, 2006: Choi, 2010; Signorelli & Coello, 2011). These approaches often incorporate a neurobiological understanding of trauma and incorporate neurological techniques to address physiological, psychological, and behavioral challenges. These challenges include: stress and survival responses; emotions of guilt, shame and fear; and behaviors and symptoms resulting from previous trauma (e.g., sensory and behavioral dysregulation,

hyperactivity, aggression, impulsivity, attention disorder, withdrawal, lack of motivation, anxiety and distrust; Signorelli & Coello, 2011).

A body of literature suggests that trauma-informed music therapy approaches can uniquely address refugees' trauma related needs both in individual and group settings, when language barriers hamper the accessibility of traditional medical and psychotherapy models (Comte, 2016). Beck et al. (2017) examines the use of Guided Imagery and Music (GIM[4]) for refugees who had experienced torture. She found that the use of trauma-informed modified GIM improved their sleep quality, social functioning, and feelings of wellbeing (Beck et al., 2017). Choi (2010) applied a cognitive behavioral approach that incorporated music and psychoeducation in her work with adolescent refugees to help them regulate trauma-induced behaviors (Choi, 2010). Alanne (2010) described a psychodynamic approach with an asylum-seeking client where music acted as a safe medium through which fear, anxiety, and loss could be explored (Alanne, 2010).

Although these examples indicate some potential for trauma-informed music therapy with refugees, individualizing and decontextualizing clients through the lens of psychopathology may not take into account the reality which clients face outside of the therapy room (Vukich, 2016). According to Zharinova-Sanderson (2004), a music therapist at a clinical institution in Germany working with refugees who had experienced torture, political persecution, and/or traumatic events: "torture and traumatic experiences are generally not their biggest concern. Instead, their insecure residential status and unhappy life in exile without money, freedom of movement and employment, and fear of East German neo-Nazis -these are the most burning issues that are shared by every patient" (p. 236). Trauma-informed approaches may not be sufficient when the debilitating effects the asylum process on clients' health and wellbeing may exceed that of pre-migration trauma (Laban, Komproe, Gernaat, & de Jong, 2008).

Sociocultural-focused music therapy practices. Another focus of the practices found in the literature is sociocultural, centering on the challenges in the post-migrative context that refugees face. Hunt (2005) explored the use of participatory-focused music-making with adolescent refugees in a school setting and found that this program helped to foster their sense of

[4] GIM is a receptive music therapy method to help an individual's exploration of their unconscious through imagery experiences evoked through specially selected classical music (Grocke, 2005).

connection and belonging in the school community. Similarly, Jin (2016) studied the experience of music therapists and facilitators working with asylum-seekers and found that reciprocal music-making nurtured a sense of connection with others as well as personal feelings of agency and empowerment.

The holistic sense of health and wellbeing that can be evoked among refugees by the use of culturally relevant music has been recognized in music therapy literature (Amir, 1998, 2004; Comte, 2016; Jones et al., 2004; Orth & Verburgt, 1998; Vukich, 2016). Orth and Verburgt (1998) emphasized the need for "transculturally embedded" (p.82) practices with refugees' populations where the use of music therapy techniques has to be determined by cultural characteristics and differences (Orth & Verburgt, 1998). In their school-based work with adolescent refugees from Sudan, Jones et al. (2004) found that integration of participants' cultural values into the songs and music played in the session facilitated reciprocal music-making among participants and music therapists, in addition to the self-expression of participants in collective music-making (Jones et al., 2004). Zharinova-Sanderson (2004) described her work with a Kurdish refugee where culturally-specific musicking contributed to therapeutic relationship-building, fostered the client's sense of ownership over his life, and enhanced his feelings of connectedness to the community. These examples highlight the importance of using culturally relevant music in music therapy contexts to address refugees' sociocultural needs. Furthermore, a growing amount of literature has focused on the need for music therapists to participate in ongoing reflexive practices, examining their own cultural values, biases, and assumptions (e.g., Comte, 2016; Coombes, 2018; Jin, 2016; Jones et al., 2004). These issues were important considerations that factored into the program design outcome of the present study.

While little has been written on how music therapists might address practical issues related to the cultural diversity of various refugee populations, several articles discuss how music-making can often surpass language and cultural barriers between music therapists and their refugee clients (Ahonen & Mongillo Desideri, 2014; Alanne, 2010; Baker & Jones, 2006: Choi, 2010; Metzer et al., 2018; Orth & Verburgt, 1998; Signorelli & Coello, 2011). Music-making can provide a "common ground" (Coombes, 2018, p. 4) in which therapists and participants can open themselves up and be "in tune" (Coombes, 2018, p. 4) with each other, as well as connecting and "share humanity" (Jin, 2016, p.23). Alternatively, Comte (2016) warns that music therapists'

belief in "music as a universal language" may result in an unintentional oppression of clients' cultural music values, practices, and preferences. While musicality can be considered as a universal forum of human communication that is central to music therapy practice, music therapists working with refugee populations must also be aware that authentic musicking processes need to unfold in consideration of the unique socio-cultural context of each client (Ansdell, 2004; Comte, 2016).

Music therapy with refugee populations is still an emerging practice. It appears that neither trauma-informed or sociocultural-focused music therapy approaches can fully address the needs of these individuals. Holistic views on refugee clients seem lacking in the music therapy literature (Vukich, 2016). Given that the present study is focused specifically on developing a music therapy program for ASPW, the following section reviews literature on what is known about the use of music and music therapy with prenatal women.

Music and health during pregnancy. Upon reviewing the relevant literature, two main types of practices were identified: treatment-focused and empowerment-focused.

Treatment-focused practices. Receptive music listening and its beneficial effects on fetal health has been a topic of discussion since the late 1990s (e.g., Shwarts, 1997; Whitwell, 1999). Recent research in obstetrics and psychology indicates that receptive music listening may be effective in addressing antenatal-related physiological and psychological challenges including: fatigue, insomnia, muscular tension, antenatal stress, fears, anxiety, and depression (Chang, Chen, & Huang, 2008; Chang, Yu, Chen, & Chen, 2015; Gonzalez-Garcia, Ventura-Miranda, Requena-Mullor, Parron-Carreno, & Alarcon-Rodriquez, 2018; Liu, Lee, Yu, & Chen, 2016; Shin & Kim, 2011; Yang et al., 2009). It is important to note that all recent research referred to in this section conceptualize music as 'treatment' in and of itself without any involvement of a certified music therapist, so these studies do not fall under the definition of music therapy as presented in Chapter One.

Empowerment-focused practices. As pharmacological treatments are not always warranted or available to help women with the physiological and psychological challenges of pregnancy and childbirth, prenatal education can help pregnant women by teaching them non-pharmacological coping strategies (Byrne, Hauck, Fisher, Bayes, & Schutze, 2014; Svensson, Barclay, & Cooke, 2008). Some music therapy literature emphasizes empowerment-focused

practices, which offer opportunities for pregnant women to develop self-regulation skills and feelings of agency during the perinatal period (Barbieri, 2015; Browning, 2000; 2001).

Studies indicate that antenatal physiological and psychological challenges can be alleviated by women's active engagement in musical experiences, such as music-listening paired with: active engagement in choice-making, relaxation, breathing, and/or imagery (Bauer et al., 2010; Browning, 2000, 2001; Liebemann & MacLaren, 1991; Short, 1993). Bauer et al. (2010) examined the efficacy of a single 1-hour individual music therapy session with 19 women and found that it effectively alleviated antepartum-related distress. The sessions were facilitated by certified music therapists and included music-facilitated relaxation where improvised string music was paired with participant-preferred imagery, progressive muscle relaxation, and breathing techniques (Bauer et al., 2010).

Benefits of using voice during pregnancy are also discussed in the music therapy and midwifery literature (Barbieri, 2015; Carolan, Barry, Gamble, Turner, & Mascarenas, 2012; Federico, 2016; Federico & Whitwell, 2001, Pierce, 1998, 2001). Federico and Whitwell (2001) described toning (i.e., free vocalization) and chanting as a spontaneous medium of self-expression and communication with the fetus (Federico & Whitwell, 2001). Similarly, Pierce (1998, 2001) described toning as a means of learning breath control, emotional release, an altered state of consciousness, and bodily vibration (Pierce, 2001). In her study examining the effects of practicing toning during pregnancy, women reported that the toning practice paired with the knowledge of vocalization helped them learn to relax, calm down, focus, and cope with anxiety and pain during pregnancy and delivery (Pierce, 1998).

Instrumental music-making during pregnancy is referred to only briefly in two studies (Bauer et al., 2010; Federico, 2016) in spite of evidence that live music-making and singing may stimulate endorphin release and reduce perceived pain, more than music listening (e.g., Kaskatis, MacDonald, & Barra, 2012). Bauer et al. (2010) described musical improvisation with participant-preferred instruments and rhythmic patterns for emotional outlet and decision-making (Bauer et al., 2010). Similarly, Federico (2016) recommended instrumental improvisation on pregnancy-related themes (e.g., fear, insecurity, and connection with one's baby) in individual, couple, and group formats to help clients explore unconscious aspects of prenatal experiences (Federico, 2016).

The empowerment-focus in music therapy with prenatal women is most fully explored in individualized prenatal preparation (e.g., music therapy-assisted childbirth programs). Barbieri (2015) created a voice-centered music therapy program to help women and their partners address labor pain (Barbieri, 2015). Browning (2000) examined the efficacy of daily music listening that incorporated coping strategies for prenatal preparation. Her music therapy-assisted childbirth program includes prenatal sessions for: (a) creation of music lists, (b) instruction of breathing, progressive muscle relaxation, and use of imagery for conditioning a relaxation response to the selected music, and (c) daily home practices (Browning, 2000). Women who listened to at least one of the music lists daily reported that this helped to promote relaxation and manage pain during labor (Browning, 2000).

While research indicates some benefits of music therapy during pregnancy, the sociocultural needs of pregnant women have not been addressed to any great extent in the music therapy literature. The proposed Community Music Therapy (CoMT) program in the present study and recommendations for future research (see Chapter Five) takes this gap into account.

Community Music Therapy (CoMT). Given the plurality of contexts in which ASPW are simultaneously situated, their needs could be well addressed by the CoMT approach. CoMT promotes flexible, context-based, culture-centered, and resource-oriented practices within a music-based communal arena. Here, individuals can be linked with other individuals, groups, and/or systems and their actions can promote positive changes in society as well as in their own health and wellbeing (Ansdell, 2002, 2004; Stige, 2015; Stige & Aarø, 2012).

I found no literature on the use of a CoMT approach with ASPW. However, I identified one publication in which similar needs of a refugee population were addressed using a CoMT approach, which had implications for the program being proposed in the present study. This publication describes a music project for young Palestinian refugees living in a refugee camp in Lebanon (Storsve, Westbye, & Ruud, 2010). These displaced youths had been experiencing "the inevitable sense of a transitory and unstable life" (Storsve et al., 2010) in poor social conditions over which they had no control. Music therapists and educators from Norway worked collaboratively with local music educators, musicians, social workers, and the young refugees, to implement a music program that offered them the opportunity to promote "self-identity, mastery, belonging, dignity and recognition" (Storsve et al., 2010). The program consisted of music skills

development, knowledge sharing, collective music-making, and community performances, in which refugee children, youth, and adults could engage as learners, mentors, facilitators, and performers.

One of the distinctive factors in this project was the flexible method of participation offered to the participants in the program. By incorporating the local practice of apprenticeship into the egalitarian relationship rooted in the CoMT perspective, the program enabled the participants to take different roles and evolve their way of learning, connecting, and negotiating in a community of practice. As a result of various social experiences of change within the program, participants' sense of mastery and identity was enhanced. Moreover, the vision and knowledge, shared through collective discussion among participants with diverse experience and values, transformed the program into a communal platform, in which participants could connect to the cultural community and heighten their sense of wellbeing through collective music experiences (Storsve et al., 2010).

This example highlights the potential of a music-based collaborative process between therapists, participants, and supporting communities whereby the participants' multifaceted needs as social-cultural beings are flexibly addressed and their quality of life is heightened as a result. The holistic support of refugees' health and wellbeing through musical experiences, presented in this example, is an essential concept which was integrated into the program design of the present study.

Chapter Conclusion

The purpose of this chapter was to review literature on topics relevant to the present study: healthcare literature on asylum-seekers and on ASPW; music therapy and music-based healthcare literature pertinent to pregnant women and refugee populations including asylum-seeking individuals; and selected literature on CoMT. As indicated in Chapter Two, I reviewed all of this literature and organized it in such a way so as to facilitate a directed content analysis process. Chapter Four presents the results of this process conceptualized within the first 1.5 steps of Fraser et al. (2009) intervention research methodology (see Chapter Two).

Chapter 4. Results

Step 1-1: Specify the Problem

Identification of the problem. Through a directed qualitative content analysis of the relevant literature presented in Chapter Three, poor health (as defined below) and absence of perceived feelings of wellbeing were identified as the main problems of ASPW during their resettlement period.

Definition of the problem. Stige and Aarø (2012) outlined the state of 'being healthy' in three dimensions: (a) absence of disease, (b) positive personal experience in one's life, and (c) quality in the relationship between a person and their surroundings (Stige & Aarø, 2012). The problems of ASPW during their resettlement period can be described as a lack of these three dimensions of health.

Presence of disease. Poor physical and psychological health outcomes among ASPW, which can also jeopardize the health of the fetus, have been globally identified regardless of diverse immigration policies and applied healthcare systems (Bozorgmehr et al., 2018; Heslehurst et al., 2018). As shown in Chapter Three, ASPW are at higher risk of overall ante- and post-natal obstetric issues, abortive outcomes, stillbirths (Goosen et al, 2009; Kurth et al., 2010; Van Hanegem et al., 2011), and perinatal mental issues (Dennis et at., 2017; Gagnon et al., 2013).

Lack of positive personal experiences in one's life. The sense of being healthy is ultimately subjective, based on the individual's understanding about health and wellbeing (Stige & Aarø, 2012). However, there is little difference in the self-reported experiences of health and wellbeing among ASPW in various host countries, or across diverse cultural and ethnic backgrounds. Many of them experience fears, worries, isolation, disorientation, multiple losses (e.g., identity, family, friends, home, community, country, substantial resources, control over their lives), being ignored or unheard, disconnection with their host communities, frustration over communication, and hardships in managing everyday life. Dealing with previous experiences of gender-based violence and trauma is also common. The unpleasant, difficult feelings ASPW experience on a daily basis could foster negative affect and lack of fulfillment in their lives, which could in turn promote negative perceptions of their own overall poor health and wellbeing.

Lack of quality in the relationship with their surroundings. Poor health and wellbeing among ASPW is shaped by the complex interaction of multiple factors in political, historical, legal, socio-economic, and cultural contexts in which they are forcibly situated. Restricted access to healthcare associated with their legal status may increase the probability of being untreated and/or lacking adequate prenatal healthcare. Poor socioeconomic conditions and low levels of social support due to the applied policies may promote the prolonged "survival" state of living without adequate social, substantial, emotional, and communal support. Conflict between ASPW and people in host societies (including healthcare and social service providers), caused by disrespect of values surrounding ethnicity, culture, language, relationships, healthcare and childbearing, may create barriers and gaps in communication and social interaction. All of these factors can hamper the promotion of ASPW's health and wellbeing, resettlement in host countries, and overall quality of life as a consequence.

What could suppress the risks. Poor physical and psychological conditions, lack of personal experience of wellbeing, and negative interactions with various contextual factors could be suppressed through adequate and comprehensive healthcare, socioeconomic support, emotional and psychological support, communication and language support, as well as cultural respect and acknowledgement in host societies towards ASPW. A music therapy program design situated within a CoMT approach could help address these problems by influencing change in physiological, psychological, sociocultural, and emotional factors which cause ASPW to fall into states of poor health and wellbeing.

Risk factors. Through a directed qualitative content analysis of the relevant literature presented in Chapter Three, the risk factors are identified and summarized under the themes of (a) restricted access to healthcare, (b) inadequate provision of healthcare, (c) poor socioeconomic conditions, (d) low level of social support, (e) negative experiences with healthcare/social service providers, (f) language and communication barriers, (g) conflict of values, (h) emotional and psychological challenges, and (i) physiological challenges. See Appendix A for examples of risk factors included in these themes.

Protective factors. Through a directed qualitative content analysis of the relevant literature presented in Chapter Three, the protective factors which suppress the poor health and wellbeing of ASPW are identified and summarized under the themes of (a) adequate provision of

care, (b) adequate socioeconomic conditions, (c) social support, (d) comprehensive assessment, (e) emotional and psychological support, (f) communication and language support, and (g) cultural respect and acknowledgement. See Appendix B for examples of protective factors included in these themes.

Step 1-2: Develop a Program Theory

Malleable mediators. Some of the factors identified within the above-mentioned themes of risk and protective factors are malleable mediators (Fraser et al., 2009), meaning that they are capable of being influenced by the proposed music therapy program, and if influenced positively, may result in improved health and perceived feeling of wellbeing for ASPW's. Malleable risk factors that are positively influenced by the program could reduce the risks, while malleable protective factors that are positively influenced by the program could promote the suppression of the risks. Both malleable risk factors and protective factors are essential elements of designing an intervention program since they are the "leverage points" (Fraser et al., 2009, p. 48) of change for intervention.

Potential malleable mediators identified are: (a) fear, feelings of loss, isolation, and/or feeling disorientation; feeling ignored and unheard; frustration over communication barriers, chronic stress, physiological/psychological tension, and acculturative stress, all of which are risk factors that could be reduced through music therapy interventions; and (b) feelings of belonging and connectedness to a community, self-motivation, resilience, sense of agency, inclusion of a holistic view of health, cultural respect and acknowledgement, openness to different values, women-centered support, and culturally-informed support, all of which are protective factors that could be enhanced through music therapy interventions. These malleable mediators were found to fall under three overarching categories contained within a proposed action strategy: agency, connection, and cultural acknowledgement.

Action strategy. The focus of the open-group music therapy program in this study will be to help ASPW: (a) enhance their sense of agency, (b) build social connections, and (c) acknowledge and celebrate cultural values of themselves and others. These could be addressed through diverse music therapy experiences with a flexible program structure, conceptualized within a CoMT framework in which participatory, resource-oriented, ecological, performative, activist, reflective, and ethics-driven aspects are valued for change (Stige & Aarø, 2012).

Culturally-informed and women-centered orientations, the other two protective factors listed above, will be also employed throughout the program. Given the plurality of contexts in which ASPW are forcibly situated, women-centered practice in this program would be conceptualized within an intersectional perspective, focusing on the intersection of individuals' social identities in implied power relationships (Crenshaw, 1991). These approaches could help ASPW rediscover their resources for empowerment and transformative change (Vukich, 2015); moreover, they could give voice to the experiences of ASPW who have difficulty making themselves heard during the resettlement in host countries.

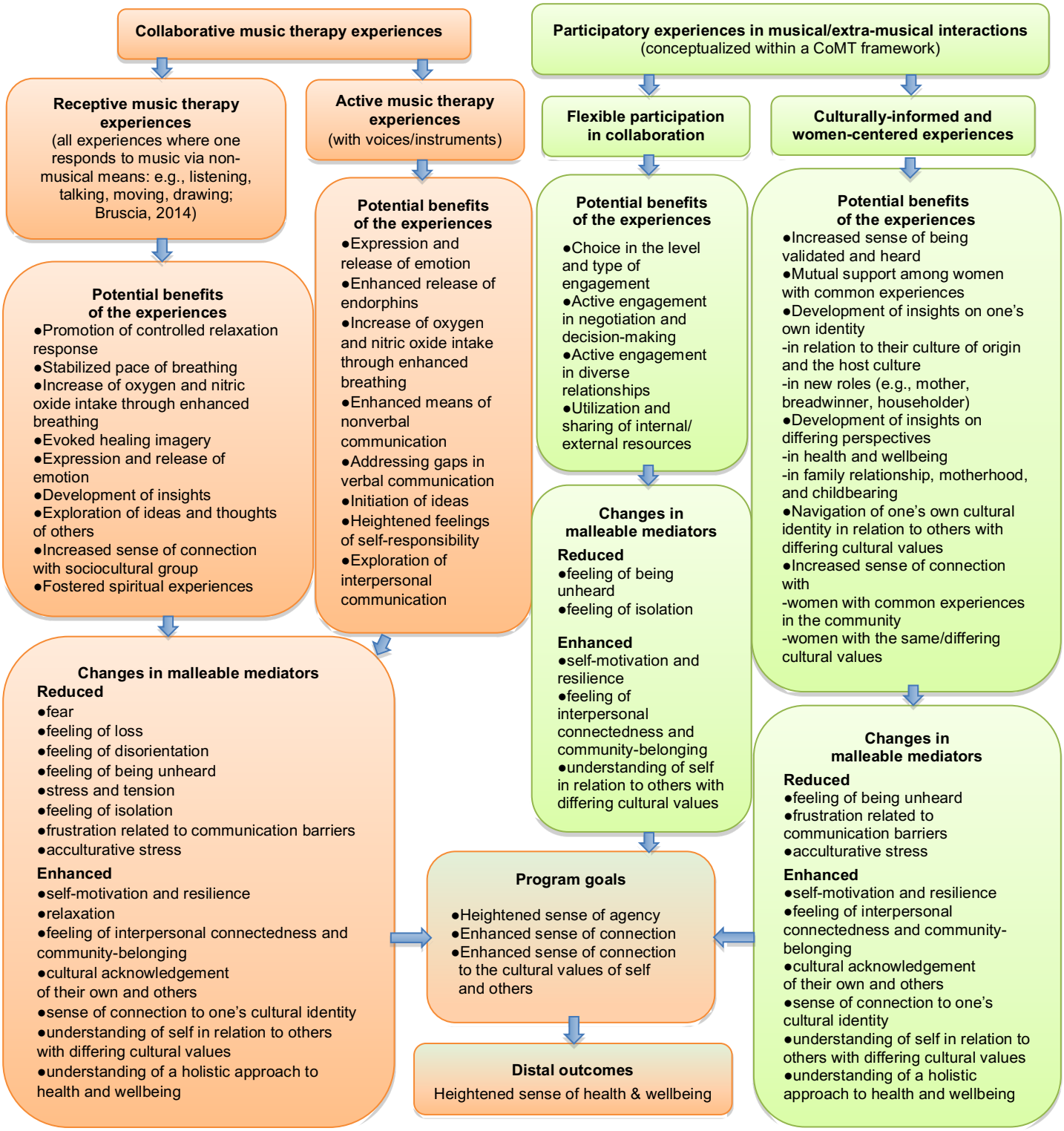
Theory of change. The strategy for promoting positive change in ASPW's sense of agency and connection, and feelings of being culturally acknowledged, is a twofold process: it involves both collective music therapy experiences and participatory methods. The proposed program will provide a flexible music-based communal arena, in which women can promote positive change in their own health and wellbeing through their music therapy experiences and participatory action; and moreover, can promote positive change in society through connecting with others, groups, and community (Ansdell, 2004). The music therapy experiences used in the program will include various types of engagement in music through receptive, improvisational, compositional, or re-creative processes (Bruscia, 2014). Flexible methods of participation throughout the program are also applied, by which the female participants are invited to be involved in decision-making, take initiatives to engage in the diverse relationships, and share their inner and external resources. The culturally-informed and women-centered practices incorporated into the participatory process described above, will provide a platform through which these women can feel heard, take ownership of their lives, and gain social connectedness. A certified music therapist will take multiple roles to support the participation, evolve the program to fit the needs of participants, and create bridges between and among different communities if the need arises. These roles may include: therapist, facilitator, negotiator, and interpreter.

The strategy to address positive change in the malleable factors identified above, through music therapy and participatory experiences, is shown in Figure 1. The potential benefits of these experiences on the malleable factors, described in Figure 1, are supported by established theory, practice, or research in music therapy regarding a refugee population, pregnant women,

community-based setting, and/or cases in which similar needs of a refugee population were addressed (See Logic model and Step 2-1).

Figure 1.

Change strategy



Logic model. Logic model specifies the intervention process and is composed of elements such as program objectives, inputs (resource needed), components/activities, outputs, intermediate outcomes (changes in mediators), and distal outcomes (Fraser et al., 2009). The framework of the open-group music therapy program needs to be flexible to address the ever-changing and multifaceted needs of ASPW during their resettlement period through constructive and supportive means, even in circumstances that may be considered non-traditional or non-typical therapy contexts. Therefore, what is being provided here are basic elements of the program, with which music therapists can flexibly apply their practices in accordance with the context-bound needs of participants. Based on literature reviewed and my own clinical experience with ASPW, these elements are as follows:

Agents. This open-group music therapy program is designed for pregnant women awaiting asylum outcomes in host countries regardless of age, ethnicity, nationality, country of origin, length of asylum-seeking, number of childbirth experiences, and/or stage of pregnancy. It is assumed that many participants may only be able to attend one or two sessions due to complex immigration processes and rapidly changing conditions related to their resettlement. The program will be facilitated by a certified music therapist (e.g., MTA, MT-BC) who has the educational background, experience, and/or knowledge to work with this population. Music therapists who are lacking in these areas should not do this work or they may work within a defined scope of practice formulated by receiving ongoing professional music therapy supervision from a music therapist who has expertise with this population.

Settings.

Frequency and length of session. This music therapy program applies an open-group format (i.e., a drop-in format) on a regular basis, in which participants will be able to choose when, how often, and in what way they participate. The group will be either ongoing or limited in duration. A minimum frequency of once a week is recommended in order to provide consistent access to support for ASPW population. Duration of each group will be between 60 and 90 minutes, depending on the selected program activities and their physiological-psychological demands on pregnant women.

Facilities. The session location may be in a clinical or non-clinical setting. A wheel-chair accessible, sound-proof room with enough space for 12 people (the ideal maximum number of participants based on my experience with ASPW in open-group setting, with the help of trained volunteers), with a thermostat and windows (to adjust light and room temperature) as well as an accessible washroom, would be needed. An extra room where partners and children can stay during the session, and/or daycare service where accompanying children could be taken care of, would help women to fully participate in the session.

Materials. Good quality musical instruments from different cultures to be used in culturally-informed ways, computer and/or tablet, CD players or other device for playing recorded music, audio-speakers, audio/video recorders (consent required), microphones, music software (e.g., Garageband), music scores, audio recordings (e.g., CDs, audio files, and internet access with a subscription to a music streaming service such as Apple music or Spotify, if possible), whiteboard, comfortable chairs and/or sofas, yoga mats, pillows, blankets, access to drinking water, cups, paper, pens, emotions stickers (e.g., emoji stickers), art materials (to provide other ways to respond to the music therapy experiences), and designated and locked storage space, would be needed.

Staff training. Volunteer interpreters would play an important role for culturally-informed practices in this open-group music therapy program. They would facilitate communication in different languages, supporting the music therapist as needed. They could also provide support by participating in music therapy experiences and other process that emerge during the session, as long as their primary focus remains on the role of language support. Initial training includes learning about (a) the unique needs of ASPW, (b) the CoMT approach and practice, (c) principles of culturally-informed and women-centered practice, and (d) perspectives and practices in the proposed music therapy program.

Funding. Costs of the music therapist's wages (may vary according to location of the program and therapist's level of experience) and capital equipment will be needed.

Program objectives. Three areas of objectives are set as follows to promote positive changes in malleable mediators:

1. First area of objective is to (a) alleviate fear, feelings of loss and disorientation, and feelings of being unheard; (b) enhance self-motivation and resilience; and (c) reduce stress and tension as well as enhancing relaxation.
2. Second area of objective is to (a) alleviate feelings of isolation, (b) reduce frustration related to communication barriers, and (c) enhance feelings of interpersonal connectedness and community belonging.
3. Third area of objective is to (a) alleviate acculturative stress, (b) enhance sense of connection to one's cultural identity, (c) enhance understanding of self in relation to others with differing cultural values, and (d) enhance understanding of a holistic approach to health and wellbeing.

These objectives work toward achieving three overarching goals: (1) heightened sense of agency, (2) enhanced sense of connection, and (3) enhanced sense of connection to the cultural values of self and others.

Program components. The participatory process in this open-group music therapy program consists of the cycle of assessment, planning, action, and evaluation/reflection, inspired by the model used in participatory action research (Reason & Bradbury, 2008; Stige & Aarø, 2012). This cycle allows the participants to "develop and learn from the actual process, rethink, return to the problem, attempt and act on a new strategy" (Elefant, 2010, p.201) and fosters their sense of agency and connection, and feeling of being acknowledged (Bolger, 2015; Elefant, 2010; Hunt, 2005; Stige, 2005). Basic participatory process involves:

- assessment, in which visions are created, values are shared, and the available means to reach the objective are examined (Stige, 2005);
- planning, in which the program structure, agenda, and activities are decided through the context analysis and appraisal of resources/challenges (Stige, 2005; Stige & Aarø, 2012);
- action*,* in which participants engage in social-musical process through building connections and navigating the predicaments within a homogenous community, a heterogenous community and between communities (Stige & Aarø, 2012); and
- evaluation and reflection, in which strengths and weaknesses of the experiences and relationships are evaluated, information for planning the next step is gained, and knowledge generated in the session is shared (Stige, 2005; Stige & Aarø, 2012).

In this music therapy program, the above cycle is applied concisely within each single session. The session structure will be arranged through collective discussion among the music therapist and participants at the beginning of each session, according to the number of participants and their expressed needs, along with their preferred method(s) of participation (some options may also be provided by the music therapist). While the participants may often be unable to attend more than one or two sessions, evaluation and reflection at the end of each session is important as it acknowledges participation and shared generated knowledge, which participants may be able to apply in their lives outside of the sessions (Elefant, 2010; Stige & Aarø, 2012) as well as encouraging future attendance. The time spent on each segment is: (a) 10 to 15 minutes for assessment and planning, (b) 35 to 60 minutes for action, (c) 10 minutes for evaluation and reflection. The guide for facilitating the participatory process will be provided below.

Program activities. Diverse music therapy experiences will be specifically used to promote positive changes in the malleable mediators identified above. Details will be described below.

***Program outputs*.** The evaluation benchmarks of this open-group music therapy program will include: (a) number of participants served; (b) number of sessions provided within a designated time period; (c) number of subsequent sessions per participant; (d) participants' self-reported experiences in the music therapy program; and (e) participants' self-reported outcomes that they attribute to their participation in the music therapy program (i.e., related to the risk factors and protective factors outlined previously). It is recommended that the last two types of evaluation are completed through a collaborative process between the music therapist and the participants (See Appendix D for a sample of collaborative evaluation).

***Intermediate outcomes (i.e., changes in malleable mediators)*.** Intermediate outcomes are positive changes in malleable mediators identified immediately after the session (Fraser et al., 2009). Through diverse collaborative music therapy experiences and flexible participatory experiences via musical and extra-musical interactions of this program as described in Figure 1, the following intermediate outcomes would be expected:

1. Achieving first area of objective results in intermediate outcomes of a) alleviated fear, feelings of loss and disorientation, and feelings of being unheard; b) enhanced self-

motivation and resilience; and c) reduced stress and tension as well as enhanced relaxation, all of which heighten the participants' sense of agency as a result.

2. Achieving second area of objective results in intermediate outcomes of a) alleviated feelings of isolation, b) reduced frustration related to communication barriers, and c) enhanced feelings of interpersonal connectedness and community belonging, all of which enhance the participants' sense of connection as a result.
3. Achieving third area of objective results in intermediate outcomes of a) alleviated acculturative stress, b) enhanced sense of connection to one's cultural identity, c) enhanced understanding of self in relation to others with differing cultural values, and d) enhanced understanding of a holistic approach to health and wellbeing, all of which enhance the participants' sense of connection to the cultural values of self and others as a result.

Distal outcomes. Distal outcomes are the outcomes observed in the longer term. The open-group music therapy program is meant to be a single session in which a follow-up of the participants is unlikely to happen. However, it could be said that the ASPW who have enhanced sense of agency, sense of interpersonal connectedness and community belonging, and sense of connection to their own cultural identity through the proposed music therapy program, could have reduced risks of social vulnerability, improved health and wellbeing, and heightened quality of life in their resettlement period. In the long term, as the number of participants increases, social connection developed among ASPW through the music therapy program could promote an opportunity to build a childbearing community, which could compensate for the shortage of public support for ASPW over the perinatal period (Feldman, 2014). The mutual support within the ASPW community could not only reduce ASPW's feelings of isolation and lack of belonging in the community, but also foster the resilience of the ASPW population at large and promote positive change in host society.

Step 2-1: Create Program Structures and Processes

The proposed open-group music therapy program utilizes two core strategies: (a) the use of participatory methods throughout the session, and (b) the application of diverse music therapy experiences within the collective format.

Participatory methods.

Assessment/planning. (10 to 15 minutes). Each session will begin with assessment and planning through collaborative discussion among the music therapist and participants to co-assess the participants' current physical and psychological health conditions, needs, interests, music preferences, and preferred methods of participation, and co-arrange the session components. See Appendix C for a sample of collaborative assessment. The music therapist will also use their professional knowledge to provide additional choices for music therapy experiences that participants might not consider as possible options. The assessment component must be executed in a brief and efficient manner to ensure that there is enough time to participate in the indicated music therapy experiences as well as in a collaborative evaluation that occurs at the end of each group.

Action. (35 to 60 minutes). Diverse music therapy experiences in a collective format, specifically selected to address the identified group goals and objectives by participants, will be conducted by the music therapist (See "Music Experiences" below for the details). Flexible participatory experiences in musical/extra-musical interactions, into which culturally-informed and women-centered approaches are incorporated, will also be employed. Each participant is considered as an expert on their experience of their own culture and its unique values (Ansdell, 2004; Stige, 2002). Therefore, each participant's ways of communicating (e.g., eye contact, gesture, delivery of speaking) and their expressed music preferences and opinions (e.g., musical genres, musical values, musical participation preferences, etc.) should be acknowledged and respected. Simultaneously, in order to facilitate collaborative music therapy experiences, the music therapist needs to encourage participants to navigate and understand themselves in relation to others with differing cultural values (Amir, 2004; Bolger, 2015; Stige & Aarø, 2012). See "Implications for Practice" in Chapter Five for some considerations regarding navigation of diverse cultural values during each session.

Reflection/evaluation. (10 minutes). The participants' overall experiences in the music therapy program and their perceived changes in malleable factors are evaluated through a brief collaborative evaluation at the end of the session (the latter can also be incorporated into the reflection section immediately after the music therapy experiences). The collaborative evaluation can be documented verbally or nonverbally depending on the method of sharing the participants prefer (Bolger, 2015; Elefant, 2010; Stige & Aarø, 2012). Some of the methods of sharing that

the participants in my open-group with ASPW explored were: (a) group reflection collage on sketchbooks or posters, to which each participant's comment, on a small colored paper, or an emotion sticker chosen by participant, was added and shared among the group (a photo was taken to keep for themselves and/or share with their families, with unanimous consent); (b) 3 minute-freestyling rap in which participants shared verbally and musically their experiences and thoughts on the session (audio-recorded and shared with unanimous consent); and (c) brief art-based collective performance in which each participant shared their reflection in one word or phrase accompanied by body movement or rhythms created by body percussion. Music therapists would provide choices as participants may not have a sense of the various forms of a collaborative evaluation. While the collaborative process in evaluation is essential, the music therapist must be actively engaged in the collaboration process within culturally-informed and women-centered framework of the program. When audio/video/photo recording is an option, the music therapist must determine what type of consent process is needed, navigating both legal and cultural considerations. See Appendix D for a sample collaborative evaluation.

Music therapy experiences. The proposed music therapy experiences are categorized by method of participants' musical engagement: receptive, improvisational, compositional, and re-creative, as defined by Bruscia (2014). See Table 1, 2, and 3 for the music therapy experiences specific to the goals and objectives outlined previously. Descriptions of participants' potential musical engagement and the role of music therapist within each music therapy experience follows the table. Unlike a closed group session where an established therapeutic alliance can be a resource for optimizing music therapy experiences over time, a single group session format requires the music therapist to consider how participants' may experience maximum benefit in this unique context. The music therapist may need to provide forms of directive facilitation that still incorporate the culturally-informed and women-centered approaches previously discussed.

Table 1

Music Therapy Experiences Specific to Goal 1: Heightened Sense of Agency

Objective 1. Alleviate fear, feelings of loss and disorientation, and feelings of being unheard	
Receptive	● Music-assisted relaxation ● Music-facilitated relaxation/breathing skills-training ● Music-assisted body scan ● Music listening and imagery ● Song (music) discussion
Improvisational	● Instrumental/vocal improvisation (referential and/or non-referential) ● Vocalization and toning ● Movement to music
Compositional	● Songwriting ● "Welcome song"-writing ● Composition without lyrics
Re-creative	● Music sharing through music-making (including songs) ● Lullaby sharing ● Music skills development ● Band ● Choir
Objective 2. Enhance self-motivation and resilience	
Receptive	● Music-facilitated relaxation/breathing skills-training ● Music-assisted body scan ● Music listening and imagery ● Song (music) discussion
Improvisational	● Instrumental/vocal improvisation (referential and/or non-referential) ● Vocalization and toning ● Movement to music
Compositional	● Songwriting ● "Welcome song"-writing ● Composition without lyrics
Re-creative	● Music sharing through music-making (including songs) ● Lullaby sharing ● Music skills development ● Band ● Choir
Objective 3. Reduce stress and tension as well as enhancing relaxation	
Receptive	● Music-assisted relaxation ● Music-facilitated relaxation/breathing skills-training ● Music-assisted body scan ● Music listening and imagery ● Song (music) discussion
Improvisational	● Vocalization and toning ● Movement to music

Table 2

Music Therapy Experiences Specific to Goal 2: Enhanced Sense of Connection

Objective 1. Alleviate feelings of isolation	
Receptive	● Music listening and imagery ● Song (music) discussion
Improvisational	● Instrumental/vocal improvisation (referential and/or non-referential) ● Vocalization and toning ● Movement to music
Compositional	● Songwriting ● "Welcome song"-writing ● Composition without lyrics
Re-creative	● Music sharing through music-making (including songs) ● Lullaby sharing ● Music skills development ● Band ● Choir
Objective 2. Reduce frustration related to communication barriers	
Improvisational	● Instrumental/vocal improvisation (referential and/or non-referential) ● Vocalization and toning ● Movement to music
Compositional	● Songwriting ● "Welcome song"-writing ● Composition without lyrics
Re-creative	● Music sharing through music-making (including songs) ● Lullaby sharing ● Music skills development ● Band ● Choir
Objective 3. Enhance feelings of interpersonal connectedness and community belonging	
Receptive	● Music listening and imagery ● Song (music) discussion
Improvisational	● Instrumental/vocal improvisation (referential and/or non-referential) ● Vocalization and toning ● Movement to music
Compositional	● Songwriting ● "Welcome song"-writing ● Composition without lyrics
Re-creative	● Music sharing through music-making (including songs) ● Lullaby sharing ● Music skills development ● Band ● Choir

Table 3

Music Therapy Experiences Specific to Goal 3: Enhanced Sense of Connection to the Cultural Values of Self and Others

Objective 1. Alleviate acculturative stress	
Receptive	● Music listening and imagery ● Song (music) discussion
Improvisational	● Instrumental/vocal improvisation (referential and/or non-referential) ● Vocalization and toning ● Movement to music
Compositional	● Songwriting ● "Welcome song"-writing ● Composition without lyrics
Re-creative	● Music sharing through music-making (including songs) ● Lullaby sharing ● Music skills development ● Band ● Choir
Objective 2. Enhance sense of connection to one's cultural identity	
Receptive	● Music listening and imagery ● Song (music) discussion
Improvisational	● Instrumental/vocal improvisation (referential and/or non-referential) ● Vocalization and toning ● Movement to music
Compositional	● Songwriting ● "Welcome song"-writing ● Composition without lyrics
Re-creative	● Music sharing through music-making (including songs) ● Lullaby sharing ● Music skills development ● Band ● Choir
Objective 3. Enhance understanding of self in relation to others with differing cultural values	
Receptive	● Music listening and imagery ● Song (music) discussion
Improvisational	● Instrumental/vocal improvisation (referential and/or non-referential) ● Vocalization and toning ● Movement to music
Compositional	● Songwriting ● "Welcome song"-writing ● Composition without lyrics

Objective 3. Enhance understanding of self in relation to others with differing cultural values	
Re-creative	● Music sharing through music-making (including songs) ● Lullaby sharing ● Music skills development ● Band ● Choir
Objective 4. To enhance understanding of a holistic approach to health and wellbeing	
Receptive	● Music-facilitated relaxation/breathing skills-training ● Music-assisted body scan ● Music listening and imagery
Improvisational	● Instrumental/vocal improvisation (referential and/or non-referential) ● Vocalization and toning ● Movement to music
Compositional	● Songwriting ● "Welcome song"-writing ● Composition without lyrics
Re-creative	● Music sharing through music-making (including songs) ● Lullaby sharing ● Music skills development ● Band ● Choir

Receptive Experiences. Receptive music therapy experiences in this music therapy program include those in which participants allow themselves to respond to music listening experiences (i.e., they are not taking part in active music making) via non-musical means. These experiences also include active engagement of participants in choice-making processes (e.g., choosing music to listen to, ways of responding to the receptive music therapy experiences such as talking, moving, drawing) and skill-building (e.g., a learning goal such as learning relaxation and/or breathing techniques paired with music listening). These experiences could help participants to have specific body responses, promote and/or control relaxation responses, pace their breathing, evoke affective states and imagery, develop insights, identify and/or explore varied feelings, explore others' ideas and thoughts, facilitate memory and reminiscence, build a connection with a sociocultural group, and foster their spiritual experiences (Bauer et al., 2010; Browning, 2000, 2001; Bruscia, 2014; Gardstrom & Sorel, 2015).

Music-assisted relaxation. Participants are invited to relax while listening to pre-recorded or live (performed by music therapist) music which may also include verbal guidance provided

by the music therapist. Participants select music and playing method (live or recorded) from a list created by the music therapist. The music therapist needs to allow enough time and provide direction for bringing the participants out of the relaxed state at the end of the music therapy experience (Alanne, 2010; Bauer et al., 2010; Glocke & Wigram, 2007).

Music-facilitated relaxation/breathing skills-training. Participants learn exercises (e.g., use of imagery, progressive muscle relaxation, breathing techniques, etc.) paired with listening to selected recorded music. The music therapist offers a choice of music to participants, and provides verbal instruction for relaxation techniques during music listening to condition a relaxation response to the selected music, or instructs how to synchronize breathing with music. Information on the benefits of practicing relaxation and breathing during pregnancy and labor are also provided. Audio recordings can be prepared for home practice. Copyright issues would be need to be taken into consideration (Bauer et al., 2010; Browning, 2000, 2001; Liebeman & MacLaren, 1991).

Music-assisted body scan. Participants are invited to bring their mental attention and awareness to various parts of their bodies through the verbal guidance of the music therapist, while listening to specially selected recorded music (Glocke & Wigram, 2007; Lesiuk, 2016).

Music listening and imagery. The music therapist invites participants to engage in a brief listening experience of carefully chosen instrumental music to stimulate and explore imagery (Gardstrom & Sorel, 2015). Participants are invited to sit upright and be in a relaxed state, while listening to selected instrumental music and imaging through the directive verbal guidance of the music therapist. Verbal processing and/or art-making or writing typically follows (Alanne, 2010; Beck et al., 2017; Gardstrom & Sorel, 2015). In order to familiarize themselves with the supportive level of practice that would be provided in the session, it is recommended that music therapists who want to implement this music therapy experience complete at least the first level of training in the Bonny Method of Guided Imagery and Music (BMGIM).

Song (music) discussion. Participants are invited to choose pre-recorded songs or music (specific recordings or performers, if requested) that are personally significant to them, and share these with other participants. The music therapist provides an option of choosing culturally relevant songs or music. The groups listens to the chosen songs or music together and the music therapist facilitates a reflective group discussion to help participants experience meaningful

connections with the songs/music and other participants. Group reflection could also take on a non-verbal form such as art-making and imagery (Alanne, 2010; Gardstrom & Sorel, 2015; Hunt, 2005).

Improvisational experiences. Improvisational music therapy experiences actively engage participants in spontaneous music-making with the therapist and other members of the group, through playing instruments, vocalizing, doing body-percussion, and creating sounds with objects (Bruscia, 2014). These experiences could help participants establish a nonverbal medium of communication, fill gaps in verbal communication, identify and/or explore varied feelings, explore and form identities, initiate new ideas, explore various aspects of self in interpersonal communication, enhance relationships with others, develop group skills, and create aesthetic experiences in context (Bruscia, 2014; Nordoff & Robbins, 2007; Wigram, 2004).

Instrumental/vocal improvisation (referential and/or non-referential). Participants are invited to explore and express themselves non-verbally in individual and collective improvisatory musicking experiences. The improvisations may be based on themes of the participants' choice (referential) or may not have an identified theme (non-referential). The improvisations may refer to music, images, stories, titles, words, feelings, and/or works of art. The music therapist offers a choice of instruments to participants (using culturally relevant instruments could be an important option), and facilitates their collaborative musical exploration. Other creative forms of expression, such as art, light and soft movement, and story/poem-writing could be incorporated into the improvisational experience, if necessary, to support individuals' multi-modal self-exploration. (Ahonen & Mongillo Desideri, 2014; Alanne, 2010; Coomes, 2018; Federico, 2016; Hunt, 2005; Jin, 2016; Jones et al., 2004; Orth & Verburgt, 1998; Zharinova-Sanderson, 2004).

Vocalization and toning. Participants are invited to engage in self-exploration through toning ("voicing the exhalation of breath on a single pitch, using a vowel sound or a hum" : Pierce, 1998, p. 41), chanting, and vocalizing as a group. The music therapist instructs the method of vocalizing and toning, as well as providing information on the benefits of practicing vocalization during pregnancy and labor, which are communicating with the fetus and optimizing stress and tension management. Home practice methods could also be provided to participants (Barbieri, 2015; Federico & Whitwell, 2001; Pierce, 1998, 2001).

Movement to music. Participants are invited to engage in light and soft movements, that should be adapted according to each woman's health status and stage of pregnancy, using pre-recorded or live music (performed by the music therapist and/or participants) chosen by participants. The music therapist offers a choice of music and instruments to participants (using culturally relevant music and instruments could be an important option) and facilitates their body awareness and musical exploration in group collaboration by playing and/or moving together (Coombes, 2018; Federico & Whitwell, 2001; Hunt, 2005; Orth & Verburgt, 1998; Zharinova-Sanderson, 2004).

Compositional experiences. Compositional music therapy experiences engage participants in creating and revising personal ideas, thoughts, and fantasies, through workable musical and/or lyrical frameworks (Gardstrom & Sorel, 2015). These experiences could help participants enhance problem-solving skills, develop organizing and planning skills, promote self-responsibility, enhance the ability to communicate their inner experiences, explore therapeutic themes through lyrics, and develop the ability to synthesize parts into a whole to build a total picture of a situation (Bruscia, 2014).

Songwriting. Participants are invited to explore themselves through composing original lyrics and melodies, or substituting lyrics of preexisting songs. Song topics can include specific emotions that participants want to explore, memories they wish to revisit and/or share, messages to significant others, or any other topic of their choice. Participants may sing their created songs a cappella, use accompanying instruments, or incorporate pre-recorded music/musical patterns (e.g., rap and hip-hop beats). Songs may be performed live or video- and/or audio-recorded according to the participants' choice. The music therapist encourages the use of culturally relevant musical genres and elements for composition, facilitates group collaboration, and provides varied levels of practical/musical support in creation and performance. Writing in different languages would be facilitated by the use of volunteer interpreters. The music therapist should structure the songwriting process so that it can be completed within a single session. (Hunt, 2005; Jones et al., 2004).

"*Welcome song" writing*. Participants are invited to compose songs specifically focused on their expected (i.e., unborn) children. The songs may be created by participants during the session, and then sung and shared with their partner and child during pregnancy, childbirth, and

post-natal period. The music therapist provides musical, emotional, and interpersonal support in creating the songs. Writing in different languages would be facilitated by the use of volunteer interpreters. The music therapist should structure the songwriting process so that it can be completed within a single session. The process may include some form of notation or recording of the final product that can be provided to the participants for individual use (Barbieri, 2015; DiCamillo, 1999).

Composition without lyrics. Participants are invited to explore themselves in composing original music or adapting precomposed musical material without lyrics. Themes, musical genres, styles, components, and the medium of composition (e.g., music software) are selected by participants. The music therapist encourages the use of culturally relevant instruments, genres, and elements for composition, facilitates group collaboration, and provides varied levels of practical/musical support in composition including notation, recording, and performance of the final product. The music therapist should structure the composition process so that it can be completed within a single session (Bruscia, 2014; Hunt, 2005).

Re-creative Experiences. Re-creative music therapy experiences include the vocal and/or instrumental reproduction of precomposed (i.e., existing) musical materials within contexts such as group sing-alongs, instrumental bands, group music lessons, and musical games/activities (Bruscia, 2014). These experiences could help participants build up the ability to interpret and/or communicate ideas and feelings through music, foster feelings of self-worth and achievement, improve attention, promote feelings of empathy for others, and develop interpersonal communication skills (Bruscia, 2014; Gardstrom & Sorel, 2015).

Music sharing through music-making (including songs). Participants are invited to choose precomposed songs or music that are personally significant to them, and share it with other participants through singing or music-making. The music therapist provides an option of choosing culturally relevant songs or music, encourages other participants to sing or play as well, and facilitates group reflection to help participants experience meaningful connections with songs/music and other participants. Using instruments relevant to participants' cultures for accompaniment and/or music-making could be an option (Coombes, 2018; Jin, 2016; Jones et al., 2004; Hunt, 2005; Zharinova-Sanderson, 2004).

Lullaby sharing. Participants are invited to select precomposed lullabies and share these with other participants by singing or playing a pre-recorded version. The music therapist encourages the group members to share, and helps those who do not have specific lullabies to refer to other participants' lullabies in order to develop their own ideas on how to incorporate lullabies into their parenting. Group reflection and information-sharing on mother-fetus/child bonding would be facilitated by the music therapist after the lullaby sharing (Carolan et al., 2012; Federico, 2016).

Music skills development. Participants are invited to learn and develop music-making skills and knowledge (e.g., skills of playing instruments and using voice), and to share with other participants if they have previous experience of music-making. Learning culturally relevant instruments could be an option if the music therapist or any participant can support the learning of those who wish to do so. The music therapist should structure music skills development process such that it can be optimized and completed within a single session, and facilitates participants' process of connecting/reconnecting to music instruments. Information on the community music circles in the neighborhood and free music concerts resources would also be provided for the participants who want to further develop their music skills (Jin, 2016; Bolger, 2015; Storsve et al., 2010; Zharinova-Sanderson, 2004).

Band. Participants are invited to try music-making in a band style. When co-arranging the session with participants, the music therapist needs to clarify the limitations of what participants can experience within a single session. The music therapist should structure the trial process such that it can be optimized and completed within a single session. This means that providing the choice of music and instruments to play, as well as facilitating group collaboration, should be done with the consideration of each participant's level of music knowledge and previous experience of music-making. In the case that participants are interested and able to be involved for multiple sessions, diverse music therapy experiences such as songwriting, skills development, rehearsals, and jam sessions would also be incorporated. Information on the community band in the neighborhood for the participants who want to continue band activities would be provided (Jin, 2016; Bolger, 2015; Jones et al., 2004; Storsve et al., 2010; Zharinova-Sanderson, 2004).

Choir. Participants are invited to try collective singing in a choir style. The music therapist needs to clarify the limitation of what they can experience within a single session, when

co-arranging the session with participants. The music therapist should structure the trial process such that it can be optimized and completed within a single session. Therefore, providing the choice of songs and facilitating group collaboration should be done with the consideration of each participant's level of musical knowledge and previous experience of singing. In the case that participants are interested and able to be involved for multiple sessions, diverse music therapy experiences such as song choice, songwriting, skills development, rehearsals, and optional community performance would also be included. Information on the community choir in the neighborhood for the participants who want to sing in a choir outside of this context would also be provided (Elefant, 2010; Jin, 2016; Stige, 2010).

In order to further conceptualize and accommodate the practice for use in diverse settings, the framework of this open-group music therapy program for ASPW was summarized in an 'at a glance' table format (see Table 4 below).

Table 4

The Proposed Framework of the Open-Group Music Therapy Program for ASPW

Assessment/Planning (10-15 minutes)
● Co-assessment of the participants' current physical and psychological health conditions, needs, and interests, by music therapist and participants ● Co-arrangement of the session components by music therapist and participants (see Step 2-1 and Appendix C)
Action (35-60 minutes)
● Diverse music therapy experiences in a collective format, specifically selected to the identified group goals and objectives (See Step 2-1, Table 1, 2, and 3) ● Flexible participatory experiences in musical/extra-musical interactions, into which culturally-informed and women-centered approaches are incorporated (see Step 2-1)
Reflection/Evaluation (10 minutes)
● Brief collaborative evaluation by music therapist and participants on: a) participant's self-reported overall experiences in the program b) participant's perceived changes in malleable factors (could also be integrated into the reflection section of the previous music therapy experiences) (see Step 2-1 and Appendix D)
Case Example
● See Appendix E

Chapter Conclusion

This chapter presented the results of directed qualitative content analysis of related literature, which was conceptualized within the first 1.5 steps of Fraser et al. (2009) intervention research methodology. The analysis revealed the main problems of ASPW, as well as multiple risk and protective factors, and potential malleable mediators inherent to the wellbeing of ASPW during their period of resettlement. These findings combined with relevant literature and my experienced-based perspectives, resulted in an action strategy and theory of change that informed the development of an open-group music therapy program design for ASPW within a CoMT approach. Essential components of the program were outlined with emphasis on participatory focus and collaborative music therapy experiences within a flexible structure.

Chapter 5. Discussion

This study aimed to create a flexible single session framework for an open-group music therapy program within a CoMT orientation, to address the needs of ASPW during their resettlement period. The primary research question was: How can an open-group Community Music Therapy (CoMT) program be designed to address the needs of ASPW during their resettlement period? The subsidiary research questions were: What are the needs of ASPW during their resettlement period?; What music therapy experiences might meet these needs in an open-group CoMT setting and why?; and What is the overarching structure of the proposed program? A directed qualitative content analysis of related literature revealed that the main problems of asylum-seeking prenatal women during their resettlement were poor health and absence of perceived feelings of wellbeing. The analysis also revealed multiple risk and protective factors, as well as potential malleable mediators inherent to the wellbeing of ASPW. These findings combined with relevant literature and my perspectives, resulted in theory of change that informed the development of an open-group music therapy program design for ASPW within a CoMT approach. Essential components of the program were outlined with emphasis on participatory focus and diverse collaborative music therapy experiences within a flexible structure. The present chapter will discuss the limitations of this study as well as potential implications for practice. Suggestions for future research will be also presented.

Limitations

As only the first step and a half of the intervention research methodology was implemented, the proposed music therapy program was not tested and the results are theoretical in nature. The results of this study are also limited by the fact that my experience of working with this population has occurred at only one facility. I am also an inexperienced researcher, and my biases and assumptions about the effectiveness of music therapy may have inadvertently influenced how I interpreted the data and presented the results. Finally, the lack of literature on the use of music therapy with ASPW may have limited how the results were realized and their potential direct applicability.

Implications for Practice

The findings of this research (i.e., the proposed program framework) indicated a need to highlight some additional considerations that music therapists should take into account when

working with ASPW. These considerations are supported by literature, by the perspectives gained during this research process, and my own experiences working with ASPW.

Need for collaboration in musical and extra-musical interactions. Collaboration between the music therapist and participants throughout this open-group music therapy program is fundamental to offering participants the potential for heightened sense of agency, increased social connectedness (Bolger, 2015), and enhanced sense of connection to the cultural values of self and other. Pointing out the music therapists' tendency to feel as if they were "'not doing their job' unless they are actively making music with people" (Bolger, 2015, p. 102), Bolger (2015) highlighted the importance of extra-musical interactions as an embedded element of music therapy process, especially in the context of culturally-appropriate practice. The extra-musical interactions help both the music therapist and participants to deepen their understanding of the person they are collaborating with, and share ideas on how they should support the collaboration. Therefore, music therapists who want to implement the proposed music therapy program need to consider the extra-musical interactions, which occur during the assessment/planning and reflection/evaluation components, as an integral part of the program in order to fully address the needs and potentials of ASPW.

Culturally-informed music therapy practice with asylum-seekers. According to Berry (2011), the strategy which migrants use to navigate their cultural identities depends on how, and how much, they want to relate to their culture of origin, and to the host culture, as well as what the residents in the host culture expect of those migrants. Migrants and residents create new ways of relating to each other through a process of interaction and negotiation (Berry, 2011). Consequentially, the balance between preserving culture of origin and adopting a new cultural identity is individual, changes over time, and is aligned with context-bound factors inherent in migration (Amir, 2004; Berry, 2011). Some find their culture of origin as a "source of comfort, pride and confidence" (Amir, 2004, p. 255), while others find it as proof of their foreignness that they want to erase in the new cultural community (Amir, 2004). There is no simple or right answer for navigating such a cultural dilemma (Amir, 2004).

The proposed music therapy program provides a music-based communal space in which ASPW's cultural dilemmas are shared and navigated through collaboration with others. Amir (2004) highlighted the potential of a CoMT group in which peer participants can validate each

others' cultural dilemmas and foster confidence in ways that music therapists cannot always offer due to the power they hold as therapists (Amir, 2004). Music therapists, particularly those belonging to the host culture, need to be aware of power dynamics in the therapist-participant relationship. It is essential that music therapists acknowledge and non-judgmentally accept participants' varied forms of cultural expression during sessions.

The various cultural values which may be explored in the proposed open music therapy program have potential to conflict (Amir, 2004; Stige & Aarø, 2012). Although participants may share some homogenous perspectives as ASPW experiencing ongoing negotiations with the host culture, their cultures of origin will differ. In the proposed music therapy program, music therapists are required to support participants who are navigating conflict through collaborative processes. Therefore, it is recommended that music therapists examine the emergent values on both individual and communal levels, and work toward achieving balance them by negotiating issues according to the context (Stige & Aarø, 2012).

Considerations pertaining to children and male partners. In my own open-group work with ASPW, participants' children and male partners often accompanied them to sessions, due to a lack of access to daycare. Mothers accompanied by children are not able to engage fully in sessions, as their attention is divided between the group activities and childminding. Some participants may also feel threatened by the presence of men in the group. To facilitate ASPW's full participation, it would be preferable to provide a daycare service or a separate waiting area for children and male partners to use during sessions. If this is not feasible and the mothers have to look after their children, the music therapist should: (a) validate the feelings of the child-accompanying mothers, (b) explain that including the children as participants (rather than distracting them with phones and tablets) is an objective of the group, and (c) suggest setting goals and choosing activities which accommodate children's participation. The music therapist also needs to create an environment that reduces the burden of child-accompanying mothers at early stages of the session. This can be achieved by creating music therapy experiences which engage children, or by identifying whom is responsible for supervising children. Since the quality of some of the music therapy experiences listed (such as music-assisted relaxation) may be reduced by the participation of children, consideration and adaptation are required to ensure that child-accompanying mothers benefit, to some degree, from the music therapy experiences.

Contraindications.

Physiological concerns. Music therapists must be alert for any physical changes in pregnant women such as nausea, difficulty in breathing, and sudden fatigue, before, during, and after the music therapy experiences. It is often contraindicated for pregnant women in their second and third trimesters to twist their bodies intensely, lie on their backs, and hold their breaths (Barbieri, 2015). The music therapists should ask participants at the beginning of the session, whether they have any medical conditions or other special considerations. As follow-up sessions are not guaranteed, music therapists should limit the music therapy experiences to those which fall within a supportive scope of practice, are of low physical intensity, and provide gentle emotional release. It is advisable to ensure that participants talk with their doctors and/or midwives prior to their participation in the music therapy program.

Psychological concerns and trauma re-stimulation. Even though the music therapy experiences provided in the sessions are limited to a supportive level, participants may still have some strong emotional experiences. Moreover, participants' stress or survival responses could be triggered by musical, sensory, and/or contextual stimuli which evoke traumatic memories (Alanne, 2010; Metzner et al., 2018; Signorelli & Coello, 2011). The music therapists should observe and support participants closely during sessions. As well as avoiding participant-identified triggers, music therapists must be aware of session components which could become triggers including: (a) aural stimuli such as sounds of clocks, high pitched, loud, sudden or rough sounds, fast drumming, sounds with intensity, dull beats, thuds, and sounds of xylophone and strings (Allane, 2010; Metzner, et al., 2018; Signorelli & Coello, 2011); and (b) sensory and contextual stimuli such as physical contact, forced eye contact, body percussion, vestibular sensations, use of red paint, use of vulnerable postures and movements, windowless rooms, closed doors, confined spaces, one way mirrors, cameras, and audio/video-recorders (Signorelli & Coello, 2011). In general, therapy work with participants with traumatic experiences requires additional specialized training along with music therapy education. Music therapists should work within their scope of practice, and should work with a co-therapist if they lack the training required to address complex mental health issues. It is also highly recommended that music therapists receive supervision to define boundaries around their scope of practice and to avoid

vicarious trauma: the trauma reaction of therapists caused by exposure to clients' traumatic experiences over time (Lonn & Haiyasoso, 2016).

Recommendations for Future Research

Following the next steps of the intervention research methodology, the proposed music therapy program should be tested in practice and refined in order to be considered as a model of best music therapy practice with ASPW. Given the specific needs of asylum-seekers and ASPW as discussed above, it is also recommended that future music therapy research could: (a) acknowledge individuals in asylum as distinct from those in refugee status, and (b) examine the role of music therapy with ASPW by integrating the two contexts of asylum and pregnancy within a continuum of care. While this study specifically examined the use of music therapy with ASPW in an open-group setting, future research could examine diverse practices in different settings on a spectrum from individual to communal and/or clinical to community-based (Ansdell, 2002). A program design specific to the benefit of children-accompanying ASPW could be developed and tested. The multiple and unique roles of the music therapist in the proposed music therapy programs could also be examined.

Culturally-informed music therapy practice specific to ASPW is another area highlighted by this study that could be further developed by additional research. The participatory and collaborative process, which the proposed music therapy program recommends as a tool for navigating participants' differing cultural values, could be further examined by incorporating more ecological and intersectional perspectives. Participants' cultural perspectives of prenatal health and the prenatal use of music and voice are other topics to be examined. As the sociocultural needs of ASPW are shaped by conflicting values in host societies, further research involving a holistic understanding of pregnancy, birth, and music on both individual and collective levels, would help to inform music therapy practice with this population.

While this study focused on a CoMT approach, the relevance of other postmodern music therapy approaches, including a Resource-Oriented approach (Rolvsjord, 2010), a Culture-Centered approach (Stige, 2002), and a Feminist approach (Curtis, 2006), could be further examined and integrated into an eclectic practice framework in order to more comprehensively address the multidimensional needs of ASPW. Likewise, future research could examine different

healthcare providers' perspectives on the relevance of community-based approaches to ASPW within the context of interdisciplinary practices.

Concluding Remarks

An inherent goal of this study was to conceptualize the experience of working with ASPW in a practical way, so that other music therapists and healthcare professionals may relate to the material and develop their practices accordingly. Although the proposed open-group music therapy program has not yet been validated via practice-based research, it is my hope that diverse health care providers inspired by this study will carefully use this material to expand their work and their perspectives. Exploring possibilities for flexible music therapy approaches with ASPW will generate new knowledge on this population, and develop effective and meaningful practices that will address these women's multifaceted needs, allowing their voices to be heard.

References

Ahonen, H., & Mongillo Desideri, A. (2014). -Heroines' journey- emerging story by refugee women during group analytic music therapy. *Voices: A World Forum for Music Therapy, 14.* doi:10.15845/voices.v14i1.686

Alanne, S. (2010). *Music psychotherapy with refugee survivors of torture: Interpretations of three clinical case studies.* Helsinki: Sibelius-Akatemia.

Alder, J., Fink, N., Bitzer, J., Hösli, I., & Holzgreve, W. (2007). Depression and anxiety during pregnancy: A risk factor for obstetric, fetal and neonatal outcome? A critical review of the literature. *The Journal of Maternal-Fetal & Neonatal Medicine, 20*(3), 189–209. doi: 10.1080/14767050701209560.

Amir, D. (1998). The use of Israeli folksongs in dealing with women's bereavement and loss in music therapy. In D. Dokter (Ed.), *Arts therapists, refugees and migrants: Reaching across borders* (pp. 217-235). London: Jessica Kingsley .

Amir, D. (2004). Community music therapy and challenge of multiculturalism. In G. Ansdell & M. Pablicevic (Eds.), *Community music therapy* (pp.249-266). London: Jessica Kingsley.

Ansdell, G. (2002). Community music therapy and the winds of change. *Voices: A World Forum for Music Therapy, (2)*2. doi: 10.15845/voices.v2i2.83

Ansdell, G. (2004). Rethinking music and community: theoretical perspectives in support of community music therapy. In G. Ansdell & M. Pavlicevic (Eds.), *Community music therapy* (pp.65-90). London, England: Jessica Kingsley.

Baker, F., & Jones, C. (2006). The effect of music therapy services on classroom behaviours of newly arrived refugee students in Australia: A pilot study. *Emotional and Behavioural Difficulties, 11*, 249–260. doi:10.1080/13632750601022170

Bansil, P., Kuklina, E. V., Meikle, S. F., Posner, S. F., Kourtis, A. P., Ellington, S. R., & Jamieson, D. J. (2010). Maternal and fetal outcomes among women with depression. *Journal of Women's Health, 19* (2), 329-34. doi: 10.1089/jwh.2009.1387

Barbieri, J. M. (2015). *Addressing perceived pain in childbirth: A music theory voicework intervention design* (Master's thesis, Concordia University, Montreal, Canada). Retrieved from: https://spectrum.library.concordia.ca/979869/

Bauer, C., Victorson, D., Rosenbloom, S., Brocas, J., & Silver, R. (2010). Alleviating distress during antepartum hospitalization: A randomized controlled trail of music and recreation therapy. *Journal of Women's Health,* 19(3), 523-531. doi: 10.1089=jwh.2008.1344

Beck, B. D., Messel, C., Meyer, S. L., Cordtz, T. O., Søgaard, U., Simonsen, E., & Moe, T. (2017). Feasibility of trauma-focused Guided Imagery and Music with adult refugees diagnosed with PTSD: A pilot study. *Nordic Journal of Music Therapy*, 27(1), 67-86. https://doi.org/10.1080/08098131.2017.1286368

Berry, J. W. (1997). Immigration, acculturation, and adaptation, *Applied Psychology*, *46*(1), 5-34. https://doi.org/10.1111/j.1464-0597.1997.tb01087.x

Berry, J. W. (2005). Acculturation: Living successfully in two cultures, *International Journal of Intercultural Relations*, *29*(6), 697-712. https://doi.org/10.1016/j.ijintrel.2005.07.013

Berry, J. W. (2011). Integration and Multiculturalism, *Papers on Social Representations*, 20, 2.1-2.21. Retrieved from https://www.researchgate.net/publication/266528000_Integration_and_Multiculturalism_Ways_towards_Social_Solidarity/link/54b3fbd40cf28ebe92e4480f/download

Biaggi, A., Conroy, S., Pawlby, S., & Pariante, C. M. (2016). Identifying the women at risk of antenatal anxiety and depression: A systematic review. *Journal of Affective Disorders, 191,* 62-77. http://dx.doi.org/10.1016/j.jad.2015.11.014

Bjerke, S. E. Y., Vangen, S., Nordhagen, R., Ytterdahl, T., Magnus, P., & Stray-Pedersen, B. (2008). Postpartum depression among Pakistani women in Norway: Prevalence and risk factors. *The Journal of Maternal-Fetal and Neonatal Medicine, 21*(12), 889-894. doi: 10.1080/14767050802320340

Bloom, B. L. (2001). Focused single-session psychotherapy: A review of the clinical and research literature. *Brief treatment and crisis intervention, 1*(1), 75-86. doi: 10.1093/brief-treatment/1.1.75

Bogic, M., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: A systematic literature review. *BMC International Health and Human Rights, (15)*29. https://doi.org/10.1186/s12914-015-0064-9

Bolger, L. (2015). Being a player: Understanding collaboration in participatory music projects with communities supporting marginalized young people. *Qualitative inquiries in Music Therapy, 10*(3), 77-126.

Bozorgmehr, K., Biddle, L., Preussler, S., & Mueller, A. (2018). Differences in pregnancy outcomes and obstetric care between asylum seeking and resident women: A cross-sectional study in a German federal state, 2010-2016. *BMC Pregnancy and Childbirth*, *18*, 417. https://doi.org/10.1186/s12884-018-2053-1

Brown-Bowers, A., McShane, K., Wilson-Mitchell, K., & Gurevich, M. (2015). Postpartum depression in refugee and asylum-seeking women in Canada: A critical health psychology perspective. *Health*, *19*(3), 318-335. doi: 10.1177/1363459314554315

Browning, C. A. (2000). Using music during childbirth. *Birth, 27*(4), 272-276. doi:10.1046/j.1523-536x.2000.00272

Browning, C. A. (2001). Music therapy in childbirth: Research in practice. *Music Therapy Perspectives, 19*(2), 74-81.

Bruscia, K. (2014). *Defining Music Therapy* (3rd ed.). Gilsum, NH: Barcelona.

Bunn, M., Goesel, C., Kinet, M & Ray, F. (2016). Group treatment for survivors of torture and severe violence: A literature review. *Torture: Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture*, *26*(1), 45-66. Retrieved from: https://pdfs.semanticscholar.org/a79d/094d23a9506f918377dcb8326e82f76c28bb.pdf

Byrne, J., Hauck, Y., Fisher, C., Bayes, S., & Schutze, R. (2014). Effectiveness of mindfulness-based childbirth education pilot study on maternal self-efficacy and fear of childbirth. *Journal of Midwifery & Women's Health, 59*(2), 192-197. https://doi.org/10.1111/jmwh.12075

Cameron, C. L. (2007). Single session and walk-in psychotherapy: A descriptive account of the literature. *Counselling and Psychotherapy Research, 7*(4), 245-249. doi: 10.1080/14733140701728403

Canadian Association of Music Therapists. (2016). *About music therapy.* Retrieved from: https://www.musictherapy.ca/about-camt-music-therapy/about-music-therapy/

Carolan, M., Barry, M., Gamble, M., Turner, K., & Mascarenas, O. (2012). Experiences of pregnant women attending a lullaby programme in Limerick, Ireland: A qualitative study. *Midwifery, 28*, 321-328.

Caulford, P. & D'Andrade, J. (2012) Health care for Canada's medically uninsured immigrants and refugees: Whose problem is it? *Canadian Family Physician, 58*(7), 725–727. Retrieved from: http://www.cfp.ca/content/cfp/58/7/725.full.pdf

Centre for Addiction and Mental Health. (2012). *Best practice guidelines for mental health promotion programs: Refugees*. Retrieved from: http://www.multiculturalmentalhealth.ca/wp-content/uploads/2013/10/CAMH-Best-Practices-Refugees.pdf

Chang, H.-C., Yu, C.-H., Chen, S.-Y., & Chen, C.-H. (2015). The effects of music listening on psychosocial stress and maternal-fetal attachment during pregnancy. *Complementary Therapies in Medicine, 23*, 509-515. doi: http://dx.doi.org/10.1016/j.ctim.2015.05.002

Chang, M. Y., Chen, C. H., & Huang, K. F. (2008). Effects of music therapy on psychological health of women during pregnancy. *Journal of Clinical Nursing*, *17*(19), 2580-2587. doi: 10.1111/j.1365-2702.2007.02064.x

Chang, S., & Chen, C. (2005). Effects of music therapy on women's physiologic measures, anxiety, and satisfaction during cesarean delivery. *Research in Nursing & Health, 28,* 453–461. doi: 10.1002/nur.20102.

Choi, C. M. H. (2010). A pilot analysis of the psychological themes found during the caring at Columbia—Music therapy program with refugee adolescents from North Korea. *Journal of Music Therapy*, *47*(4), 380-407. Retrieved from https://0-search-proquest-com.mercury.concordia.ca/docview/853978130?accountid=10246

Cignacco, E., Sayn-Wittgenstein, F. Z., Sénac, C., Hurni, A., Wyssmüller, D., Grand-Guillaume-Perrenoud, J. A., & Berger, A. (2018). Sexual and reproductive healthcare for women asylum seekers in Switzerland: a multi-method evaluation. *BMC Health Services Research, 18*, 712. https://doi.org/10.1186/s12913-018-3502-2

Citizenship and Immigration Canada (CIC) (2017) *Annual report to parliament on immigration*. Retrieved from: https://www.canada.ca/en/immigration-refugees-

citizenship/corporate/publications-manuals/annual-report-parliament-immigration-2017.html

Cleveland, J., & Rousseau, C. (2013). Psychiatric symptoms associated with brief detention of adult asylum seekers in Canada. *The Canadian Journal of Psychiatry*, *58*(7), 409-416.

Collins, C. H., Zimmerman, C., Howard, L. M. (2011). Refugee, asylum seeker, immigrant women and postnatal depression: Rates and risk factors. *Archives Women's Mental Health, 14*(1), 3–11. doi: 10.1007/s00737-010-0198-7.

Comte, R. (2016). Neo-colonialism in music therapy: A critical interpretive synthesis of the literature concerning music therapy practice with refugees. *Voices: A World Forum for Music Therapy, 16*(3). https://doi.org/10.15845/voices.v16i3.865

Coombes, E. (2018). We all came from somewhere. *Voices: A World Forum for Music Therapy, 18*(1). https://doi.org/10.15845/voices.v18i1.915

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review 43*(6), 1241–1299. doi:10.2307/1229039

Curtis, S. L. (2006). Feminist music therapy: Transforming theory, transforming lives. In S. Hadley (Ed.) *Feminist perspectives in music therapy*, 227-244. Gilsum, NH: Barcelona.

Dennis, C. L., & Dowswell, T. (2013). Interventions (other than pharmacological, psychosocial or psychological) for treating antenatal depression. *Cochrane Database of Systematic Reviews, 31*(7), CD006795. doi: 10.1002/14651858.CD006795.pub3

Dennis, C. L., Merry, L., & Gagnon, A. J. (2017). Postpartum depression risk factors among recent refugee, asylum-seeking, non-refugee immigrant, and Canadian-born women: results from a prospective cohort study. *Social Psychiatry and Psychiatric Epidemiology, 52*(4): 411-422. doi: 10.1007/s00127-017-1353-5.

Dennis, C. L., Ross, L. E., & Grigoriadis, S. (2007). Psychosocial and psychological interventions for treating antenatal depression. *Cochrane Database of Systematic Reviews, (3)*. Art. No.: CD006309. doi: 10.1002/14651858.CD006309.pub2.

DiCamillo, M. P. (1999). A Bio-psycho-social model of music therapy assisted childbirth: An integrative approach to working with families (Doctoral dissertation, Pepperdine University).

Dokter, D. (1998). Introduction. In D. Dokter (Ed.), *Arts therapists, refugees and migrants: Reaching across borders* (pp.11-24). London, England: Jessica Kingsley.

Drožđek, B., & Bolwerk, N. (2010). Evaluation of group therapy with traumatized asylum seekers and refugees—The Den Bosch model. *Traumatology*, *16*(4), 117-127. doi: 10.1097/NMD.0b013e318266f860

Elefant, C. (2010). Given voice : Participatory action research with a marginalized group. In B. Stige, G. Ansdell, C. Elefant, & M. Pavlicevic (Eds.), *Where music helps. Community music therapy in action and reflection* (pp. 199-215). Aldershot, England: Ashgate.

Elliott, D. (1995). *Music matters.* Oxford, England: Oxford University Press.

Encyclopedia Britannica. (2020). *Egypt uprising of 2011.* Retrieved from: https://www.britannica.com/event/Egypt-Uprising-of-2011

Fassetta, G., Da Lomba, S., & Quinn, N. (2016). *A healthy start? Experiences of pregnant refugee and asylum seeking women in Scotland*. Glasgow: University of Strathclyde.

Federico, G. (2016). *A musical journey through pregnancy: Prenatal music therapy*. Santa Cruz de Tenerife, Spain: Editorial OB STARE.

Federico, G. F. & Whitwell, G. E. (2001). Music therapy and pregnancy. *Journal of Prenatal & Perinatal Psychology & Health, 15*(4), 299-311.

Feldman, R. (2014). When maternity doesn't matter: Dispersing pregnant women seeking asylum. *British Journal of Midwifery, 22*(1), 793-798. doi: 10.12968/bjom.2014.22.1.23

Fraser, M. W., & Galinsky, M. J. (2010). Steps in intervention research: Designing and developing social programs. *Research on Social Work Practice, 20(5),* 459-466. doi: 10.1177/104973150935842

Fraser M. W., Richman, J. M., Galinsky, M. J., & Day, S. H. (2009). *Intervention research: Developing social programs*. New York, NY: Oxford University Press.

Gagnon, A. J., Dougherty, G., Wahoush, O., Saucier, J-F., Dennis, C-L., Stanger, E., Palmer, B., Merry, L., & Stewart, D. E. (2013). International migration to Canada: The post-birth health or mothers and infants by immigration class. *Social Science & Medicine, 76*. 197-207. doi: http://dx.doi.org/10.1016/j.socscimed.2012.11.001

Gardstrom, S., & Sorel, S. (2015). Music therapy methods. In B. Wheeler. (Ed.). *Music Therapy Handbook* (pp.116-128). New York, NY: The Guilford Press.

Gewalt, S. C., Berger, S., Ziegler, S., Szwcsenyi, J., & Bozorgmehr, K. (2018). Psychosocial health of asylum seeking women living in state-provided accommodation in Germany during pregnancy and early motherhood: A case study exploring the role of social determinants of health. *PloS One, 13*(12), e0208007. doi: 10.1371/journal.pone.0208007

Glocke, D., & Wigram, T. (2007). *Receptive methods in music therapy*. London, England: Jessica Kingsley.

Gonzalez-Garcia, J., Ventura-Miranda, M.I., Requena-Mullor, M., Parron-Carreno, & Alarcon-Rodriquez., R. (2018). State-trait anxiety levels during pregnancy and fetal parameters following intervention with music therapy. *Journal of Affective Disorders, 232*, 17-22. https://doi.org/10.1016/j.jad.2018.02.008

Goosen, S., Uitenbroek, D., Wijsen, C., & Stronks, K. (2009). Induced abortions and teenage births among asylum seekers in the Netherlands: analysis of national surveillance data. *Journal of Epidemiology and Community Health, 63*(7), 528– 33. doi: 10.1136/jech.2008.079368.

Government of Canada. (2019). *Interim federal health program: Summary of coverage.* Retrieved from: https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/help-within-canada/health-care/interim-federal-health-program/coverage-summary.html

Grocke, D. E. (2005). The role of the therapist in the Bonny Method of Guided Imagery and Music (BMGIM). *Music Therapy Perspectives, 23*, 45–52.

Haith-Cooper, M., & Bradshaw, G. (2013). Meeting the health and social needs of pregnant asylum seekers, midwifery students' perspectives: Part 1; dominant discourses and midwifery students. *Nurse Education Today, 33*, 1008-1013. doi:10.1016/j.nedt.2012.05.005

Hedgkiss, E., & Renzaho, A. (2014). The physical health status, service utilization and barriers to accessing care for asylum seekers residing in the community: A systematic review of the literature. *Australian Health Review*, *38,* 142–159. doi: http://dx.doi.org/10.1071/AH13113

Heron, J., O'Conner, T.G., Evans, J., Golding, J., & Glover, V. (2004). The course of anxiety and depression through pregnancy and the postpartum in a community sample. *Journal of Affective Disorders 80*, 65–73. https://doi.org/10.1016/j.jad.2003.08.004

Heslehurst, N., Brown, H., Pemu, A., & Rankin, J. (2018). Perinatal health outcomes and care among asylum seekers and refugees: A systematic review of systematic reviews. *BMC Medicine, 16*(89), https://doi.org/10.1186/s12916-018-1064-0

Housden, O. (2013). Egypt: Coup d'etat or a revolution protected? *The RUSI Journal, 158*(5). 72-78. https://doi.org/10.1080/03071847.2013.847727

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288. doi: 10.1177/1049732305276687

Hunt, M. (2005). Action research and music therapy: Group music therapy with young refugees in school community. *Voices: A World Forum for Music Therapy, 5*(2). doi: 10.15845/voices.v5i2.223

Illiadou, M., Papadakaki, M., Sioti, E., Giaxi, P., Leontitsi, E., Petelos, E., Van den Muijsenbergh, M., Tziaferi, S., Mastroyiannakis, A., & Vivilaki, V. (2019). Addressing mentral health issues among migrant and refugee pregnant women: A call for action. *European Journal of Midwifery, 3*(9), 1-8. doi: https://doi.org/10.18332/ejm/108626

International Organization for Migration. (2019). *International migration law: Glossary on migration.* Retrieved from https://publications.iom.int/system/files/pdf/iml_34_glossary.pdf

Jespersen, K. V., & Vuust, P. (2012). The effect of relaxation music listening on sleep quality in traumatized refugees: A pilot study. *Journal of Music Therapy, 49*(2), 205-29. doi:10.1093/jmt/49.2.205

Jin, S. (2016). Giving and gaining: Experiences of three music facilitators on working and musicking with asylum seekers in Australia. *Australian Journal of Music Therapy, 27*, 13-26.

Jones, C., Baker, F., & Day, T. (2004). From healing rituals to music therapy: Bridging the cultural divide between therapist and young Sudanese refugees. *The Arts in Psychotherapy, 31*, 89-100. doi:10.1016/j.aip.2004.02.002

Kaskatis, K., MacDonald, I., & Barra, V. (2012). Performance of music elevates pain threshold and positive affect: Implications for the evolutionary function of music. *Evolutionary Psychology, 10*(4), 688-702.

Kim, S-A. (2013). Stress reduction and wellness. In L. Eyre (Ed.), *Guidelines for music therapy practice in mental health* (Chapter 23). Gilsum, NH: Barcelona. Retrieved from https://www.barcelonapublishers.com/index.php?route=account/download/download&order_download_id=9328&title=Guidelines%20for%20MT%20Practice%20in%20Mental%20Health%20Care%20-%20Chapter%2023:%20Stress%20Reduction%20and%20Wellness

Kira, I. A, Ahmed, A., Wasim. F., Mahmoud, V., Colrain, J., & Rai, D. (2012). Group therapy for refugees and torture survivors: Treatment model innovations. *International Journal of Group Psychotherapy, 62*(1), 69-88. doi: 10.1521/ijgp.2012.62.1.69

Kurth, E., Jaeger, F.N., Zemp, E., Tschudin, S., & Bischoff, A. (2010). Reproductive health care for asylum-seeking women -a challenge for health professionals. *BMC Public Health, 10*: 659. Retrieved from: http://www.biomedcentral.com/1471-2458/10/659

Laban, C. J., Komproe, I. H., Gernaat, H. B. P. E., de Jong, J. T. V. M. (2008). The impact of a long asylum procedure on quality of life, disability and physical health in Iraqi asylum seekers in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology, 43*, 507–515. doi:10.1007/s00127-008-0333-1

Lephard, E., & Haith-Cooper, M. (2015). Pregnant and seeking asylum; Exploring experiences 'from booking to baby'. *British Journal of Midwifery, 24(2)*, 130-136. https://doi.org/10.12968/bjom.2016.24.2.130

Lesiuk, T. (2016). The development of mindfulness-based music therapy (MBMT) program for women receiving adjuvant chemotherapy for breast cancer. *Healthcare, 4*, 53. doi:10.3390/healthcare4030053

Lewis, S. E. & Nicolson, P. (1998) Talking about early motherhood: Recognizing loss and reconstructing depression. *Journal of Reproductive and Infant Psychology, 16*(2–3), 177–197.

Li, S. S. Y., Liddell, B. J., & Nickerson, A. (2016). The relationship between post-migration stress and psychological disorders in refugees and asylum seekers. *Current Psychiatry Report, 18*(9), 82. doi 10.1007/s11920-016-0723-0

Liebman, S. S., & MacLaren, A. (1991). The effects of music and relaxation on third trimester anxiety in adolescent pregnancy. *Journal of Music Therapy, xxviii*(2), 89-100.

Liu,Y.-H., Lee, C. S., Yu, C.-H., & Chen, C.-H. (2016). Effects of music listening on stress, anxiety, and sleep quality for sleep-disturbed pregnant women. *Women & Health, 56*(3), 296-311. https://doi.org/10.1080/03630242.2015.1088116

Lonn, M. R., & Haiyasoso, M. (2016). Helping counselors "stay in their chair": Addressing vicarious trauma in supervision. *VISTAS 2016*. Retrieved from: https://www.counseling.org/docs/default-source/vistas/article_90_2016.pdf?sfvrsn=cbe2482c_4

Matthey, S., Silove, D., Barnett, B., Fitzgerald, M. H., & Mitchell, P. (1999). Correlates of depression and PTSD in Cambodian women with young children: A pilot study. *Stress Health*, 15(2),103–107. https://doi.org/10.1002/(SICI)1099-1700(199904)15:2<103::AID-SMI791>3.0.CO;2-T

McCarthy, R., & Haith-Cooper, M. (2013). Evaluating the impact of befriending for pregnant asylum-seeking and refugee women. *British Journal of Midwifery, 21*(6), 404-409.

McColl, H., McKenzie, K., & Bhui, K. (2008). Mental healthcare of asylum-seekers and refugees. *Advances in Psychiatric Treatment*, *14*(6), 452-459. doi:10.1192/apt.bp.107.005041

McDonald, R., Kreutz, G., & Mitchell, R. (2012). What is *music, health, and wellbeing* and why is it important? In R. Macdonald, G. Kreutz, & R. Mitchell, (Eds.), *Music, health, & wellbeing.* (pp.3-11). Oxford: Oxford University Press.

McKinney, C. H. (1990). Music therapy in obstetrics: A review. *Music Therapy Perspectives, 8*, 57-60.

Metzer, S., Verhey, J., Braak, P., & Hots, J. (2018). Auditory sensitivity in survivors of torture, political violence and flight -An exploratory study on risks and opportunities of music therapy. *The Arts in Psychotherapy, 58*, 33-41. https://doi.org/10.1016/j.aip.2018.02.001

Morgan, G., Melluish, S., & Welham, A. (2017). Exploring the relationship between postmigratory stressors and mental health for asylum seekers and refused asylum seekers

in the UK. *Transcultural Psychiatry*, *54*(5-6), 653-674. https://doi.org/10.1177%2F1363461517737188

Nickerson, A., Bryant, R. A., Steel, Z., Silove, D., & Brooks, R. (2010). The impact of fear for family on mental health in a resettled Iraqi refugee community. *Journal of Psychiatric Research*, *44*(4), 229-235. https://doi.org/10.1016/j.jpsychires.2009.08.006

Nickerson, A., Steel, Z., Bryant, R., Brooks, R., & Silove, D. (2011). Change in visa status amongst Mandaean refugees: Relationship to psychological symptoms and living difficulties. *Psychiatry Research*, *187*(1), 267-274. https://doi.org/10.1016/j.psychres.2010.12.015

Nordoff, P., & Robbins, C. (2007). *Creative Music Therapy: A guide to fostering clinical musicianship.* Gilsum, NH: Barcelona.

Orth, J. (2005). Music therapy with traumatized refugees in a clinical setting. *Voices: A World Forum for Music Therapy*, *5*(2). http://dx.doi.org/10.15845/voices.v5i2.227

Orth, J., & Verburgt, J. (1998). One step beyond: Music therapy with traumatized refugees in a psychiatric clinic. In D. Dokter. (Ed.). *Arts therapists, refugees and migrants: Reaching across borders* (pp.80-93). London, England: Jessica Kingsley.

Pavlicevic, M. (2010). Crime, community, and everyday practice: Music therapy as social activism. In B. Stige, G. Ansdell, C. Elefant, & M. Pavlicevic (Eds.), *Where music helps. Community music therapy in action and reflection* (pp. 223-241). Aldershot, England: Ashgate .

Pereira, P. K., Lovisi, G. M., Pilowsky D. L., Lima, L. A., & Legay, L. F. (2009). Depression during pregnancy: Prevalence and risk factors among women attending a public health clinic in Rio de Janeiro, Brazil. *Cadernos de Saude Publica. 25*(12), 2725–2736. Retrieved from: http://www.scielo.br/pdf/csp/v25n12/19.pdf

Pierce, B. (1998). The practice of toning in pregnancy and labour: participants experiences. *Complementary Therapies in Nursing & Midwifery, 4*. 41-46.

Pierce, B. (2001). Toning in pregnancy and labor. *Journal of Prenatal & Perinatal Psychology & Health, 15*(3), 217-223.

Reason, P., & Bradbury, H. (2008). *The Sage handbook of action research: Participative inquiry and practice* (2nd ed.). Los Angeles: SAGE

Rolvsjord, R. (2010). *Resource-oriented music therapy in mental health care*. Gilsum, NH: Barcelona.

Ryan, D., Kelly, F., & Kelly, B. (2009). Mental health among persons awaiting an asylum outcome in Western countries: A literature review. *International Journal of Mental Health, 38*(3), 88-111. Retrieved from: http://0www.jstor.org.mercury.concordia.ca/stable/41345295

Schopler, J. H. & Galinsky, M. J. (1984) Meeting practice needs: Conceptualizing the open-ended group. *Social Work with Groups, 7*(2), 3-21. https://doi.org/10.1300/J009v07n02_02

Schwartz, F. J. (1997). Perinatal stress reduction, music and medical cost savings. *Journal of Prenatal & Perinatal Psychology & Health, 12*(1), 19-29. Retrieved from https://0-search-proquest-com.mercury.concordia.ca/docview/198721396?accountid=10246

Shin, H. S., & Kim, J. H. (2011). Music therapy on anxiety, stress and maternal-fetal attachment in pregnant women during transvaginal ultrasound. *Asian Nursing Research, 5*(1), 19-27. doi: 10.1016/S1976-1317(11)60010-8.

Short, A. (1993). GIM during pregnancy: Anticipation and resolution. *The Australian Journal of Music Therapy*, 4, 7-18.

Signorelli, R., & Coello, M. (2011). STARTTerS collaborative early childhood services for refugee families -Drumming, dancing, and the wobbly wall. Paper presented at *The Early Childhood Intervention Australia (ECIA) NSW Chapter Conference Proceedings 2011*, Australia. Retrieved from: http://www.startts.org.au/media/startts-ECIA-Drumming-Dancing-and-the-Wobbly-Wall-Signorelli&-Coello.pdf.

Silove, D., Ventevogel, P., & Rees, S. (2017). The contemporary refugee crisis: An overview of mental health challenges. *World Psychiatry*, *16*(2), 130-139. doi: 10.1002/wps.20438

Slive, A., McElheran, N., & Lawson, A. (2008). How brief does it get? Walk-in single session therapy. *Journal of Systemic Therapies, 27*(4), 5-22. doi: 10.1521/jsyt.2008.27.4.5

Small, C. (1998). *Musicking*. Hanover, NH: Wesleyan University Press.

Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhairi, B., & Susljik, I. N. A. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. *The British Journal of Psychiatry*, *188*(1), 58-64. doi: 10.1192/bjp.bp.104.007864

Stewart, D. E., Gagnon, A. J., Merry, L. A., & Dennis, C. -L. (2012). Risk factors and health profiles of recent migrant women who experienced violence associated with pregnancy. *Journal of Women's Health, 21*(10), 1100-1106. doi: 10.1089/jwh.2011.3415

Stige, B. (2002). *Culture-centered music therapy*. Gilsum, NH: Barcelona.

Stige, B. (2005). Participatory Action Research. In B. Wheeler. (Ed.) *Music Therapy Research* (2nd ed.). (pp.404-415). Gilsum, NH: Barcelona.

Stige, B. (2010). Practicing music as mutual care. In B. Stige, G. Ansdell, C. Elefant, & M. Pavlicevic (Eds.), *Where music helps. Community music therapy in action and reflection* (pp. 253-274). Aldershot, England: Ashgate.

Stige, B. (2015). Community music therapy. In B. Wheeler. (Ed.). *Music therapy handbook* (pp.233-245). New York, NY: The Guilford Press.

Stige, B., & Aarø, L.E. (2012). *Invitation to Community Music Therapy*. New York, NY: Routledge.

Storsve, V., Westbye, I., & Ruud, E. (2010). Hope and recognition: A music project among youth in a Palestinian refugee camp. *Voices: A World Forum for Music Therapy, 10*(1). doi:10.15845/voices.v10i1.158

Svensson, J., Barclay, L., Cooke, M. (2008). Effective antenatal education: strategies recommended by expectant and new parents. *The Journal of Perinatal Education, 17*(4), 33-42. doi: 10.1624/105812408X364152

The American College of Obstetricians and Gynecologists. (2015). *Prenatal development: How your baby grows during pregnancy.* Retrieved from http://www.acog.org/~/media/For%20Patients/faq156.pdf?dmc=1&ts=20120731T1026504777

United Nations High Commissioner for Refugees. (2017). *Asylum seekers.* Retrieved from: http://www.unhcr.org/asylum-seekers.html

United Nations High Commissioner for Refugees. (2014). *Asylum trend 2014.* Retrieved from: http://www.unhcr.org/statistics/unhcrstats/551128679/asylum-levels-trends-industrialized-countries-2014.html

United Nations High Commissioner for Refugees. (2015). *Emergency handbook.* Retrieved from: https://emergency.unhcr.org/entry/114761/refugee-definition

United Nations High Commissioner for Refugees. (2016). *UNHCR Statistics.* Retrieved from: http://popstats.unhcr.org/en/overview#_ga=1.63545004.2013428220.1483645773

United Nations High Commissioner for Refugees. (2019). *Resettlement.* Retrieved from: https://www.unhcr.org/resettlement.html

United Nations Population Fund. (2016). *Women and Girls in the Syria Crisis: UNFPA Response. Facts and Figures.* Retrieved from https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA_FACTS_AND_FIGURES_2016.pdf

Van Hanegem, H. V., Miltenburg, A. S., Zwart, J. J., Bloemenkamp, K. W. M., & Roosmalen, J. V. (2011). Severe acute maternal morbidity in asylum seekers: A two-year nationwide cohort study in the Netherlands. *ACTA Obstetricia et Gynecologica*, 90, 1010-1016. doi: 10.1111/j.1600-0412.2011.01140.x

Vukich, E.M. (2015). *Reframing refugee care in music therapy: Exploring context through intersectionality and ecological theory* (Master's thesis, University of East London, London, UK). Retrieved from: https://www.academia.edu/30432661/REFRAMING_REFUGEE_CARE_IN_MUSIC_THERAPY_EXPOLORING_CONTEXT_THROUGH_INTERSECTIONALITY_AND_ECOLOGICAL_THEORY

Whitwell, G. E. (1999). The importance of prenatal sound and music. *Journal of Prenatal & Perinatal Psychology & Health, 13*(3), 255-262. Retrieved from https://0-search-proquest-com.mercury.concordia.ca/docview/198685276?accountid=10246

Wigram, T. (2004). *Improvisation: Methods and techniques for music therapy clinicians, educators, and students.* London: Jessica Kingsley.

Wilson-Mitchell, K. (2008) Mental illness in refugee and immigrant women: A midwife's perspective on culturally competent care. *Canadian Journal of Midwifery Research and Practice, 7*, 9–18. Retrieved from: https://www.cjmrp.com/files/v7n3_wilsonmitchell_mental-illness-immigrant.pdf

Wood, S. (2016). *A matrix for community music therapy practice.* Dallas, TX: Barcelona.

Woodward, A. (2014). *Tapestry of tears: an autoethnography of leadership, personal transformation, and music therapy in humanitarian aid in Bosnia.* Los Angeles, CA: Antioch University.

Woodward, A.M. (2012). Arts-based practices in regions affected by war. *Voices: A World Forum for Music Therapy, 12*. doi:10.15845/voices.v12i2.633

World Health Organization (2006), *Reproductive health indicators: Guidelines for their generation, interpretation and analysis for global monitoring.* Retrieved from: http://afrolib.afro.who.int/documents/2006/eng/reprod_health_ind.pdf

Yang, M., Li, L., Zhu, H., Alexander, I. M., Liu, S., Zhou, W. (2009). Music therapy to relieve anxiety in pregnant women on bedrest: A randomized, controlled trial. *American Journal of Maternal Child Nursing*, 34, 316–323. doi: 10.1097/01.NMC.0000360425.52228.95

Zharinova-Sanderson, O. (2004). Promoting integration and socio-cultural change: Community music therapy with traumatized refugees in Berlin. In M. Pavlicevic & G. Ansdell (Eds.), *Community music therapy* (pp. 358-387). London, UK: Jessica Kingsley.

Appendix A

Examples of Risk Factors

The risk factors which promote the poor health and wellbeing of ASPW are summarized under the themes of (a) restricted access to healthcare, (b) inadequate provision of healthcare, (c) poor socioeconomic conditions, (d) low level of social support, (e) negative experiences with healthcare/social service providers, (f) language and communication barriers, (g) conflict of values, (h) emotional and psychological challenges, and (i) physiological challenges.

1. Restricted Access to Healthcare

- Limited access to healthcare (e.g., lack of eligibility or insurance)
- Has to go through complex and long procedure to receive maternal care during asylum
- Unfamiliarity with the healthcare system in host countries
- Lack of knowledge of entitlements (social, financial, and/or healthcare supports)
- Difficulties in using the healthcare system
  (e.g., registration, appointment, General Physician system, waiting list, re-visit)
- Lack of appropriate, consistent, up-to-date, and timely treatment
- Provided healthcare information is incomplete or partial
- Lack of sharing information with the healthcare team and/or link
- Fewer choices in specialized or alternative healthcare services (midwife, doula, prenatal class)
- Lack of antenatal class tailored to asylum status and/or shared language
- Lack of paid interpreters and less access to them
- Less access to female contraceptives and family planning
- Lack of substantial support to access care (e.g., transportation, childcare, telephone fee)
- Low health literacy
- Lack of medical documents due to migration and/or relocation
- Lack of assessment, support, and referral for psychosocial concerns
- Lack of inclusion of some healthcare professionals in the healthcare link specialized to the population
- Delay and/or avoidance of seeking care until the situation is urgent
  (e.g., for fear of harming their asylum process, mistrust)

2. Inadequate Provision of Healthcare

- Patchy, unstructured, and intricate nature of public support provided
- Maternity healthcare system designed for a homogenous pregnant population
- Insufficient coordination between asylum centres and external healthcare providers
- Lack of response or delayed response when being accessed by women
- Administrative and/or substantial delays on decision-making and provision of services
- Third sector organizations limited in ability to support
- Lack of communication between different health and social care services

3. Poor Socioeconomic Conditions

- Being women and/or pregnant
- Asylum process
- Precarious immigration status
- Multiple dispersal and relocation
- Inappropriate housing (e.g., sharing with an individual of different gender, rooms without locks, low standard of hygiene, long distance from healthcare services)
- Homelessness
- Shortcomings of substantial resources for living and pregnancy
- Lower access to adequate food and clothing
- Lack of income
- Financial constraints
- Difficulties in proving destitution
- Lower educational level

4. Low Level of Social Support

- Family dispersal
- Disrupted family structures
- Living without a male partner
- Lower level of overall social support
- Dependence on statutory and/or third sector agencies for all needs

- Lack of access to supporting-networks of family and friends
- Delay and/or avoidance in seeking care until the situation is urgent

5. Negative Experiences with Healthcare/Social Service Providers

- Experience of racism, discrimination, labeling, micro-aggression, cultural/gender stereotypes, and stigma in encounter with healthcare/social service providers
- Mistrust of healthcare/social service providers
- Previous negative experiences with healthcare/social service providers
- Feeling ignored
- Healthcare/social service providers' lack of knowledge and understanding (on specialized needs, adequate healthcare, and services women are entitled to)
- Healthcare/social service providers' lack of sensitivity on women's history and culture
- Healthcare/social service providers' lack of training specific to care of ASPW

6. Language and Communication Barriers

- Not being asked or listened to, feeling ignored
- Lack of information and/or prenatal class in the first language or specific to asylum-seekers
- Lack of culturally-informed overall support
- Frustration over communication

7. Conflict of Values

- Refusal to receive service from male healthcare providers
- Local views of race, ethnicity, gender, age, class
- Public views of ASPW as scroungers or burden on the health service
- Acculturative stress

8. Emotional and Psychological Challenges

- Worries
- Fear (e.g., to be sent back, to be denied, to be separated from children, to harm their asylum outcome by seeking care)

- Feeling of uncertainty (e.g., asylum procedures, new situations in host countries, future)
- Feeling of not belonging to the host country/community
- Feeling of loss (e.g., identity, family, friends, home, community, country, substantial resources)
- Trauma-exposure
- Previous experience of gender-based violence in pre-/post migration
- Feeling isolated
- Feeling disoriented
- Feeling ignored and unheard
- Frustration over communication
- Feeling difficult to manage everyday life
- Chronic stress
- Blind belief (that women giving birth after arrival will be granted a residence permit or sent back after giving birth, or that their inability will decide the children's future)
- Depression (ante/post-partum)
- Psychological tension

9. Physiological Challenges

- Antepartum pain
- Fatigue
- Malaise
- Sleep disturbance
- Physical tension
- Decreased physical mobility
- Changes to appetite
- Trouble breathing

Appendix B

Examples of Protective Factors

The protective factors which suppress the poor health and wellbeing of ASPW are summarized under the themes of (a) adequate provision of care, (b) adequate socioeconomic conditions, (c) social support, (d) comprehensive assessment, (e) emotional and psychological support, (f) communication and language support, and (g) cultural respect and acknowledgement.

1. Adequate Provision of Care

- Full access to reproductive healthcare services
- Continuous and regular care
- Adequate assessment and referrals
- Provision of care in a timely manner
- Accessible and responsive information services
- Access to interpreters/translators
- Inclusion of non-physician healthcare professionals in the healthcare link
- Midwife-led comprehensive perinatal healthcare
- Gender-appropriate or women-centered care and/or services
- Asylum-seekers-friendly care and/or services
- Culturally-appropriate care and/or services
- Holistic view of healthcare
- Review and/or revision of policies
- Health education (e.g. general and/or reproductive health education in host countries)
- Special training for healthcare/social service providers
- Autonomous/competent healthcare providers

2. Adequate Socioeconomic Conditions

- Adequate housing (e.g., meeting the standard of host countries, allocating with the needs of pregnant women)
- Integration program to address food security

3. Social Support

- Adequate level of support ensuring basic human rights
- Consistent practical and substantial support throughout pregnancy
- Legal support
- Gender-appropriate support
- Culturally-informed support
- Social connection-building which could sustain over perinatal period
- Referrals to community organization to create social networks in the community
- Ensured support in the healthcare of children
- Support from other mothers in the community

4. Comprehensive Assessment

- Assessment for basic human needs (e.g. food security, entitlement)
- Assessment for the needs of social/emotional/psychological/physiological support
- Assessment of recent life stressors, history of abuse/violence, poor mental health, and pain

5. Emotional and Psychological support

- Feeling of belonging and connectedness to a community
- Feeling heard
- Self-motivation
- Resilience
- Openness to different values
- Sense of agency
- Woman-centered support
- Healthcare professionals' awareness of the high risk of postpartum depression in asylum-seekers
- Psychological support provided on an outpatient basis by healthcare professionals
- Additional psychosocial support specific to the needs defined by their immigration status

6. Communication and Language Support

- Access to interpreters/translators
- Interpreters available during information-taking and documentation

7. Cultural Respect and Acknowledgement

- Inclusion of holistic view of health and/or healthcare
- Cultural respect and acknowledgement
- Openness to different values

Appendix C

Sample of Collaborative Assessment

Prior to the session, ask each participant their language preference. The core concepts of the group would be written on the white board (e.g., "this is a music-based democratic space in which all of us, including me (=music therapist), can connect by working and 'musicking' together. So, please bring your voice, and let's make this happen together"). The ideal duration of the assessment is around 10-15 minutes, depending on how long the session goes for. To make the best of the limited amount of time and optimize the collaborative process, music therapists may need to actively facilitate the participants' involvement (e.g., establishing a trusting environment during the introduction and check-in, using questions for dialogue facilitation, navigating the discussion in a way to equally give participants space to contribute).

1. Introduction and check-in

● Participants are invited to briefly share (a) basic personal information such as name, country of origin, stage of pregnancy, expected delivery date, primipara/multipara, (b) any medical conditions or other specific considerations that need to be taken care of, and (c) one thing that they want to change positively about themselves today, one by one.

● The music therapist briefly explain the core concepts of the group verbally to invite participants to join the collaboration.

2. Decision-making

● Depending on the expressed needs common to the participants, the music therapist selects two or three music therapy experiences that participants can try in the session, explains what they are about, and outlines how participants can get involved. The music therapist encourages them to decide on a music therapy experience (or two, depending on the duration of the session).

● The music therapist also helps participants think of ways they can engage in the collaboration in selected music therapy experiences, using their unique skills or experiences (e.g., *"Are there any knowledge and skills you can share with others in this music therapy experience?"*).

● As for the preference of music genre and instruments, this will emerge as the music therapy experiences are implemented.

Appendix D

Sample of Collaborative Evaluation

In the collaborative evaluation at the end of the session, (a) participant's self-reported overall experiences in the music therapy program, and (b) participant's perceived changes in malleable factors (this can also be incorporated into the reflection section of the previous music therapy experiences), are shared in the group. The ideal duration of the evaluation is around 10 to 15 minutes, depending on how long the session goes for. Brief and easy methods of documentation and sharing would be: (a) each participant documents verbally and/or non-verbally (e.g., music, movement, analogical images, and icons) their own reflection, and (b) each documentation is integrated in one collective format that all participants can share. The volunteer interpreters would translate documentation received in different languages. Music therapist provides options depending on the sharing method the participants prefer and the remaining time (See samples below). Consent for all participants is required when audio/video/photo recording is an option.

1. Sample questions:

(a) Participants' self-reported overall experiences in the music therapy program:
"How was your experience in the session?"

(b) Participants' perceived changes in malleable factors:
"Did you notice any change in your feelings and your body after the music therapy experience? If so, can you describe them?"

2. Sample of the methods of documentation and sharing:

● Art-based documentation:
Each participant is invited to write/draw her reflection on a small colored paper, or select emotions stickers, and use it to make a collective art collage. The music therapist can provide the framework to easily and briefly integrate each reflection into the collective form (e.g., a shape of a tree, having roots with the name of each music therapy experience implemented, as well as branches with the name of the program. Participants can place their reflection on each music therapy experience on each root, along with the reflection on overall experience of the session on the branches).

● Live documentation in music and movement:
Each participant is invited to rap or recite one reflective phrase in her own language in a collective improvisation, or speak out one reflective word or phrase accompanied by light body movement or rhythms created by body percussion (according to each woman's ability given their current health and stage of pregnancy). Again, the framework for brief and easy integration (e.g., pre-recorded music patterns, steady beats by a drum) can be provided by the music therapist.

Appendix E

Case Example

Twelve asylum-seeking prenatal women from different countries gathered. During check-in, all participants shared their consistent insomnia and physical/psychological tension. After a brief discussion, participants decided as a group to address said insomnia and physical/psychological tension in the session. From options that the music therapist suggested, participants unanimously selected music-facilitated relaxation and breathing-skills training to try. Paired with the soft piano music played by the music therapist, which was requested by the group, participants first experienced the music-facilitated relaxation. Verbal guidance provided by the music therapist were interpreted by volunteer interpreters. After the experience, participants spontaneously reported how the experience helped them release their physical tension and feel relaxed. After that, participants learned breathing techniques, accompanied by the recorded music they chose, with the help of volunteer interpreters who interpreted the verbal instruction that the music therapist provided. Some of the participants who already knew the skills gave the others some tips. In subsequent reflection, participants shared the physical and psychological changes they perceived. One participant shared how she practiced the breathing technique learned last week and used it during stressful medical examinations. Music therapist informed the benefits of practicing the breathing technique and incorporating the time of relaxation during pregnancy, and provided those who wanted to do home practice with the audio recording. After that, music therapist invited participants to join the collaborative evaluation of the session. Through a brief discussion, participants decided to share one “takeaway” from the session one by one, verbally in their own languages (interpreted by volunteer interpreters) with hand movements. Each participant took turns expressing her own reflection while continuing to be a part of the group improvisation, accompanied by the four chord progression structure which music therapist provided by a guitar.