Full-Length Article

The Role of Culture in Music and Medicine: *Considerations to Enhance Health*

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Abstract

The expression and understanding of culture is relative to time and social context as individuals and groups within cultures struggle to negotiate the substance and implication of specific cultures [1]. Music and medicine are culturally derived as is the intersection between music and medicine, which at times can be integrated disciplines while at other times they may fester as disconnected treatment modalities. Analyzing the role of culture in music and medicine can reveal unique possibilities that may serve to enhance health.

Keywords: ***cultural competence, anti-oppresive practice, social justice feminist, critical analysis, research, ethical, music therapy, health initiatives.***

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Introduction

Power is ubiquitous; it exists in all practice settings. Even with the best of intentions we can cause harm [2]. Historically, health research approaches and practices have developed in a culture of privilege, in particular that which has been described as *white male privilege* [3]. Privilege represents the power and increased status disproportionally afforded to specific groups within culture [4,5]. *White male privilege* has influenced everything from research protocols, informed consent and data collection procedures, discussion of results and subsequent conclusions and real-world application of outcomes [6].

Cultural considerations in medicine

The medical model is the primary philosophy at work in therapeutic and healthcare services. Notwithstanding a respected and appreciated history of ethical medical developments, sources from previous decades recount a significant history of abuse and discrimination in medical research: from unethical research protocols with unethical employment of results to the generation and application of psychological theories developed with gender, race, socioeconomic, and other unremarked bias [7,8,9,10,11,12,13,14,15]. Exploitation of privilege via a process of medicalization in individualized experiences, concentrating on symptoms and sufferings and not the social structures that produced and compounded inequitable distribution of health support and services within culture.

Access to medical interventions is often determined by privilege. “Drugs and other pharmaceuticals constitute up to 40% of the healthcare budget in developing countries, yet a large proportion of the population frequently lack access to the most basic medicines. This can be attributed to poverty levels in the communities” [16]. The financing of health care coverage, type of and accessibility to health insurance as well as lack of coverage, where one receives health care including how one enters a health care institution through ER or controlled appointment process all influence the type and scope of care provided: how health care providers see their patients. Whether stereotyping prototyping or profiling, their are consequences for treatment choices and medical decisions [17]. The historical medicalization of people with disabilities provides a representational example.

The traditional medical view of disability professed that disability was caused by individualized impairments in contrast with post-modern ontologies that view disability as a result of collective social and environmental influences located outside the body, i.e. a social model [18]. Social models of disability purport that uncompromising environments and rigid social structures designate a person able or disabled. In the past, non-disabled people who had no first-hand knowledge of disability conducted disability research, research that subsequently privileged a positivistic approach that perpetuated the individualistic medical model. Although this body of knowledge claimed to be objective and value neutral,

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the true needs and values of the participants were often overlooked. This privileged perceptual lens of disability by most researchers influenced all subsequent understanding. Disabilities studies developed from activism in the 1980's by people labeled *disabled* who took on the historical activist phrase, *Nothing about us without us* [19]. This approach focused on inclusive critical methodologies that involved detailed descriptions of the participation of people with disabilities, their roles, contribution, the challenges encountered or the support provided [20].

The professional culture of medicine continues to employ a shared system of beliefs regarding health in a culture of *white male privilege* impacting every aspect of service delivery. Inclusive research processes that incorporate critical methodologies is indicated across healthcare practices. Treatments for universal conditions such as depression or pre-natal care need to account for cross-cultural variation of the experience. Identification and treatment protocols are not culturally neutral. Cultural validity can only be achieved through studies collaborating with minority population groups, which according to Murphy et al, have yet to be completed [21].

Cultural considerations of music

Music is a culturally derived phenomenon; it is a way of organizing vibrations, it is coded sound. While vibrations may be universally felt, understanding music implies knowing the codes or manner of representation prevalent in the culture, which also means knowing the culture [22]. Musical conduct is inter-human, interpersonal, or social [23].

Since the beginning of recorded history music has been a part of human experience. Music is shaped by culture and in turn influences culture [24] and is a powerful social and political practice [25] that cannot be divorced from social context [26]. Music offers a way for societies to become evident to their members [27] shaping, strengthening and channelling social, political, economic, linguistic, religious, and other kinds of behaviour [28]. From the most basic and physical to the most elusive and abstract, from the simplest musical element to extended musical works, the experience of music is dependent upon the perceiver's attention and personal cultural context. Music's role is contextualized by its sociocultural and political context. For example, in religion, music functions to reinforce identity, increase collectivity, express theology, and focus and stimulate religious experience [29,30]. The same can be said of soccer anthems of amateur clubs in Rio de Janeiro [31]. Research indicates that music is central to the development and transference of cultural identity for the people of central Appalachia [32], performance of race in the United States [33], complex social practice of popular song of Kinois music both in the Congo and in the diaspora [34], and protest songs of the American civil right movement [35] offer additional examples of cultural transmission through music. Popular song has provided an important vehicle for cultural resistance in Iraq because of accessibility: the impossibility of banning song listening [36]. Music can promote cultural exchange; listening to each other's music helps in discovering commonalities [37]. Music's intrinsic cultural and political value can be used as a means of emancipation from but also as a tool for domination [38]. Inasmuch as the cultural context of music has also progressed within a framework of *white male privilege* music can transmit oppressive information, gender cultural information offering opportunity for review.

The gender gap between men and women's legitimization in popular music was identified [39,40], echoed in the field of orchestra music [41], jazz [42], the fiddle contest circuit in Canada [43], country music [44], traditional Irish Pub music [45], and hip-hop; femininities and masculinities are subject to socioeconomic concerns of white supremacist, patriarchal, multinational, corporate capitalism [46]. Negative representations of women in male-produced urban grooves in Zimbabwe are considered a result of Western popular music standards and contributing to the erosion of women's equality [47,48]. Research in Malawi and Swazi exploring men's appropriation of female music concluded that initiatives to exploit female music for female empowerment are needed [49,50,51]. Music practices are culturally derived. Throughout history music has been employed in health contexts and like medicine and medical practice, therapeutic practices in music and are shaped by sociocultural and political experience [52].

The culture of music in medicine

The goal of contemporary critical inquiry is to address ever-present power inequities. Forces of oppression systematically block, restrain and contain the actions and abilities of members of marginalized groups [53]. Practices that suppress difference and dissent can be addressed by constantly defending and developing ways to amplify the voice of the voiceless bringing the needs of marginalized clients and their communities to the attention of decision makers [54].

Medicine is reported to be in the process of an international cultural revolution. Health, as a culture is being studied [55] along with tools to guide culture-change strategies among different healthcare worker groups [56]. The culture of medical education is being explored as a framework for teaching cultural competence [16]. The National Initiative on Gender, Culture and Leadership in Medicine, C - Change (for culture change) works to refine the culture of academic medicine through research and action, promoting an inclusive, humanistic, relational, and energizing workplace culture for medical school faculty and trainees and increasing diversity of leadership in academic medicine [57]. Aboriginal knowledge and practice in health care is growing [58]. Research concludes that cultural factors not be considered separate from other determinants, but rather, as an ubiquitous

influence on all stages of the disease process, from the first symptoms to the medical decisions, duration of illness, and treatment adherence by the patient [59].

Music and music therapy research is experiencing a similar cultural shift as critical methodologies are applied. As Aigen [60] described, music's central role in human experience politicizes the role of the music therapist. Because music therapy practice is embedded in the culture in which the music therapist practices [61,62], service users' personal histories with music must inform music therapy research and practice. Music can hold a fundamental role in people's lives, a close personal relationships and an essential resource. Preferred music has the potential to prompt or remind people of happier times, safety, and may work to instil a sense of identity. Inclusive collaborative music therapy practice requires a philosophy of deep respect to accommodate differences through working to understand and empathize with the service users' experiences particularly as they have the capacity to result in increased cultural competence. Within increasingly multi-cultural settings, music therapists must prepare themselves to support the music and cultural practices of service users. Concurrently, they must reflect on their personal sense of culture and culture of music therapy. Respectful practice develops organically through courteous competence informed by cultural sensitivity and awareness [63].

It is increasingly clear that the therapist is not the benign *helper*, but rather an active being who is undertaking a social and political work. First, this occurs because the helper believes that by belonging to a particular professional occupation and orientation, they are capable of prompting and supporting change in others. Second, by believing that such interventions are necessary, required, and helpful the helper is obliged to take particular actions. We are not separate from these interactions and experiences in music therapy, but rather are actively engaged in their construction, interpretation, and consequently their meaning [64].

Conclusions

Research is a social action and involves interactions and relationships, which entail ethical, procedural and political issues [65]. The minority status of the music therapy profession within healthcare may offer a unique reflection and one that calls upon more dominant practices to consider power differentials and imbalances. It can be contended that ignoring certain treatments such as music therapy in favor of conservative traditions of therapy that are allied with the medical model is oppression of the socially radical and creative. Correspondingly within the field of music therapy, approaches more closely allied with the medical model may be favored as a result of this bias [66]. Integrating critical cultural analyses within research and treatment processes for health can work to address oppression and inequities. Research indicates that rather than healthcare workers relying on their socioculturally derived personally referential responses, respect for service users' experiences and aspects that integrate service user preferences can serve to increase healthy responses and in turn a culture of healthier communities. Practitioners in all facets of healthcare practice including research practices can benefit from self-reflective analysis extrapolating beyond traditional ethical terms toward profoundly and reliably participating in critical examination and analysis of the impact of their worldviews and political perspectives on their work [63].

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Biographical Statement

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