Perspectives of Indian Music Therapists on the State of Music Therapy as a Profession in Mumbai, India: A Narrative Inquiry

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ABSTRACT

Perspectives of Indian Music Therapists on the State of Music Therapy as a Profession in Mumbai, India: A Narrative Inquiry

Aprajita Saxena

The purpose of this narrative inquiry was to explore the experiences of music therapists from Mumbai, India providing professional music therapy services to a clinical population intersected by class, caste, and gender. Three participants from Mumbai were interviewed to study both pre-determined themes based on the current literature and emerging themes that unfolded in each of the participants individual narratives. The following were the four primary themes that are discussed in the study: (a) caste, class, and gender; (b) professional challenges; (c) benefits of practicing music therapy in Mumbai; and (d) vision for the profession in India. Results revealed the various challenges, benefits, and scope for policy enhancement within the existing music therapy profession in India. The findings also raised important questions about equity, access, awareness, funding, and advocacy of music therapy in India. Finally, this study hopes to support the formulation of a standardized music therapy practice in India and increase the much-needed representation of diverse voices in the global music therapy landscape. Information on limitations of the inquiry as well as potential implications and areas for future research are addressed.

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Chapter 1. Introduction

The use of music as a healing practice in India has a rich historical background. Vedic traditions dating back to about 5,000 years ago used chants and music as a source of healing by intuitively reflecting on each intonation and inflection of voice that could heal mind, body, and soul (Sundar & Sairam, 2005). According to Hicks (2020), music therapists in India find that although music is identified as a traditional healing practice, there is confusion within the national population as to how this is different from music therapy when practised as a professional discipline in India. It is important to note here that music is an integral part of the Indian culture. The music varies from one Indian State to another (Hicks, 2020). However, music therapy as a profession and clinical field faces challenges being recognized in India as a legitimate discipline and profession (Sundar & Sairam, 2005; Swamy, 2017). One of the ongoing challenges described by music therapists is that "Healing practices have to be integrated into music therapy practice, education, and research with a scientific inquiry in mind" (Sundar & Sairam, 2005, p. 7). It would be critical to review the existing literature on music therapy in India, to understand the profession's current identity and experiences of music therapists in India. The findings from the literature would help evaluate future discourses and changes needed in the music therapy profession in India.

Significance and Need for the Study

There are few studies that discuss challenges and barriers music therapists face in relation to practicing music therapy in India. Some of the challenges identified by Indian music therapists are distinguishing healing practices and the broader music therapy profession, insufficient pay, and impact of complex and evolving cultural identities (Hicks, 2020; Sundar & Sairam, 2005; Singh, 2021). There is not enough data to understand the gap between the rich history of music used as therapy in India and why it still has not been widely recognized as a legitimate profession in this country. Due to the limited number of studies discussing challenges faced by music therapists in India, a global context was taken into consideration to understand other challenges faced by music therapists in different parts of the world. For instance, Clements-Cortes (2013) discussed a variety of challenges music therapy professionals face globally, including

insufficient pay, work overload, unrealistic expectations, lack of rewards, and gender inequality.

Furthermore, within the context of the present study, it is critical to examine the roles that social challenges related to caste, class, and gender may play within an Indian context (Velaskar, 2016). Swamy (2017) points out that apart from caste, there has been evidence of gender bias and class discrimination in accessing equal professional opportunities, healthcare services, and education, among other prevalent social locators in India. Even though caste is considered a taboo subject, it continues to impact attitudes about religion, careers, matrimonial choices, access to education, and resources and opportunities; and it can contribute to oppression and violence within communities in India (Swamy, 2017). Unfortunately, caste discrimination is still alive in India and indicates that, over 30% of Indians still prohibit lower castes from entering temples, socializing, or sharing food with higher castes (Chisthi, 2014; Desai & Vanneman, 2012). For instance, a research report from Iyer et al. (2007) found that women were doubly discriminated against by differentially having to bear the burdens of unaffordable health care and by adverse gender norms. All women suffer from the consequences of gender bias, but it is poor women in particular who disproportionately bear the burdens of both gender and economic class (Iyer et al., 2007). This further solidifies the continued role played by the intersectionality of gender and social class in the presenting inequities and challenges faced by the citizens of India.

In the context of professional challenges, there is not enough literature that specifically addresses how caste, class, and gender impact the practice of music therapy in India. As a pre-professional music therapist who identifies as a cisgender, upper-caste, middle-class, abled Indian woman currently residing in Canada, I found that the literature rarely represented voices from Indian music therapists and their experiences of practicing in India. Thus, the gaps found in the literature and the insufficient inclusion of these voices suggest the need to explore the music therapy practice in India as it is intersected by caste, class, and gender. It is important to continually expand international dialogue and bring to the foreground other underrepresented voices to develop the profession, heighten awareness, and enhance inclusivity within the field of music therapy. Through the literature review process, it was found that there is a need for more dialogue with

music therapists practicing in India to understand their experiences within the rapidly evolving professional landscape.

Understanding the workplace challenges faced by music therapists in a global context will provide insight on what has worked so far in different regions within their socio-political contexts and will help reimagine certain dimensions of policy in a local context as well. Michael McGuire, in conversation with Dr. Sumathy Sundar, suggested that experts in music therapy can share their knowledge with the professionals in countries where music therapy is in nascent stages. The challenges faced by experts in music therapy in developing the field could provide deep insights on the nuances of historical development of the field (Sundar, 2007).

Personal Relationship to Topic

My personal relationship with this research topic began when I moved to Canada from India in September 2017 to pursue formal music therapy education. I found my personal vocal training in North Indian classical music to be very enriching. This form of music became my space of safety and emotional release. It introduced me to an infinite source of abundant joy and fulfillment, which inspired my belief in its potential benefits as therapy in India and around the world. Hence, I sought out informal conversations with two music therapists in India to understand the use of this music in therapy thus far. However, these conversations led to an unexpected outcome. The conversations revealed to me the ongoing and current challenging realities of the music therapy profession in India. I learned that it is not necessary for a musician to be a licensed music therapist in order to provide those services. This brought up a lot of questions on the pace at which the music therapy practice is currently growing in India. It raised issues around the legitimacy of music therapy, the opportunities and impediments that exist and are foreseen and unforeseen in the near future for its development in India. Some of the challenges shared during these conversations included unpaid positions, absence of standardization of the practice, and lack of resources, among others.

These informal conversations with music therapy professionals in India redirected my research interests and motivated me to design a research project where I would conduct in-depth interviews with three music therapists, based in India, to further

understand their experiences and perceptions on the professional music therapy landscape of India.

It is my hope that this study will result in insights on how to facilitate a much-needed shift in current perspectives on the music therapy profession in India and make it a licensed profession in the country. Additionally, the goal is to implement advocacy practices in the field of music therapy so that all citizens of India, regardless of class, caste, and gender, will be able to avail themselves of and access this service.

Statement of Purpose

The purpose of this research is to understand the experiences of music therapists working in Mumbai, India, to provide professional music therapy services to a clinical population intersected by class, caste and gender.

Assumptions

As a student-researcher, I had the following assumptions about this research thesis: (a) my participants will willingly share their experiences of practicing music therapy; (b) caste, class and gender influence the practice of music therapy in Mumbai; (c) the challenges and insights that are shared by my participants will be relevant to the purpose of my thesis; (d) the data collected in the Hindi language would sufficiently capture the participants intentions and emotions when translated into English; and (e) there is no study published on my specific research topic in other spoken languages of India or other languages apart from English spoken world over.

Research Question

The primary research question was: How do three professional music therapists, employed in Mumbai, India, describe their experiences providing music therapy services to a national population intersected by caste, class, and gender?

Background of Key terms

Music Therapist: The Canadian Association of Music Therapists (CAMT) defines an accredited music therapist as a person who has successfully completed a designed certification process and undergone a thorough review of specific eligibility requirements for professional competence (CAMT, n.d.).

Gender: The complexity of gender issues in India needs to be understood in relation to the multilingual, multicultural nature of India, which has paved the way to a

variety of perspectives on gender, intersectionality, and power dynamic. Purkayastha, et al. (2003) describe three major dimensions within which scholars define gender in India. First, there is a tension between scholars who foreground gender and who use intersectionality to define gender. Second, there is push back on understanding gender through a feminist lens. Third, there is discussion on the role of the nation, state, and international structures in furthering gender inequalities. This research focused on intersectionality to define gender.

Caste: The Indian caste system is at least 3,000 years old. It comprises four *varnas* (groups), which are further divided into subcategories. Initially, individuals were classified based on their occupation. These categories were: *brahmin*s (priests), *kshatriya*s (warriors and kings)*, vaishya*s (farmers), and *shudra*s (unfree servant) (Dumont, 1980). British colonialism reshaped and capitalized on India's caste system. The British were interested in building up on a stratified society which was based on dividing and ruling the subcontinent (Riser-Kositsky, 2009). Thus, after India achieved independence in 1947, the discrimination based on caste was prohibited, but prejudice still exists and impacts individuals from lower castes, such as those of the Scheduled Castes and Scheduled Tribes (Dumont, 1980).

Class: According to the statistical analysis of the India Human Development Survey II (Data Sharing for Demographic Research, 2011–12), the size of the middle class in India is 28.05% of both the urban and rural population—of which 14% is lower middle class and about 3% is upper middle class. Importantly, more than 32% of the comfortable middle class and more than 23% of the upper middle class are located in rural India (Aslany, 2019). Although patterns for the upper caste show mobility in class (economic), they are not synonymous as there is an interplay of various social factors in understanding the complexity and differences of caste and class (Deshpande & Palshikar, 2008).

Intersectionality: Crenshaw (1991) coined the term intersectionality. Intersectionality refers to the ways of complex interaction between various categories such as race, class, gender, age, sexuality, and disability. These interactions result in mutually constituting these categories and in perpetuating power structures in our societies.

Outline of Chapters

Following this chapter, which outlines the need for and significance of the present study, chapter two entails a review of the literature on topics related to the student researchers primary research question. These include existing music therapy practice in India, workplace challenges music therapists face both in India and Western countries, the difficulties faced in integrating traditional Indian music practices into music therapy, and, finally, the impact experienced on the music therapy practice by the intersection of caste, class, and gender in India and Western countries.

Chapter three is centred around the narrative inquiry research methodology followed by the data collection and analysis procedures used for this study. Chapter four reports the results of the data analysis and finally, Chapter five includes discussion on implications of the findings, limitations of the study, and recommendations for future research.

Chapter 2. Literature Review

The purpose of this chapter is to review and analyse existing literature to reveal what is established and what is missing in relation to the research topic. The literature is organized into four topic areas: (1) overview of music therapy landscape of India, (2) workplace challenges in India and Western countries, (3) integration of traditional sound healing practices into music therapy, and (4) intersection of caste, class and gender in India and the Western countries. Due to a lack of studies on workplace challenges specific to music therapy professionals in India, this review includes voices from an international community of music therapists to delineate the challenges faced by music therapy professionals in their workplace.

Overview of Music Therapy Landscape of India

Despite the rich musical heritage of India, and the ancient use of music for healing practices, music therapy as a profession and clinical discipline has still not been recognized as a legitimate clinical practice (Swamy, 2017). The Indian Association of Professional Music Therapists was founded in 2011, with approximately 10 professional members and two schools (World Federation of Music Therapy [WFMT], 2013). However, it is not the official licensing body that can provide certification to individuals to practice music therapy in India. According to the WFMT report, in 2019, there were 50 music therapy professionals in India (WFMT, 2019). Luthra (2014) points out that one of the reasons for the slow professional growth of the practice in India is due to the fact that musicians are paid much more than music therapists.

Currently, music therapy is used in a variety of settings in India including prisons and armies and to address problems of substance use and different types of disabilities (Luthra, 2014). As far as what the practice of music therapy in India actually looks like, it appears that receptive listening experiences were most commonly used in the past (Sundar, 2014). Luthra (2014) argues that much of the focus in India has traditionally been on music therapy for individuals with learning disabilities. Music therapy in India is also being used for women's empowerment, civil services, and general wellbeing (Luthra, 2014). Hicks (2020) argues that the use of music therapy in India has expanded to include different populations and address diverse goals apart from healing due to the development of music therapy education and training programs in the country.

The limited available literature reflects that in a diverse country like India with a population of 1.4 billion people (The Economic Times, 2021), currently there are only 50 music therapists practicing, as recorded in 2019 (WFMT, 2019). It was not made clear in the available literature as to why there is not a centralized body yet to standardize the music therapy practice in India, as to whether there is one in the process of being created, and what the reason is for the low availability of educational programs for aspiring music therapists in the country.

Workplace Challenges in Western Countries

Despite the fact that music therapy is growing as a profession, every culture has its own influences, challenges, and professional barriers in practicing music therapy (Hanser, 2005). Data from 2013–2019 American Music Therapy Association (AMTA) Workforce Analysis Surveys and data from the Certification Board for Music Therapists demonstrate that a large proportion of music therapists have been in the field for 5 years or less (Oden, 2020). While there are very few studies that discuss the occupational challenges that music therapists face globally and what needs to be done to change the workplace situation, burnout was a recurring theme under occupational challenges (Decuir & Vega, 2010; Murillo, 2013). Clements-Cortes (2013) defined professional burnout as ‘‘a syndrome of physical exhaustion including a negative self-concept, negative job attitude and loss of concern and feelings’’ (p.166). The manifestations of burnout are embedded in work, individual, and social factors (Clements-Cortes, 2013). These factors include insufficient pay, work overload, unrealistic expectations, and lack of rewards (Clements-Cortes, 2013). Many music therapists experience low salaries, low recognition of their work, and a lower place in the power structures in the workplace (Bitcon, 1981; Kim, et al., 2013).

Furthermore, music therapists may lack resources to care for clients who are suffering from multiple health issues, which may hinder their capacity to devise treatment plans (Rykov, 2001). Lipe (2015) argued that music therapists often experience a creative tension between the art of music and science of therapy, and to achieve desired results through music therapy they require conducive workplaces and resources. To address this tension in clinical settings, it is important to provide music therapists with critical resources to help people gain awareness about the science of music therapy. They may

also experience isolation because they may be the only music therapists working in a facility (Lipe, 2015). Although individuals' commitment and self-efficacy beliefs may enhance their resilience to face the challenges experienced at their workplace situated in the larger sociocultural context, workplace challenges may surpass their individual strengths and contribute to their professional burnout (McFadden et al., 2015).

Aigen (2014) argues, "while a number of different positions are occupied by contemporary music therapy theorists in relation to traditional notions of health and medical practice, the predominance of contemporary music therapy theorists are seeking a framework for music therapy beyond that provided by an orthodox medical model" (p. 233). On the contrary, Baines & Edwards (2015) note that the field, as a creative arts therapy, may experience marginalization and devaluation while working with the dominant medical models.

In summary, workplace challenges include professional burnout, a lack of resources to care for clients, a creative tension between the art and science of music therapy, and marginalization while working with the dominant medical therapies.

Workplace Challenges in India

In the Indian context, Sundar (2007) points out that music therapist's express concerns that musicians receive higher wages than music therapists. Sundar (2007) calls for appropriate salaries and governmental recognition of professional music therapists. Dr. Sumathy Sundar, in conversation with Hicks (2020), emphasizes the importance of learning about music therapy practices within a global context. She notes:

> Be open to learning music therapy from your colleagues all over the world. There is so much excitement happening within this young field. Each region has something unique to offer. There are similarities, and all programs operate within a global framework. However, the art side is different. Learn and enjoy its complexity. (p. 1)

As discussed in the quote, music therapy as a field should embrace the diversity from across the world rather than situating itself in a local context as there are partial

similarities between various regions that can help build on the local contexts to provide creative solutions.

In summary, in the overall literature review, the global workplace factors reflect low autonomy and power in addition to low wages, high job demands, and lack of governmental recognition of the profession, among others. Also, there appears to be significant gaps in the literature discussing music therapy and cultural considerations that might influence workplace settings in a diverse country like India. The gaps in existing research data, solidified the need to further engage with currently practicing music therapists to gather their insight on the existing literature and the current realities of the music therapy landscape of India. Understanding the experiences of practicing music therapists and the challenges they face can lead to important insights that will further help create innovative solutions and advocacy support needed for the music therapy profession in India.

Integrating Indian Traditional Sound Healing Practices into Music Therapy

India has a long history of using music as therapy. Vedic traditions dating back to about 5,000 years ago used chants and music as a source of healing by intuitively reflecting on each intonation and inflection of voice that could heal mind, body, and soul (Sundar & Sairam, 2005). The Vedic chants were used by the people to please the presiding deities of different Vedic sacrifices to get benedictions of brilliance, power, and wisdom to cure diseases (Sundar, 2007). Phrases from *Atharvana Veda* indicated that the drinking of various liquids in a healing ceremony during Vedic hymns was also used against disease arising from hurtful changes of wind, bile, or phlegm and for paying homage to lightning which was considered the cause of fever, headache, and cough, to release the sufferer from headache and cough (Sundar, 2007).

Apart from the Vedic chants, the ragas within Northern Indian classical music were also used for the purpose of healing. *Raga* comprises a unique set of selected notes (Sanivarapu, 2015). Ragas are associated with particular *rasas*, which signify a particular emotional state (Rao & Rao, 2014; Clayton, 2001). *Raga Chikitsa* in Indian traditional music therapy literally translates to “treatment by raga” (Sundar & Parmar, 2018). In the ancient times, specific ragas were considered to have therapeutic characteristics that could be used with individuals with health needs. All of the ragas known to have healing

properties require rigorous analysis to validate the claims of their therapeutic value (Sairam, 2005).

However, music therapy practitioners find it challenging to differentiate their profession from that of traditional healing practices (Hicks, 2020). This is because the modern-day music therapy practice of India integrates some healing practices but is not limited just by those traditional ways of using music in a clinical setting. For instance, present day music therapy does involve use of *archika, gathika,* and *samika* verses (Vedic verses with one, two, and three notes respectively) to improve attention and memory and to help get into meditative and relaxed states (Sundar, 2007). These Vedic verses are used in education settings for children with disabilities in the areas of mental health, behavioral psychology, and development of personality traits (Sairam, 2006).

According to Hicks (2020), music therapists practicing in India, expressed concern about the growth of music therapy profession in the country. According to them, although music is identified as a traditional healing practice in India, there is a lack of understanding of how it is different from music therapy (Hicks, 2020). Therefore, one of the challenges is to make people understand the difference between music used for healing and music therapy used for other clinical goals that do not necessarily result in the conventional idea of healing, which is defined as "free of ailment" (Stevenson & Lindberg, 2010). Dr. Sundar, in building her education and training programs, found that integrating healing practices into music therapy practice, education, and research foregrounded in scientific inquiry continues to be a constant challenge in India (Hicks, 2020). Dr. Sundar further argues:

> Healing is only an art. Music therapy is both an art and a science. The science side of music therapy is the same throughout the globe. It is only the art side where music therapy becomes different in India as many healing traditions are integrated in an evidence-based manner. (Hicks, 2018, p. 7)

In summary, the concept of healing being addressed as only an art is limited and excludes the scientific nature of healing. The argument could have been strengthened if Hicks elaborated the reasons for healing being labelled as an art and also elaborate on their own perception of art and science. Further, the assertion made by Dr. Sundar on the

scientific side of music therapy being the same across the globe needs evidence. Hence, the literature makes it even more apparent that there is a further need to investigate the perception of practicing music therapists in India of their experiences with traditional healing practices and their integration into the broader music therapy framework in sessions with their clients.

The effort to understand the music therapy practitioners' perceptions of the art and science of music therapy and the fluidity between them in a specific context will pave the way to contributing to diversity both in national and international music therapy practices.

Intersection of Caste, Class and Gender in India and Western Countries

According to an AMTA report published in 2018, music therapists received lower salaries in comparison to other healthcare professionals (AMTA, 2018). Since the field comprises mostly females (87%), it may be marginalized as a profession (AMTA, 2018), which in turn may be one of the reasons the field experiences low wages (Kim et al., 2013). Understanding how the occupational experiences of music therapy practitioners intersect with gender, class, and caste is crucial to analysing the nuances of the challenges music therapists face in their occupation.

Importantly, none of the research on music therapy professionals provides a rich description of issues faced by them intersected by caste, class, and gender in an organizational structure specific to the field of music therapy in India. Edwards and Hadley (2007) argue, "Theorists' gender, their experiences, and their views of other players can impact and change the music therapy landscape, especially when they appear in the powerful medium of print" (p. 202). However, this view is not uncontested. Several music therapists do not consider the impact of gender bias on their professional lives. In a study conducted by Curtis (2013), 42% of male participants and 46% of female participants did not experience gender bias in the field. On the other hand, participants who agreed that gender bias impacts their lived experiences talked about its subtleness. They argued that gender bias is manifested in the form of wage disparities, gender role stereotypes, and access to opportunities. Interestingly, men (31%) and women (25%) music therapists displayed similar awareness about feminist music therapy. Furthermore, Edwards and Hadley (2007) call for exploring "gender relations in relation to career

achievement, education, and salary where data is available, to see whether differentials exist. Investigating gender ratios in professions, and in practices within professions, is one way to examine existing power relations" (p. 204).

Significantly, Sajnani (2012) calls for a critical examination of the larger socio-political cultural context to understand how clinicians and researchers situate their understanding of beneficiaries of interplay of power structures in the creative arts therapies. Hadley (2017) suggests that music therapists should identify subtle gender microaggressions and their manifestation in academic, critical, and professional settings. McSorley (2020) conducted a qualitative study with eight music therapy clinicians of a marginalized gender identity. Participants described 49 specific gender microaggression incidents they experienced.

"Understanding the complex interplay of gender and power in the music therapy field, has the potential to translate knowledge in various settings" (Rolvsjord & Halstead, 2013, p. 425). However, to date there is a lack of research on workplace factors embedded in the practice of music therapy in India. Therefore, it is critical to examine the overall challenges professionals face in India as they intersect caste, class, gender, and region.

Caste in India is one of the most inevitable characteristics of a person's identity (Parmar, 2020). Caste identity and status of individuals in society are not determined in isolation. It is a relational process that provides grounds for social categorization, social interaction, and social differentiation (Parmar, 2020). Even though the caste system has been abolished in India, it continues to play an important role in determining social identities; however, sectors of society are no longer the same. In some sectors, occupational hierarchies determine social status, identities, and self-esteem. Interestingly, a caste system rooted in occupational structure and based on hereditary division of labor now seems to have occupational mobility, and inequalities are reproduced based on occupations rather than the castes (Beteille, 1991). Even though caste is considered a taboo subject, it continues to impact attitudes about religion, careers, matrimonial choices, access to education, and resources and opportunities, and can contribute to oppression and violence within communities in India (Swamy, 2017). Unfortunately, caste discrimination is still alive in India. Studies indicate that over 30% of Indians still

prohibit lower castes from entering temples, socializing, or sharing food with higher castes (Chisthi, 2014; Desai & Vanneman, 2012). However, more privileged, and upper castes often experience caste as a source of pride and may openly discuss their own caste associations (Swamy, 2017). In particular, lower castes, also known as scheduled castes and tribes, are particularly vulnerable and have been subject to increasing oppression and violence in India (National Crime Records Bureau Ministry of Home Affairs, 2014). Swamy (2017) argues that there is a need for music therapists to be aware of microaggressions between different castes that could lead their clients from lower caste families to feel marginalized. For instance, certain questions posed to individuals are ways to uncover what caste and class one belongs to. Some direct indicators of this can be revealed based on an individual's last name, address in India, the city an individual was born and raised in, etc.

Parmar (2020) points out that surnames have always been important markers for caste, but in a globalizing urban environment, it has become perhaps the most prominent marker of caste identity and therefore carrier of discrimination. Caste-revealing surnames can result in ostracization of individuals belonging to lower castes and exclusion from institutional and non-institutional resources, such as housing, private sector jobs, education, and business (Parmar, 2020). The point made by Parmar (2020) is crucial and makes it imperative for music therapists in the country to sensitively engage with a client and frame questions that do not focus on markers associated with caste but on the individual's therapeutic goals and objectives. However, this is a complex issue, and it is also important to understand the experiences of music therapists and the role that caste, class, and gender have played in their lives and in the lives of their clients thus far.

Further, Swamy (2017) points out that apart from caste, there has also been evidence of gender bias and class discrimination in accessing equal professional opportunities, healthcare services, and education, among other prevalent social locators in India. However, it is evident from the literature that social categories like caste, class, and gender operate not as unitary, mutually exclusive entities, but as reciprocally constructing phenomena that in turn shape complex social inequalities (Patnaik & Jha, 2020). People are part of more than one social category at the same time and embed multiple layered identities derived from gender, caste, class, race, sexuality, social relations, and power

structures. Hankivsky et al. (2010) argue that to understand social inequality, an outcome of intersections of different social locations, power relations, and experiences, needs to be deconstructed on the basis of different identities instead of forcing complex social realities into a binary model. In India, intersection of these identities has been used to understand social inequalities by analysing the role of caste, class, and gender in constructing privileges and preventing access to resources, services, or livelihoods (Patnaik & Jha, 2020). However, currently there is a gap in the literature when it comes to understanding the effect of multiple human identities and the complex interplay of caste, class, and gender in providing music therapy services as well as accessing them in India.

Conclusion

The literature review provides insight on the existing music therapy practice in India, workplace challenges music therapists face both in India and Western countries, difficulties faced in the integration of traditional Indian music practices into music therapy, and finally, the intersection of caste, class, and gender in India and Western countries. Currently, the music therapy practice in India appears to be at a development stage with 50 practising members as compared to Canada, which has over 600 practising music therapists currently (CAMT, n.d.). There are gaps in the literature as to what steps have been taken to support current music therapists in India, advocacy measures, and the formulation of a centralized body to support this profession and its practitioners. However, there is rich data on healing practices in India and also the challenge faced by music therapists to distinguish between healing practices and the broader music therapy framework. The literature supports that this has been a barrier in advocating for music therapy and creating demand for it, however, does not include information on what has been done so far to distinguish both of these important therapeutic practices within clinical settings.

Further, there are no articles or scholarly studies in India that discuss the challenges music therapists face in relation to intersectionality of caste, class, and gender. The need for such an analysis is profound because these are defining parameters for other professions as disclosed within the literature. However, the extent to which music therapy services are impacted by caste, class and gender is yet to be determined.

Chapter Summary

The purpose of this chapter was to review literature on topics relevant to the present study: existing music therapy practice in India, workplace challenges music therapists face both in India and Western countries, difficulties faced in integrating traditional Indian music practices into music therapy, and the intersection of caste, class, and gender in India and Western countries. Chapter three focuses on the research methodology, which is narrative inquiry and the data collection and analysis procedures.

Chapter 3. Methodology

Research Design

The research study used a narrative inquiry methodology to study how participants describe challenges they experience working as music therapists in India. The epistemological aspect of narrative inquiry is "the acknowledgment of the tentative ways in which narratives reference external reality such as objective facts and externally verifiable conclusions" (Hadley & Edwards, 2016, p. 843; Clandinin & Connelly, 2000). This study focused on the challenges, benefits and professional realities perceived by the practising music therapists in India, rather than on the verifiable facts. The use of narrative inquiry seemed an ideal design for this research thesis to provide the framework to describe participants' lived experiences in their day-to-day practice of music therapy with a clinical population intersected by caste, class, and gender. The purpose of this study design was to also co-construct knowledge in understanding the meanings that Indian music therapists working in Mumbai attach to their experiences. In addition, this research methodology attempts to capture how these music therapists are impacted by their stories and how the student-researcher makes meaning of their experiences by collaborating with the participants through the data collection and analysis process (Charmaz, 2000; Guba & Lincoln, 1994).

Participants

Participants were recruited through purposeful sampling. The student-researcher was informally introduced to a music therapist in India, who eventually helped connect with other music therapists and recruit the three participants for the research, based on the inclusion and exclusion criteria.

The student-researcher was provided, by a peer, with email addresses for eight potential participants whom she reached out to via email and LinkedIn. The email laid out brief details on the intent of the research, procedures, risks and benefits of the study, and conditions of participation and confidentiality along with a blank consent form for participants (see Appendix B). The student-researcher provided the participants a week to get back with their confirmation or any questions they had regarding the consent form and participation requirements.

Three practicing music therapists based in Mumbai, India, participated in this research. The inclusion criteria for the study participants were that they each needed to: (a) be over the age of 18, (b) have an education qualification that includes a post-graduate degree in music therapy in India, and (c) have a minimum of two years of experience practicing as a music therapist in the city of Mumbai, India, as the student researcher was able to connect with them through a peer's support.

The exclusion criteria for the participants were that the interviews would only be conducted in English and/or Hindi, depending on the participants' preferences. While the interviews were primarily conducted in English, some interviewees switched to Hindi as per their comfort and to express certain emotions.

Two of the participants identified as male and the third as female. The participant demographic includes current full-time, part-time, and former music therapists, with a minimum of two years of experience in the field. Each of them has also had exposure to training in the North Indian classical style of music, either vocal or instrumental. All three music therapists have also had professional experience working in other cities and villages across India. Some of the participants hold a post graduate diploma in music therapy from the Chennai School of Music therapy in Tamil Nadu, India, and some participants have graduated from the Music Therapy Trust in New Delhi, India. Apart from their music therapy education, the participants do not hold any license to practice music therapy and expressed interest in writing the North American Certification Board for Music Therapists (CBMT) exam in the future. These three participants will be addressed by pseudonyms throughout the thesis to maintain their anonymity.

Delimitations

The delimitations of my research included: (a) only three participants were interviewed due to the scope of the master's thesis; (b) the participants had to be of Indian origin and residing in that country; (c) the participants interviewed were from only one city of India- Mumbai; (d) the interviews were conducted in English and Hindi (as needed) and in no other local languages spoken within India; (e) the interviews were conducted online only via Zoom, which limited communication from body language cues

that were not visible on camera; and (f) the interview was one hour in length with no follow-up opportunities.

Materials

For the interviews, the materials used were the Zoom meetings audio and video recording feature, a laptop, a Wi-Fi connection, and noise cancelling headphones to ensure exceptional audio clarity to interview participants. During the interviews, the waiting room feature and the "lock meeting" feature were enabled so that the conversations with the participants were secure and no one could join without permission.

After the interviews, the data collected was saved on an encrypted flash drive and the files were password protected to ensure maximum data security. The data was stored in a password protected locker when not in use. Additionally, the student-researcher maintained an online journal, which along with the laptop was also password protected, to reflect on their own journey and positionality in the research process.

Data Collection Procedures

The data collection process began upon receiving certification of ethical acceptability from Concordia University Human Research Ethics Committee (UHREC).

Three participants were shortlisted on a first come, first served basis of responses received. Each participant had to sign an informed consent agreement (see Appendix A1–A4) and share a copy electronically. They also consented to have their anonymity maintained in the thesis. It was further communicated to the participants that they were free to withdraw consent and discontinue participation at any time until the data analysis procedure began two weeks after the interview completion, without any negative consequences or prejudices. If a participant chose to withdraw their participation, then the information obtained during the interview would have been destroyed and not used for the data analysis procedure. Upon receiving the participants confirmation and signed consent to participate, the student-researcher set up virtual meetings with each of them via Zoom.

Prior to interviewing the study participants, the student-researcher conducted a pilot interview with a non-participant to check privacy settings, audio volume, the recording feature, the internet connection, and clarity of audio and video. The three

interviews were scheduled for and conducted in the months of September and October 2021.

These were semi-structured qualitative interviews to understand the participants' respective experiences of practising as music therapists in two cosmopolitan cities of India: Mumbai and New Delhi. However, the focus had to be changed to only Mumbai since there were no participants available from New Delhi. In a semi-structured interview, the interviewer prepares a list of questions for each topic within a predetermined thematic framework that they wish their subject to address during the interview. However, the interviewer does not explicitly ask about the themes because that could direct the interview too much (Carspecken, 1996). The interviews included specific and open-ended questions about participants' professional experience as music therapists in Mumbai, India, and the overall challenges they face providing services to a national population intersected by caste, class, and gender. Interview recordings were only used by the researcher for listening, transcribing, and coding themes.

Each of these interviews lasted for approximately one hour. The interview questionnaire was shared in advance with the participants via email, in case they wanted to know the subject of the interview in more detail and better prepare their responses. The interview guide contained open-ended questions to allow space for the participants individual narratives and stories to unfold. The research interview guide is appended in Appendix C.

Data Analysis Procedures

The data analysis procedures began with describing the narratives from the perspective of a hermeneutic circle in the following steps: The student-researcher (a) started the analysis by listening to the audio recordings of each interview and transcribing them word for word; (b) prior to beginning the data analysis, provided participants with the option to view their transcript in case they wanted to make edits to ensure accuracy of the information; (c) conducted an overall review of each interview transcription to understand the structure of the narratives and general themes that were emerging; (d) reread transcriptions multiple times in different spaces and intervals of time to form an understanding of the unique yet diverse voices and how they interrelated with each other, and continued engaging in this process over a period of 1.5 months until there was a

sense of the "gestalt of the narrative" (Hadley & Edwards, 2016, p. 850); (e) started to work on exploring the narratives in relation to the literature and research question to get insights, identify themes, and focus on meanings that grew as the relationship with participants evolved through their transcriptions; (f) simultaneously explored positionality in her online journal in relation to the narratives received and the evolution of insights during the research process; and (g) finally, focused on co-constructing knowledge with participants by maintaining a heightened reflexivity as she analysed how her personal life story and biography played a role in the subjectivities captured in the analysis procedure (Ricoeur, 1981).

Ethical Considerations

As part of this study, the ethical considerations provided by Concordia's University Human Research Ethics Committee were followed. The collected information on participants' experiences and perceptions of their professional practice was kept confidential, and only the researcher had access to this information. The data from the participants' interviews was used only to the extent described in the consent form. Further, participants were advised regarding the possibility of an overseeing faculty advisor from the university reviewing the information collected for the purposes of study. However, participants' identities would not be disclosed to the faculty supervisor. The data gathered through the interviews was coded and, after that, was identified by the participants' respective codes rather than by their names. While the results of this study are published in partial fulfilment of the master's program, the participants were informed that their identity would not be disclosed in the thesis. The participants were provided with the opportunity to indicate whether or not they wished to be named at the end of the thesis in the Acknowledgments section of the research.

A relationship of trust was maintained with the participants as the student researcher navigated her insider-outsider status. The insider status comes from the researcher's education and work experience from India, and the outsider status comes from the researcher's music therapy training and certification in Canada. Scholars argue that an insider researcher understands the nuances of the culture and can navigate the social issues being discussed better than an outsider (Foley, Levinson & Hurtig, 2001).

Moving between the fluid boundaries of an insider and outsider is critical to bring in-depth understanding of the research findings (Delgado-Gaitan 1993).

Chapter Summary

After receiving the ethics approval in August 2021, the data collection process began in September 2021 and closed in mid-October 2021. The data analysis procedure took place from October 2021 to November 2021. During this time, there were four global themes that emerged in the analysis procedures along with sub-themes. These will be highlighted and detailed in the following two chapters that discuss results, the overall implications of the results and scope for future research.

Chapter 4. Results

The primary research question of this thesis was as follows: How do three professional music therapists, employed in Mumbai, India, describe their experiences in providing music therapy services to a national population intersected by caste, class, and gender? The interview guide was semi-structured to explore certain pre-determined themes while simultaneously providing space for the possibility of other themes to unfold centred on the participants individual narratives. Based on the data analysis of the three participant interviews, the following four global themes are presented in the results chapter:

1. caste, class, and gender
2. professional challenges
3. benefits of practising music therapy in Mumbai
4. vision for the profession

Some of these global themes consist of a few sub-themes that emerged based on my interpretation of the participants narratives and will be shared in detail in the following sections. The results provide a gestalt of my interpretations of the participants' experiences as they relate to the primary research question (Kinchloe & McLaren, 1994). This section also incorporates selected interview quotes of each of the participants in order to support the global themes and sub-themes. This section uses pseudonyms for participants and does not contain any identifying information, in order to protect and respect participants' anonymity.

1. Caste, Class, and Gender

The participants revealed an interesting mix of opinions about the role played by caste, class, or gender in providing music therapy services. Participant "Siddharth," who identifies as a cisgender male, shared that he did not broadly experience any bias intersected by caste, class, and gender in his professional experience as a music therapist in Mumbai. However, he described the task of balancing differences in choice of music brought by clients in group music therapy sessions as a cultural challenge. He also shared his belief in the significance of regional and language identity and that they more often affected his music therapy sessions than caste, class, and gender. In his view, it was important to consider the region and language spoken by a client while considering what

music to choose for a session. For example, he stated it would broadly be contraindicated to use North Indian music with a client who is South Indian and based in Southern India. The resistance to North Indian music with South Indian clients is a recurring challenge experienced by the participant in his professional music therapy practice of 5 years. He further mentioned the need to be aware of each client's religious identity and be mindful about the choice of devotional music brought in by the music therapist or other clients in a group session because it could lead to conflicts or not be considered to have therapeutic value. He observes:

> Broadly, I have not experienced any bias in terms of caste, class or gender. But I think sometimes in group sessions, there will be one or two individuals who may not like the choice of music because of cultural differences. But yes, it's a very mixed culture in Bombay…But, in the South [of India] I would never be able to use North Indian music, because [clients] only want either Tamil music or Telegu music depending where in South they come from. So, I guess it's more of a religion and language problem. I mean, it's good to know in India that these factors could come in—caste, class and genders—so that you know what to do when the issue comes up. But I've not seen any barriers yet in my practice…

Siddharth attributed the differences in practicing music therapy to religion, region, and languages spoken rather than to caste, class, and gender identities.

Participant "Nandini," on the other hand, who identifies as a cisgender female, described the class, caste, and gender markers as physical appearance and accessories expected to be worn by Indian women post-marriage. According to her, these markers have been identified and questioned by her clients in her lived experiences of practicing music therapy in Mumbai. However, in line with Siddharth's opinion, she too added that religious identity played a stronger role in influencing the music therapy session than caste, class, and gender markers. She believed it to be more prevalent in metropolitan cities like Mumbai and New Delhi than in small towns of India. She notes:

> People here look at your colour and clothes to guess what class or caste you are from. These days issue of caste and class are happening a lot, however, I feel religion plays a bigger role, then comes caste and then class. It is happening more in metro cities vs in tier two-towns and villages, I've worked there as well. Sometimes patients/clients will ask me, "Okay, what is your name, what is your surname" and guess my caste…. If I am married and I am not wearing any jewelry on my neck, then some clients will come and say, "You haven't worn anything in your neck." "How can you leave your house without wearing any jewelry, married women should not do this."

Nandini shared her personal experience of being questioned by her clients for not wearing jewelry indicative of her marital status. She compared her work experience from Mumbai and some villages and shared that religion was a bigger challenge in Mumbai.

On the gender discussion, Nandini shared the privileged position women held in the profession because, in her opinion, clients were more willing to work with women music therapists. She notes: "I will say for a change, women are the privileged ones. I feel people are more willing to listen to women as compared to men in our profession with clients." Nandini added that she was not sure why, but she mentioned that:

> People tell me it's my body language that engages people. That aside, there are definitely times when women are not in an empowered position, like we can't travel alone by public transit at night or go to certain unsafe areas in the city by ourselves. But with respect to our profession and in my personal experience, I believe we are in a position of privilege when it comes to receiving engagement with clients as compared to men. But overall, I don't think gender makes much difference in our profession at the moment.

Nandini believes that women face gender discrimination in terms of travelling alone at night to certain neighbourhoods, but the profession holds a privileged position for them. She also mentioned that she shared this because she was questioned further by the student researcher, otherwise gender discrimination in her experience does not exist in the profession per se.

For participant "Ram," gender and caste discriminations do not exist because it is his belief that music transcends these barriers. He added that class mattered in the case of being able to afford music therapy services. Similar to Siddharth, Ram also shared that language identity based on the region and religion to which clients belong play a stronger role in influencing the music therapy session and client-therapist relationship as compared to caste, class, and gender identity. He shared:

> I have never come across any issues on this front as I feel music transcends these challenges. I have conducted group session[s] of more than 100 people also at a time. But it never occurred to me that caste or their religion or financial status can come in the way of achieving their goals. Yes…their financial abilities matter if they can afford it or not. I've experienced language being a bigger challenge vs religion or caste. I was working at the hospital where I had a variety people …their language is different, and their music too. So, language can be a barrier, but focusing on music can help navigate these barriers.

He added about gender roles:

> I have not experienced gender bias. I have worked with both genders, and there are a couple of my colleagues who have worked with transgenders, and nothing significant has been mentioned in terms of gender-specific challenges.

Ram's experience indicates that he does not believe that there are differential experiences in music therapy services and access in relation to male, female, and transgender people.

In sum, the participants speak to religion, language and regional identities having a greater impact on the profession than caste and class affiliations. Siddharth and Ram do not believe that gender discrimination exists in the profession. Nandini, however, mentioned her clients inquiring about her physical and accessorial gender markers. Nevertheless, she believed that women have a privileged position over men in the music therapy profession in India, a privilege that is not usually experienced by women in other aspects of life in the country. She supported this statement by sharing her experience of feeling empowered as a woman in the music therapy profession but feeling discriminated against when having to travel by herself by public transit at night in certain areas of Mumbai.

2. Professional Challenges

This section delineates the professional challenges faced by the participants in providing music therapy services in Mumbai. There are various sub-themes that unfolded within this theme that include the following: funding support, brain drain, lack of supervision, and regional and religious affiliations embedded in power dynamics. Some of these challenges are also analyzed based on the research thesis primary question that aimed to understand the role played by the intersection of caste, class, and gender.

Funding Support

Nandini brought to the surface an interesting revelation on funding channels. Nandini discussed the continued lack of awareness around music therapy as a profession in Mumbai and the rest of the country, which made it difficult to find jobs. She also expressed that music therapists in India were presented with a unique challenge of not only finding jobs, but more often needing to create music therapy positions by finding appropriate funding channels that could support these positions in different institutes and professional settings. For instance, she explained that even if a hospital wanted to hire her as a music therapist, she would need to first find the funding channel to finance her for the entire duration of her contract at the hospital. She says:

> You have to do a lot of back work because organizations and funding channels want to see Indian content. So, if you bring a video from another country to advocate for music therapy, they ask you what is being done in our country.…

> Another challenge is funding. Where do we get the funding from? So of course, there are challenges, and it takes a lot of efforts to find out who should we approach and how can one educate them about music therapy and convince them to provide funds for the organization you want work with, and then also clarify how it's different from sound healing, etc.

According to Nandini's experience, sourcing funding channels was not easy as they requested video content on how music therapy was being conducted in India. This would present additional ethical dilemmas and consent concerns. If music therapy knowledge constructed in other countries was provided by Indian music therapists to potential funding channels in India, it would be rejected and only material that demonstrated music therapy practices within India would qualify as evaluation material for funding. This knowledge would often confound with healing practices, adding to the challenge of securing funding and advocating for music therapy as a distinct profession.

Lack of Supervision and Allied Healthcare Professionals' Support

One of the key professional challenges shared by Siddharth was the isolation experienced in his profession due to the low number of music therapy professionals in Mumbai and rest of India. The limited number of experienced music therapists in India also made it difficult for him to find supervision for his work, leading to a feeling of stagnation and separation in the music therapy profession. He observed:

> I think the biggest challenge was, it was a very lonely and long journey, you know, because there was not that many music therapists in Mumbai. So, to find someone for supervision was difficult. I think for me it was the biggest challenge because so many times you can get lost. This is a big challenge and while you do have support from other psychologists and therapists, it's not enough in terms of getting specific supervision for your music therapy work and overall growth.

He further talked about the nonprofit organizations he worked with, and the amount of work his inter-disciplinary team was engaged with that caused professionals

burnout and made them less motivated to engage in any other collaborative efforts with the music therapist. This made it challenging for Siddharth to collaborate or receive any secondary supervision from the inter-disciplinary team working with the same client.

Additionally, he expressed the concern of producing quarterly reports for the funders describing progress made by the organization based on parameters set by the funding channel. The parameters were not necessarily specific to client progress but were more focused on business growth and monetary goals. Overall, Siddharth reflected on the imbalanced power dynamics and conflict of interest at play between the non-profit, the funding channel, and the patient, causing Siddharth to reassess who he was working for and how he could continue to prioritize his clients/patients. He expressed:

> Most organizations here are run by trustees. And therapists out there who've been working for years were very burnt out and after a point got so fatigued that the attempt to collaborate became very one-sided from…from my side. Because I was coming in once a week, I wasn't so burnt out, but they were there every day. So that was a big problem; they were not sort of involved in what I'm doing. I really wanted to collaborate but didn't get to. We just had to do a quarterly report, which was more for the trustees to see that. Since they are funding, it becomes less about the patient and more about the trustee for the organization. So, in that sense, it was very challenging. I wondered if I was working for the patients or the trustees or the nonprofit.

Overall, based on the participants' experience, there is lack of supervision and support from allied healthcare professionals in Mumbai. Siddharth expressed that the reasons for lack of supervision include a shortage of practicing music therapists, low awareness for the profession, and immense workload on allied healthcare professionals causing burnout.

Additionally, the participants shared that often organizations did not address challenges faced by their employees and patients/clients but instead focused on quarterly managerial reports for funding channels. This situation made it difficult for music

therapists to distinguish for themselves if they were working for their patients/clients, the funding channel, or the host organization.

Traditional Healing Practices and Music Therapy

Participants described that in non-profit organizations it was hard to find work because of lack of awareness of music therapy and the difficulty of differentiating it from traditional healing practices. Siddharth also mentioned that the challenge to find work was immense on his journey as he personally did not want to join hospitals because they required him to do administrative work, taking away hours from his music therapy practice. He says:

> Getting myself work was challenging because of low awareness for music therapy, the unclear distinction between sound healing and music therapy. Many people in India do sound healing, sound baths, etc. But I don't. So, it was tough to get private clients and explain what I do as a music therapist.

Additionally, he shared how it has been difficult for him to approach private clients due to the constant advocacy efforts becoming challenging when establishing the distinction between healing practices and music therapy. On the other hand, Nandini talked about sound healing being confused with music therapy as a challenge that she has embraced and justifies the use of sound healing as a subset of the overall music therapy practice. She explains:

> The confusion of music therapy and sound healing has been around for a long time. But now I have stopped fighting it. When people think I am doing sound healing, I agree and call it receptive music therapy but explain the active way of practicing music therapy and how it's different. I show them examples if needed.

She shared that the way she distinguishes sound healing from music therapy for her audience is by referring to the practice of sound healing as one of the methods to do receptive music therapy. She further explains to her clients that there is also an active component of music therapy that involves entirely different methods of engaging clients, which she demonstrates through her own video recorded music therapy sessions.

Brain Drain

Nandini discussed the concern of aspiring music therapists leaving India and moving overseas due to educational and occupational challenges, and for better financial opportunities and recognition for their professional roles.

> Unfortunately, another challenge is that most music therapists move abroad to pursue their research interests or do clinical work. So, when somebody is a PhD from another university outside of India, they won't come back to the country and practice here, because in the other country they will get more money, which makes practice in India smaller and advocacy even harder. Outside you don't have to always find channels that will finance your music therapy services, but in India most often music therapists need to not only find a job but also a funding channel.

From what participants are sharing, it appears there is a lack of educational resources, professional opportunities, and supervision support within the music therapy practice in India. Such challenges have resulted in many leaving the country and moving abroad to pursue better career prospects in the field of music therapy. When qualified music therapists leave India, it results in burdening the remaining few music therapists to take on added unpaid responsibility of advocating and bringing recognition and regulation for music therapy in India.

Lack of Awareness About the Profession Causing Occupational Challenges

As evidenced from the three participant conversations, one of the biggest challenges faced is a lack of awareness about the music therapy profession in Mumbai, India. The overall lack of awareness makes it difficult to receive funding, respect, and dignity for both music therapy practitioners and the overall profession. Ram notes that within the healthcare system there is a lack of awareness and willingness to understand what music therapy is, leading to resistance in hiring a music therapy professional. He describes his challenges in detail below.

> First of all, lack of awareness. Second thing is the lack of willingness. People are not willing to take it as profession or even hire music therapists in their institution because they are not sure of it. They don't understand the art and science and the importance of what we do. So, getting a job is a problem; getting referrals for music therapy was a challenge. I tried to educate my team professional but there seemed to be no desire to learn about music therapy. So, that was again a challenge.

Ram's experience shows that the willingness to learn about music therapy was inconsistent among other team professionals involved with the same client, which resulted in further challenges of attaining referrals for music therapy. Ram often received referrals for music therapy without a logical foundation, leading to more hours spent by the music therapist in educating team professionals and making systemic changes. Additionally, he discussed how only few people from a specific social class can afford this treatment because the costs are high. He states:

> First of all, we need to understand that in India, only a certain category in our society can afford it, because the cost is high. The individual overhead cost is high because there are very [few] people who are trained in music therapy…And we can't offer our services for free or always keep reducing our price just to keep going. So, patients who are already burdened with hospital charges will not sign up for music therapy, especially because it is not even covered under any kind of insurance. Also, if they sign up, then the results they expect are like swallowing a magic pill…they want immediate results. So, this makes it complicated for people to see the value in affording such services.

Ram makes a reference to class challenges witnessed in providing music therapy services in Mumbai. As music therapy is not covered under any insurance plan and most often does not guarantee immediate results, its value is reduced in the life of a patient

and/or caregiver. He further tries to explain why music therapists in Mumbai are compelled to maintain a fixed service fee and find it challenging to charge less than what might already be a reasonably low session rate. Thus, music therapy becomes available only to a certain social class because it is an additional expense for patients, which they are often discouraged from investing in because of other ongoing treatment and medical expenses.

To summarize, participants in this study raised the issue of social class determining who has access to music therapy. They also each found it difficult to convince people that traditional healing practices are different from music therapy. The demand by funding channels to see Indian content and the difficulty of distinguishing between traditional healing practices and music therapy may also indicate that people consider music therapy as a Western concept which may colonize their music because it is viewed through a Western lens. Hence, this lack of awareness about the profession has resulted in compelling music therapists to obtain funding without any systemic help. Participants also discussed other systemic barriers, like music therapy not being insured resulting in additional expenses for patients. The additional expense of music therapy discourages individuals from pursuing music therapy sessions alongside other ongoing treatments and medicines. It was further discussed that professionals and society at large need to be educated about music therapy and its legitimacy in India. As the participants expressed, due to such systemic challenges, many aspiring and practicing music therapists leave India for better educational and occupational opportunities, making advocacy attempts even harder for the ones who continue to reside and practice in the country.

3. Benefits of Practising Music Therapy in Mumbai

When asked about the benefits of practising music therapy in Mumbai, participants reiterated the advantage of the rich cultural diversity that each individual brings with them depending upon the region they come from, the languages they speak and above all their religious affiliations. This cultural multiplicity provides more scope to experiment with various genres of music, making the three participants view this as a benefit from a learning perspective. One participant shared the difference in practice and choices of music being dramatically different between southern and northern India. In the

participant's experience, clients/patients based in Mumbai preferred Bollywood music, whereas South of India was more inclined toward devotional music. For example, Siddharth observed:

> India is a very culturally rich country, right. We are predisposed to the arts. It's amazing to do music therapy here. It always feels new and exciting, because each individual has so much culture in them that's different from the other patients, so you're always sort of learning and increasing your repertoire. Like when I was in the South, I had to learn a lot of Tamil songs and devotional music…a lot of prayer music, things like that. But then in Mumbai you're using more Bollywood music so it's different. I also use more ambient music and experimental music with people in Mumbai. Second, I've seen especially with children, they respond really quick to music therapy mostly because they haven't seen something like this. So, when you come in with your instruments and with your technique, they are so fascinated by it and I think that plays such an important role in their healing as well—their fascination about music therapy.

Siddharth also viewed children's lack of awareness around music therapy as a benefit because their openness, curiosity, and fascination to engage in a music therapy session can prove beneficial in their healing process. He also elaborated on his preference of working with schools because children on the spectrum responded well to his music therapy sessions. He shared that since music is an important part of Indian culture, every child has been exposed to some kind of culturally diverse music, which made it motivating for him to work with them and capitalize on their music identity to maximize therapeutic benefits. He noted:

> But with the schools that I work with [it] was pretty fantastic because, there, you know, personally working with kids was just really nice because kids really respond well to music, and I don't think too many of the parents in India know

> about music therapy, yet they were open to music therapy possibly because it was being provided within the school system. Every child in India is exposed to some sort of music, whether it's devotional music or culturally specific music identified by parents or something, or schools—they are exposed to it early on. So, that makes it even more interesting and stimulating for me also to work with them.

Since it is challenging to explain to clients the difference between traditional healing practices and music therapy, Siddharth explains how he felt motivated to work with children in a school setting because he did not need to constantly advocate to the parents about the music therapy profession as it was a service being offered by the school without any additional fee. He was also motivated as he did not need to constantly prove its distinction from traditional healing practices, which had often been the case in his professional experience. However, despite the rich ancient use of music as therapy, music therapy continues to be considered the same thing as sound healing.

In summary, participants discussed the cultural diversity of India as one of the great benefits of practising music therapy. It requires sensitivity and basic knowledge of a variety of music of various states of India, including a variety of religious groups residing in the country. They described the diverse cultural population of India as one of the challenges as well as a great benefit that allows music therapists to examine, experiment, and enhance knowledge about cultural beliefs and values. Additionally, the cultural diversity exposes music therapists to different perspectives and worldviews.

4. Vision for the Profession

Participants highlighted their vision for the music therapy profession in Mumbai and how they see themselves evolving in their places of work. The vision of the participants is replete with the challenges that they have experienced, and that they foresee in the future. At the same time, they identified that due to the expansive diversity of music across the country, the music therapy field is predisposed to growth. However, all three participants agreed that a lot more awareness campaigns need to be initiated by the music therapy community to further instil belief in the value of music therapy.

Siddharth observed that a lack of consistent belief in the impact of music therapy and clients seeking quick, tangible results make it challenging to retain and work with clients on a long-term basis. He notes:

> When I get a referral or call, the parents [are] so excited to do music therapy. But after a month or two months, they are sort of like, “Oh no,” or they discontinue without any reason, just expecting quick results. They don't understand that therapy in general ...even talk therapy takes time. Results are built slowly, and they may not be visible now. So, the audience really needs to be educated on music therapy so the right expectations can be set.

On being asked about how he thinks his role would evolve in the future; Siddharth responded:

> I don't think I'll be doing music therapy full time; I don't do it today as well because I'm also a life coach. And I knew this very early on, that just music therapy is not going to cut it financially.

He does not see himself doing music therapy as a full-time profession due to financial reasons. He would rather get into training more social workers, caregivers, or other individuals working with potential music therapy clients. He finds advocacy exhausting and is therefore interested in sticking to part-time music therapy work or being a consultant who provides music-therapy-related training programs.

> I'm trying to do a lot of workshops for the “train the trainer programs” for people working with individuals with autism or young children, and train them to use music on their own in their capacity. I think that's really powerful because there's so much a parent can do or somebody else can do with music, not the level that music therapists do, but just basic things that can really help the child in the long run. As opposed to me sort of really pushing myself to work with the

child, and advocating gets very exhausting. So, more consultation work, more sort of training work, that kind of system for me is what I see.

However, Siddharth described that through his experiences, he has witnessed the field of music therapy grow in the country and he is hopeful for it to further advance in the coming years. He shared the need to regulate the music therapy profession in India and move beyond theoretical perspectives to gain practical experience through more allocation of clinical hours during music therapy training. He shared his disappointment of not having enough hours during his own training and believes this change in the music therapy training programs in India could better prepare aspiring music therapists for potential job opportunities across India. He also expressed that the implementation of this change could be done immediately as compared to licensing the profession. He states:

> But aside from my personal journey, I do believe the field is going to grow in India. It's grown so much in the past three or four years so it's a nice hope for, you know, to do it full time…I think that would be good in terms of regulation to get certification and set number of clinical hours. Just learning theory is not enough. I faced this challenge. I had to learn on the job for a year or two….in hindsight if I had more hours under my skin, I would have been much better equipped to work with people. I think one thing is you know, because a lot of people are studying expressive arts therapies which includes art, dance and music therapy…I think it's very important for these people to get in a lot of specific music therapy hours, before they start practicing or working with individuals. While licensing the profession will take a long time, I think having certain number of clinical hours is something that can be possible to introduce right away.

Siddharth stresses the need for more practical experience than theoretical knowledge to prepare aspiring music therapists for future professional opportunities. In

his view, the current requirement for clinical hours is not enough at the training level and has scope for improvement. On asking Siddharth a follow-up question about the expressive arts therapies program and its specific clinical hours requirement, he responded:

> I am not sure how efficient and how many clinical hours are dedicated to music therapy, how much to dance therapy, I don't know. I think it should be mandatory to have a standard number of clinical hours no matter what program you are in.

For Nandini, the challenge lies in diversity of schools of thought and a lack of trust and cooperation among them. She observes the difference in how music therapy is practiced in the South and north of India and the difficulty in accepting each other's methodologies of music therapy practice. She shares:

> We are again very culturally centered people. So today Chennai school of music and music therapy trust in New Delhi don't really believe in each other. Whereas they are practicing the same thing.

In her conversation, she continues to discuss a lack of collaboration among educational and professional organizations. The difference of opinions between the South and North of India on how to practice music therapy appears to be one major hindrance in formalizing a centralized licensing body that accurately represents and regulates the profession in India.

In her vision for the profession, Nandini also recommended changing the way music is taught from an early stage. She suggested music training in India is essentially traditional and structured in a way that distinguishes a right note from a wrong note. She observes:

> I may say we are still growing…. I think if I want to change something in our country it is the hardcore musicians in the country, because when we talk about music therapy, we do not always talk about good sounds and good music. It took me really long... like two to three years to understand, okay fine this noise is also

very important in the music therapy room. Earlier, a wrong note, is a wrong thing, but within music therapy it is not wrong or right. So, if we change that little perspective from the beginning of music training itself...I think it will help produce really quality music therapists and also distinguish it from sound healing.

Nandini suggested that music training in India needs to be more inclusive of unconventional sounds. When music therapists increase their tolerance to sounds that deviate from the convention, it helps aspiring music therapists to naturally have far more insight into a client's music. She is positive that this change in the practice of music therapy in India could help differentiate it from sound healing and also invite more people to explore this field.

On the other hand, Ram discussed the need to change the lack of trust that inter-disciplinary team members have in music therapy and thus also in music therapists.

First of all, team members should refer clients to music therapy…If they're not referring, then there is no point. So first of all, they should have faith in music therapy. If a music therapist has been hired in the hospital, then you should have that faith, that this person, and this profession, works. Once they have faith, then they can refer a patient with confidence to a music therapist. So, awareness is key at this point.

He believes that there is a lack of faith in music therapy even when a professional is hired at a hospital. He suggested that professionals and society need to be educated about music therapy for clients to be referred in the first place. He notes:

Forget society, even professionals are also not aware of it. We need to educate both. We need to educate society, we need to educate professionals, because then only can they refer clients, and the profession can grow. Also, when another professional refers a client for music therapy then half the trust has already been

built on a placebo effect. Clients will trust it more when the referral comes from another healthcare professional.

Ram shares that his vision for the profession is for people in India to understand what music therapy is, accept its value, and believe in its power to bring change at an individual and societal level. Furthermore, Ram explains that for every ten trained music therapists there are only two full time working music therapists. Hence, in the future the number of full-time working music therapists need to grow. Siddharth shares similar beliefs and argues:

> So, the ratio of people who are getting trained in music therapy in India, and the people who are working full time is probably 2:10. Basically, people whose monthly income is solely based on music therapy; I think are hardly any. So, if 10 people are getting training in one batch hardly one person or two from that batch are working in this field full time…. that to some people might be already some other therapists, physical therapists, counselors, psychologists.…We need to do more social campaigns so our community can grow.

Currently, in Ram's experience, most professionals add other skills and practice as counselors or psychologists or in other related fields where they can use music therapy. He suggests that the community of full-time music therapists is very small and needs to grow. Ram talks about doing more awareness campaigns, which will help create more job opportunities and bring the much-needed systemic change this profession needs in India.

Although the visions for the future are foregrounded by challenges the participants have experienced, they are hopeful that the field will grow and suggest the following measurements to be the focus: (1) access to equality of resources, (2) meeting the needs of demographic challenges to focus on ethics of care and urgency, (3) certification by a centralized body to regulate the music therapy practice in India, (4) training in music to be inclusive of diverse sounds defying convention, (5) more clinical hours in existing and future music therapy training programs, (6) number of full-time

practicing music therapists to grow, and (7) campaigns run by the music therapy community to raise awareness among allied professionals and society at large.

Chapter 5. Discussion

In this Chapter, findings are examined by situating the analysis in themes emerged and the broader sociocultural and economic context of India intersected by caste, class, gender, region, and religion. This is followed by limitations of the current study, implications of the findings for the music therapy profession in India and recommendations for future research.

Caste, Class, and Gender

India's significant multicultural and multilingual identity has given rise to very different perspectives on gender, caste, and class inequalities embedded in differential systemic power structures and social stratification (Purkayastha et al., 2003). In this study, it was interesting to observe the emerging themes of religion, region, and language identities in all three participants' responses when asked questions on caste, class, and gender. The reason for participants to focus on religion, region, and language identities can be attributed to the immense diversity of Indian music and spoken languages seen across 28 states and 8 union territories of the country. The 2001 census recorded 30 languages spoken by more than a million native speakers and 122 were spoken by more than 10,000 people (Census Data, 2001). In addition, according to a 2011 census, Mumbai has 8 million Hindus, 2 million Muslims, 407,031 Christians, 60,579 Sikhs, 603,825 Buddhists, 509,639 Jains, and 439 other religious identities (Office of the Registrar General & Census Commissioner, India, 2011).

It is also worth noting that the two participants who identified as cisgender male did not think there was any prevalent gender and caste bias in the music therapy profession of India. However, the participant who identified as cisgender female argued that she was often viewed by her clients through her physical appearance and gender markers for married women of a specific caste.[1] Although the participant was not questioned more, it would be interesting to understand the self disclosure policy music therapists in India adhere to, given there is no standardization of the profession in India as yet. The participant expressed in the interview that she shared some of her personal information requested by her clients, indicating that the self-disclosure policy between a

[1] In India, married women are typically identified with their mangalsootra (a necklace worn after marriage) and sometimes sindoor (vermillion put on the forehead).

music therapist and client appears to be different in India as compared to the disclosure policies established by CAMT and AMTA in North America.

Men in India do not have such markers, and they are not questioned on these physical appearances. She further compared the gender disparity she experienced outside of her profession with the gender privilege she felt within the profession. She described this privilege as a rare yet prevalent occurrence in the music therapy profession in India.

It was also learned that both male participants believed that language, regional, and religious identities were stronger than the caste and gender identity in Mumbai. The opinion shared by the two male participants is further validated by Modi (2021) who argued that cultural feminism focuses on the idea that men and women have different perceptions and experiences about gender issues in India because of the culture and different values they were raised in.

Moreover, the female participant talked about not being able to travel in certain neighbourhoods due to safety issues, which was not the case with the male participants. Phadke et al. (2011) argued that although women have more access to public spaces, they have highly unequal claim to public spaces in Mumbai. Phadke (2012) mentioned that:

> Women spatially inhabit a city [Mumbai] differently from men. They/we not only negotiate the city differently but also perceive it differently. This difference lies not only in the strategies women use to produce safety but also in the mind-maps that women carry in their heads of the city. (p. 51)

Kaushik et al. (2011) further found in their study conducted in India that men and women differ significantly on their opinion regarding the issues of interpersonal mindset. It is evident from the male participants' interview responses that they view gendered experiences in practicing music therapy from a privileged lens of their own gender. It was also interesting to observe the inclusion of transgender people by one of the participants, despite not having worked with them. Notably, transgender people continue to struggle for visibility in the Indian census and society. For example, in a 2011 census, the survey included sex-related data in a binary male/female format, assuming the rest as "other" and further assuming them to be "trans" (Behal, 2021).

Finally, participants unanimously agreed that music therapy is only available in 2-3 metropolitan cities of India. India has 40 cities with more than a million people, 396 cities with between 100,000 and 1 million people, and 2500 cities with between 10,000 and 100,000 people (Population of cities in India, 2022). Additionally, it is only sought by a particular social class because lower social classes do not have the knowledge, means, and funds to seek creative arts therapies in the country.

Professional Challenges

Based on the results, the following sub-themes emerged under the global theme of professional challenges: funding support, brain drain, lack of supervision, and regional and religious affiliations embedded in power dynamics intersected by caste, class, and gender. One of the biggest hurdles for music therapists in Mumbai has been acquiring funding support, due to a lack of awareness of the profession. Further, because music therapy is conceptualized as a Western phenomenon that might colonize their traditional music, the funders ask the music therapy practitioners to provide videos of sessions or research that is specific to their own country in order for Indian music therapists to obtain funds. Music was used during colonization to fight for the country's freedom from the British. In India, there has been a culture of bringing changes in society through music (Hicks, 2020). Possibly due to the roots of oppression in economic, social, and cultural contexts, along with colonization of minds, people are wary of using techniques that come from the Western world.

Furthermore, getting the money is not the only obstacle: moving that money through the proper channels is a herculean task, and the responsibility of doing so oftentimes lies with the music therapists rather than the organizations. Since music therapists are working with nonprofit organizations that follow neoliberal ways of functioning, where they focus on progress and growth to prepare the quarterly report for the funders, they lose touch with ethics of care for their employees or patients/clients. Such differential power structures in the field compel music therapy practitioners to divide their focus, skills, and knowledge between patients and trustees. Neoliberal systems incorporate economization of policies at the risk of compromising with the social issues. Ball (2003) notes,

> While we may not be expected to care about each other, we are expected to 'care' about performances and the performances of the team and the organization and to make our contribution to the construction of convincing institutional spectacles and 'outputs'. (p. 224)

Hence, the important issues do not make it to the policy circles, creating a dilemma for the employees whether they work for the organizational goals or focus on their client's needs that are not always aligned with the organizational goals. Further, lack of awareness for the music therapy profession within the allied healthcare setting, along with burnout experienced by these professionals, has resulted in little to no collaboration with music therapists. This leads to music therapists feeling isolated in their journey and a lack of support and trust from their own team of professionals. Music therapists also expressed how they experience stunted growth due to the lack of partnership and potential supervision from healthcare professionals in other client-related areas.

Additionally, as found in the literature (Hicks, 2020; Luthra, 2014; Singh, 2021; Sundar & Parmar; 2018), participants reiterated the struggle to distinguish between traditional healing practices and music therapy because of the lack of awareness for music therapy and the large number of sound healers present in the country compared to music therapy professionals. Hicks (2020) discusses an interview where Dr. Sumathy Sundar argues,

> Music is religious, ritualistic and a socio-cultural experience, a medium of prayer to seek health from God...music and chanting are tools to meditate and keep one's body, mind, and soul in a balanced manner. (p. 4)

According to her, different genres of Indian music are very important aspects of everyone's life (Hicks, 2020). In the same interview she asserts that, despite the deep religious roots that music has in India, in her training program, "all music therapists are trained to be secular in practice." That could be one of the disconnects of distinguishing between healing practices and music therapy and a lack of awareness on the practitioners' part too might be embedded in the struggle to differentiate between traditional healing practices and music therapy. Due to these educational, occupational, sociocultural, and

economic challenges, many aspiring music therapists move out of the country, causing a brain drain and exhaustion among remaining music therapists who must put in extra efforts for advocacy and regulation for the profession in India.

Benefits of Practicing Music Therapy in Mumbai

The participants argued that the diversity of culture is an integral part of music therapy practices in India because of religious beliefs and regional affiliations that include different languages and devotional music practiced in various religions. They cited this as both a challenge and a benefit to practicing music therapy in India. Stige (2002) argues that topics of culture are of significant interest to music therapists, which gives rise to questions of types of music and interventions. Music therapists in the Western countries practice effective ways to maintain and sustain therapeutic relationships with clients from diverse cultures (Dileo & Magill, 2005). In this study, participants described learning a song in a different language based on their client's preference and selecting music based on the client's religious beliefs. Mumbai is a metropolitan city and has a diverse population encompassing numerous religious beliefs. Music therapists, in this study, were able to view this diversity as a benefit and opportunity to improvise their interventions and experience growth by learning songs in different languages and enhancing their repertoire.

This study brought to the surface more challenges than benefits of the current music therapy landscape of Mumbai. There were also issues of gender that were discussed by the female participant alone. The two male participants talked in gender-neutral language portraying their privileged status in a patriarchal society. It was also noted that in a culturally rich country like India a structure is missing to address challenges of diversity and it is left to the individual music therapist to devise their own ways to engage with their clients and create culturally respectful therapeutic alliances.

Overall, participants identified various challenges, benefits, and scope for policy enhancement within the existing music therapy profession in India. They raised important questions about equity, awareness, access, funding, advocacy, standardization, and cultural diversity that need further research. It is also worth noting that all three participants speak passionately of music therapy and have over 5 years of experience

each, even though the current challenges outweighed the benefits of practising in India. It is interesting to observe all three participants continued desire to contribute to the field despite the challenges outnumbering the benefits currently.

Implications for the Music Therapy Profession in India

Participants profoundly articulated the implications for the future in five specific categories. Despite facing numerous challenges, they are hopeful that the field has the potential to continue to grow as they reflect on the expansion the field has experienced in the past 5 years. Music therapy, as a field, needs to look into creative ways to incorporate these suggestions into policy and advocacy. The participants specifically discussed: (1) transforming policies to provide equitable access to resources, (2) addressing the challenges of diversity to focus on ethics of care and urgency, (3) formulating a centralized licensing body to regulate the differences in practicing music therapy in different parts of the country, (4) addressing the issue that there are less than 50 practicing music therapists in the country, and (5) running awareness campaigns about the field because currently the responsibility of advocacy and acquiring funding lies on the individual seeking employment. The hope from this study is to initiate a shift in current perspectives on the music therapy profession in India, help formulate a centralized body to make it a standardized profession in the country and to promote advocacy practices so that all citizens, regardless of class, caste, and gender, will have access to this service.

Limitations

The completion of this thesis encountered several obstacles, some of which were limitations to my research study. This was my first research project and my lack of experience in research may have influenced my data collection and data analysis processes. I delimited my sample size to three music therapists. However, adding more participants to the study could have provided additional perspectives and improved the validity of the study. This study is situational and exploratory with partial perspectives of three music therapists based out of Mumbai, India. The results of this study cannot be transferred to other music therapists practising within the same city or other states in

India as the findings are attributed to the individual narratives emerging from their personal experiences of practising music therapy.

The male and female participants of this study and I belong to the upper caste and middle-class population of India, which excludes the perspectives of lower caste men and women from this study. Throughout this project I reflected on my positionality and perspectives as an upper-caste, middle-class and cisgender woman who is getting a postgraduate degree in a Western country. I had to navigate through the fluid and difficult boundaries of insider-outsider status while analyzing my data, so that the co-creation of knowledge with my participants came from a place of wisdom and not bias. However, they may have still influenced my data collection and analysis procedures.

Finally, this research included my nascent journey as a music therapist and a novice researcher. The research was conducted in partial fulfillment of my master's degree, which impacted the time and resources available for data collection and analysis procedures. Additionally, I was not based in India to conduct these interviews face to face, which limited possibilities afforded by in person data collection (observations at the workplace, body language etc.). Further, conducting online interviews through conflicting time zones and the fatigue of extensive virtual activity may have impacted the quality of responses received and their interpretation.

Recommendations for Future Research

This study aimed to heighten awareness about the overall challenges that music therapists face in India, which in turn may inspire various relevant stakeholders to address these obstacles and work toward establishing music therapy as a recognized profession. In the future, the results from this study could influence collaboration between various creative arts therapists as they address their struggles in India. Furthermore, this study may lead to future ethnographic studies where Indian music therapists' lived experiences are examined through participant observation and interviews to provide in-depth understandings (Carspecken, 1996). Additionally, this research may lead to future research into formulation and appropriation of policies in the music therapy field that construct and reproduce cultural themes within a policy process structured by caste, class, and gender.

Overall, this study did not only aim to fill the current gaps in the literature, but also exposed readers to the similar challenges that music therapists face in different cultures and possible insights on potential solutions and future policy and clinical research needed in India.

It is recommended that the benefits of cultural diversity should be researched and integrated into sociocultural aspects of education policy and appropriation. The formulation of the benefits of cultural diversity will help reduce marginalization of some clients due to a lack of understanding by music therapists about various cultures and their integration into music therapy sessions. Seung-A Kim (2015) argues that music therapy should further develop multicultural theoretical frameworks and competencies and that the questions emanating from diversity should be further researched.

Studying the perspectives of more Indian music therapists based in different regions of the country is another potential area for future examination that may be explored but is beyond the scope of this research thesis.

In India, some other areas for further investigation include and are not limited to the following: (a) how traditional healing therapies specifically hinder the growth of music therapy as a field, (b) an evaluation of the availability and/or lack of resources for music therapists, (c) the interplay of castes and class issues in practising music therapy, (d) how funding is obtained and distributed through various channels and the structural funding challenges faced by music therapists, and (e) learning the perspectives of Indian music therapists based in different regions of the country and conducting an evaluation of other themes that might emerge.

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Appendices

APPENDIX A1

Participants Information and Consent Form

INFORMATION AND CONSENT FORM

Study Title: Perspectives of Indian Music Therapists on the State of Music Therapy as a Profession in India: A Narrative Inquiry
Researcher: Aprajita Saxena
Faculty Supervisor: Dr. Guylaine Vaillancourt
Faculty Supervisor's Contact Information: g.vaillancourt@concordia.ca | 514-848-2424 ext. 5670
Source of funding for the study: In partial fulfillment of the Master's program at Concordia University

You are being invited to participate in the research study mentioned above. This form provides information about what participating would mean. Please read it carefully before deciding if you wish to participate or not. If there is anything you do not understand, or if you want more information, please do not hesitate to ask the researcher.

A. PURPOSE

The purpose of the research is to better understand the experiences, perspectives, and challenges of music therapists of India in providing professional music therapy services to a population intersected by class, caste, and gender.

B. PROCEDURES

1. I understand that by accepting to participate in this research means that I am agreeing to participate in a one-hour online interview. I understand that during that interview I will be asked questions on myself, my work experiences, challenges, and perspectives as a professional music therapist in India.
2. I understand that the interview will be audio-recorded. The recording will be accessible only to the researcher and for the purpose of collecting, transcribing, and analysing data only for later use in developing the thesis results.
3. I understand that all the data from the audio recordings will be immediately saved to a password protected laptop and flash drive and will be stored in a locked filing cabinet at the primary researcher's house and will be accessible only to the researcher.

4. I understand that I could chose to withdraw my participation any time before the data analysis procedure begins
5. I understand that the audio recordings will not be published or part of any public presentation.
6. I understand that my identity and information shared will remain anonymous and I could choose to have my identity disclosed in the acknowledgment section of the thesis
7. I understand that the results of the research might be presented in educational settings, scientific publications, or conferences and that the researcher will assure that information is presented in a way to preserve my identity.
8. I understand that the interview will be conducted either in English or Hindi depending on the participants comfort level
9. I understand that in order to participate I need to be over 18 years and practicing in either Mumbai or New Delhi.
10. I understand I need to have a minimum of two years of experience working as a music therapy professional and also have completed a diploma in music therapy in India.
11. I understand that my participation is voluntary and there is no monetary compensation for my participation in this research.
12. I understand that this thesis will be published on Spectrum by Concordia University

C. RISKS AND BENEFITS

Overall, this study involves minimal risk, however you might face certain minimal risks by participating in this research. These potential risks are as follows:

1. The interview will be conducted virtually on Zoom, hence there is a possibility of feeing fatigued by the end of the one-hour long interview.
2. There might be a possibility of slight emotional discomfort as I share on the professional challenges faced intersected by caste, class, and gender.
3. I understand that if I share with peers regarding my participation I might be judged by some music therapists in India for being vocal on these challenges. As a result of this, my relationship with colleagues could be altered since the research process requires a certain level of disclosure of my work and challenges.
4. I understand that in case I feel extremely physically fatigued while giving the interview, I will have the option of switching off the Zoom video and take breaks between the interview process if needed.
5. I understand in case I experience emotional discomfort during the interview then a list of support resources will be made available during the interview

APPENDIX A3

Participants Information and Consent Form

Potential benefits include:

1. I understand that through my participation in this study, I could help heighten awareness about challenges that music therapists face in India, which in turn may inspire various relevant stakeholder to address these challenges and work toward establishing music therapy as a recognized profession in the country.
2. I understand that this study will benefit the growing field of music therapy from a global context by bringing to the fore diverse voices and their perspectives.

D. CONFIDENTIALITY

1. We will gather the following information as part of this research:
   - I understand this narrative inquiry aims to understand the perspectives and experiences of Indian music therapists on the state of music therapy as a profession in India
   - I understand I will be sharing information on my personal experiences, perspectives and challenges intersected by caste, class, and gender.
2. We will not allow anyone to access the information, except people directly involved in conducting the research. We will only use the information for the purposes of the research described in this form.
3. The information gathered will be coded. That means that it will not be possible to make a link between you and the information you provide.
4. We will protect the information by:
   - Locking the Zoom interview with a passcode and enabling the waiting room option. The audio files from the interview will be immediately saved to an encrypted flash drive and later to a password protected laptop. Both the laptop and flash drive will be stored in a locked cabinet when not in use. The transcriptions will be completed by the researcher and will be saved on a password protected laptop and an encrypted flash drive for additional back up. The recordings will be accessible only to the researcher. There will be no public presentations and no publications that will use the raw audio or video files.
5. We intend to publish the results of the research. However, it will not be possible to identify you in the published results.
6. The information will be destroyed five years after the end of the study.

E. CONDITIONS OF PARTICIPATION

1. I understand that I am free to withdraw my consent and discontinue my participation at any time until the data analysis procedure begins without any negative consequences and prejudices.

APPENDIX A4

Participants Information and Consent Form

2. I understand that if I withdraw from the research, the interview data will be discarded and the data from other participants will still be used but no information will allow any identification.
3. I understand that my participation in this study is confidential, and that the researcher will know but will not disclose my identity.
4. I understand that the results of the research could be presented in educational settings, scientific publications, or conferences and that the researcher will assure that no identifying information is presented to preserve my identity.

Please note that you do not have to participate in this research. It is purely a voluntary decision. If you do participate, you can stop at any time before the data analysis procedure. You can also ask that the information you provided not be used, and your choice will be respected. If you decide that you do not want us to use your information, you must tell the researcher before August 20th, 2021.

There are no negative consequences for not participating, stopping in the middle, or asking us not to use your information.

F. PARTICIPANT'S DECLARATION

I have read and understood this form. I have had the chance to ask questions which have been answered. I agree to participate in this research under the conditions described.

NAME (please print) _____

SIGNATURE _____

DATE _____

If you have questions about the scientific or scholarly aspects of this research, please contact the researcher. Their contact information is on page 1. You may also contact their faculty supervisor.

If you have concerns about ethical issues in this research, please contact the Manager, Research Ethics, Concordia University, 514.848.2424 ex. 7481 or oor.ethics@concordia.ca.

APPENDIX B

Electronic Invitation Letter for Participants

Dear _____

I am happy to be connected to you through _____

Thank you for your interest in understanding my research project further. I will take this opportunity to share with you briefly about me, the research project, expectations from participants and consent information in this email.

I am currently pursuing my master's in music therapy at Concordia University, Montreal, Canada, and working on my research thesis in partial fulfillment for the degree requirements. I moved to Canada from India in September 2017 to pursue formal music therapy education. I found my personal vocal training in north Indian classical music to be very enriching and became my space of safety and emotional release. It introduced me to an incessant source of abundant joy and fulfillment which inspired my belief the power of music as therapy.

My research is focused on understanding the perspectives of Indian Music Therapists on the State of Music Therapy as a Profession in India. My personal relationship with this research topic began when I sought out informal conversations with two music therapists in India to understand the music therapy practice there. The conversations revealed to me the ongoing and current challenging realities of the music therapy profession in India. This motivated me to design a research proposal where I would conduct in-depth interviews with three music therapists based in India, to further understand their experiences and perceptions on music therapy professional landscape of India.

It is my hope that this study will result in insights on how to facilitate a much-needed shift in current perspectives on the music therapy profession in India, make it a licensed profession in the country and implement advocacy practices so that all citizens, regardless of class, caste, and gender, will have access to this service.

Please find attached the document that details out other information of my research project and the sample consent form that will need signatures from the participants.

Please feel free to get back to me with any additional questions you may have. I will be shortlisting participants on a first cum first basis and would appreciate to have your response within one week to finalize my three interview candidates.

Thank you,
Aprajita Saxena, MTA, MT-BC

APPENDIX C

Interview Guide

I. Can you share a bit about your journey thus far in music and music therapy?

II. What has your experience been practicing music therapy in Mumbai?

III. What are some of the challenges that you face in practicing in your profession?

IV. What are some of the benefits that you have experienced practicing in /Mumbai?

V. How do you envision your role and the profession to evolve in the future?

VI. What do you think are some of the developments in the profession?

VII. What do you think needs to change or improve in the music therapy profession in India?

VIII. What role does gender, caste, or class play in your professional experience (both client/patient and music therapist)?

IX. Anything else you would like to share?