

Choral Singing as Health Musicking

A Discussion on Music, Education and Health

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ABSTRACT

In this article, the relationship between music, education and health related to choral singing is discussed. The discussion actualizes both the borders between and the common ground shared by different music professionals such as music therapists, community musicians, music educators, and musicians. How can the fields of Music, Health and Education be combined in a relevant manner in relation to content, as well as theoretically, practically and methodologically? The discussion is exemplified by three studies of different choir practices; a local community choir, a multicultural gospel choir, and various chamber choirs. The studies were based on qualitative methods such as observation and in-depth interviews. The author's own experiences as a trained choral conductor are also used actively as a basis for further reflection. The material in question is illuminated by the notion of health musicking, and the discussion leads to reflections on the implications that health-related issues have for music education practices in general and, more specifically, in the training of choral conductors. The article demonstrates how music education research may interact with and contribute to music education practice.

Keywords: Choral singing, Health Musicking, Music Education.

Introduction

In this article I will discuss the relationship between music, education and health as they relate to choral singing. This actualizes both the borders between and the common ground shared between different music professionals such as music therapists, community musicians, music educators, and musicians. The discussion is exemplified by three studies of different choir practices, whilst the author's own experiences as a trained choral conductor are brought into the discussion. The material is illuminated by the notion of *health musicking* (Stige 2012) and the discussion leads to reflections on what implications health-related issues have for music education practices in general and, more specifically, the training of choral conductors. In many cases, there is little correlation between the training and the reality which newly qualified choral conductors encounter (Balsnes 2009). This article demonstrates how music education research may interact with and contribute to music education practice. Thus, the objective "is not to 'produce' teaching methods, but to deliver research results to the praxis field," as Folkestad suggests (2006:136).

Why then discuss choral singing from a health perspective? Perspectives related to health and quality of life in connection with culture in general, and not least in relation to music, are highly relevant in our society. From a political point of view, we can see a shift towards considering the meaning of cultural life as it relates to health issues. Another trend can be seen in the health sector, where the focus has changed from concentration on one-sided, curative activities to preventive and health promoting ones. For many people, poor health or poor quality of life is connected to non-material health issues such as a lack of fellowship, faith, meaning and hope (Fugelli 1998). These factors are a natural part of cultural life, rather than medical contexts. Other examples include the World Health Organisation (WHO), which for decades has acknowledged that the determinants of health to a great extent lie outside the health sector (Stige 2006), and the Ottawa-charter¹ which states that "health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyle to well-being" (p.1).

Within the Choral Movement there exists a great interest in health issues. This is something 'choir people' recognize and identify with. In a previous study, I examined an amateur choral practice from a music educational perspective (Balsnes 2009). I found that the singers were much more interested in discussing the health-promoting effects of singing than the learning processes of the choir, which I had intended to explore. The singers told stories about the joy of singing, "peak experiences," the importance of regular activities and social networking – elements that might indeed relate more to health than to music educational issues. A choir is a music educational context: somebody (a conductor) teaches someone (the singers) something (a choral

song) (Nielsen 1997). But even if the choir is an arena of learning, choral singing can simultaneously provide secondary benefits related to health and well-being – hence my own study. Recent research shows that various forms of choral practice contribute to singers' health and quality of life (Balsnes 2010; Clift et al. 2008; Gregorsson 2007; Lindström 2006; Theorell 2009)

Such psychological benefits allow the music education field of practice in many instances to overlap with music therapy and the music and health-field (see figure, MacDonald et al. 2012:8). In many amateur musical activities, the aim is not necessarily to learn *about* music, but to “be together with music” (Folkestad 2006:136). We must, therefore, investigate “how various musical phenomena are perceived, experienced and expressed in musical activities” (ibid.:136). The choristers' experiences from their participation in choirs are important areas for analysis – also for music educational research. When such experiences include perceptions of choral singing as something which promotes health, music education practices (especially choral pedagogy) and choral leaders must address the music and health field. Focussing on the potential health-promoting effects of music educational practice is, at this time, at a very early stage, even though a consciousness of the “non-musical outcomes” of music educational activities has a long history – for example Plato and his theory of forming and upbringing.² In the on-going postdoctoral project *Choral Singing for a Better Life*, I am in the process of studying the connections between choral singing and health more closely.

What are the consequences of integrating a health perspective for music education practice in general and, in this regard, for choral pedagogy in particular? How can the fields of music, health and education be combined in a relevant manner in relation to content, as well as theoretically, practically, and methodologically? In the following section I explore borders and overlapping areas between different music professions and disciplines related to a health perspective.

The Enhancement of Human Lives Through Music

The combination of music and health leads to new areas of practice, new roles and new identities for the different music professions and, not least, inspires new theoretical discussions. This development challenges the boundaries between the disciplines. This is not new – the different disciplines are not essential categories with an intrinsic identity (Dahlgren 1989). “The contents and activities [of a subject] might be negotiated and eventually change due to the introduction of new disciplines and fields

of knowledge” (2009:27), state Dyndahl and Ellingsen.³ Consequently the borders between the disciplines are constantly displaced and blurred. But what of the current situation? What borders exist between the different music professionals and their disciplines today? Is there any shared ground?

Different music professionals have traditionally operated far apart from one another. Music therapy has focused on meetings between client and therapist behind closed doors inside health institutions (Stige et al. 2010). Music educational professionals and research have traditionally concentrated on the intentional musical education which takes places under the auspices of formal institutions, focussing on children and adolescents (Olsson 2005). Musicology has, in turn, been defined by an elitist and ethnocentric mindset and an essentialistic view of music (Stige et al. 2010).

In recent years, this has changed, both within the separate professional areas and in the relationship between them. Music therapists have become more concerned with non-clinical contexts (cf. the Community Music Therapy movement – see Ansdell and Pavlicevic 2004), and have approached non-clinical theory such as, for example, situated learning theory, which was brought in from the educational field (Stige et al. 2010).

Within music education research there is an increasing realisation that a narrow focus on the classroom alone is not sufficient to do justice to the diversity of the music educational contexts that are appearing (Ruud 2010b). For the last two decades, studies in music education that focus on musical learning in other than institutional contexts have been published (e.g. Balsnes 2009; Heiling 2000; Saether 2003; Söderman 2007). One recent example is the newly published *Oxford Handbook of Music Education* which offers two volumes (McPherson and Welch 2013). The first focusses on children during school-ages, but the second volume explores music learning outside of the classroom environment. One aspect of this is the profound demographic shift which is occurring around the globe. Longer life expectancy and decreased birth rates lead to an increase in the overall age of the human population. These changing demographics are influencing the landscape of education philosophy, policy and practice (Dabback and Smith 2013:229). As people live longer they seek engagement in meaningful activities. This development motivates music education to focus more on lifelong learning and adult music learning, which in turn allows for wider perspectives.

Musicology in general has also changed in focussing to a greater extent on music as a social and situated activity. It is more interdisciplinary through greater interest in music, culture and society, not least through specific movements such as “New Musicology” (Cook and Everist 1999; Scott 2000), “the cultural turn” within ethnomusicology (Merriam 1964), music sociology (DeNora 2000) and popular music studies (Middleton 2003). This suggests a movement in the direction of “a musicology

with people in it, a ‘populated musicology’” (Stige et al. 2010:7) – something which promotes dialogue with other professional environments. Music educators have made important contributions to this debate, such as David Elliot and his term ‘musicing’ (1995) and Christopher Small’s variant ‘musicking’ (1998). Both focus on music as an activity connected to a contextual and relational understanding of human existence, and their theories are used extensively within music therapy and the music and health field, together with theories about situated learning (such as Lave and Wenger 1991). However, moving in the other direction (from music therapy to other musical disciplines) has, in terms of the transfer of applicable theories, been less pronounced.

If one considers music as a situated activity, rather than as an object, it becomes relevant to study where and how people use it. In this way, the different music professionals and disciplines can meet. As music therapist Kenneth S. Aigen states: “It is the enhancement of human lives through music that binds together all music professions: teacher, therapist, community musician, and performer” (2012:152). According to Stige, diversity in practices, contexts and research paradigms amongst the different disciplines should not be a cause of too much concern; rather they should be thought of as resources representing supplementary perspectives (2012:183).

Here, it is the use of choral singing as a health promoting resource which is in immediate focus. Music therapy does not have a monopoly on working within music and health. Many different musical activities can promote health in various ways and there are common territories and possibilities for sharing across practices and disciplines (Stige 2012). In this context, the growing music and health field builds a bridge between the different music disciplines. Within the music and health field, one is able to look with more of an overview perspective at *all* areas where music is of significance for the development, maintenance and inclusion of health factors in people’s lives, such as the lay-therapeutic musicking of everyday life and community musicking, and not just therapy situations (Bonde and Trondalen 2012). Health, in this context, is concerned with a good emotional life, positive skills of mastery, healthy social contacts and relationships to others, as well as generally experiencing meaning and life context in one’s existence (Ruud 2010a). Consequently an interpretative understanding of health is emphasized (ibid.). With this understanding we can equate health with alternative terms which are not, to such an extent, associated with medical contexts, such as *quality of life*, *well-being* or simply *a better life*.

There are already existing backdrops within music education where music is discussed in light of such perspectives. One example is Small’s *musicking* term (1998), which includes both the relational aspect and the experience of meaning, and has clear existential overtones. Another example is Varkøy, who works within the field of music education philosophy. He underlines the fact that music appears to fulfill the

life-quality criteria on most levels (2003:122) and mentions different sets of criteria. One set might be activity, cohesion, self-esteem and a basic mood of happiness. Another set of criteria might be life quality as a result of the satisfaction of the following needs: warm fellowship, meaningful occupation, as well as varied, exciting and engaging life activities and experiences (ibid.: 122). As we see, these overlap to a great extent with Ruud's model (2010a, mentioned above), which is central within the music and health field. Varkøy believes that music educational reflections are essential in connection with the nuances which can exist between and in terms such as "happiness", "joy", "quality of life", "a good life" and the "meaning of life" and "meaning in life" (2003:123).⁴

A third example is the increasing focus on lifelong learning within music education, as previously mentioned. In the *Oxford Handbook of Music Education*, health is not thematized in relation to music education and children in the first volume. However, in Volume 2, well-being is emphasised as both a motivation and outcome of music practices for adults (Drummond 2013).

Furthermore I will refer to the emerging *Community Music* field. According to Veblen and Waldron, community music is an umbrella term for a variety of music practices, but also an emerging field in music education grounded in research (2013:203). Many of the themes which characterise the community music field also touch on the music and health field. Community music emphasises lifelong learning, open access, multiple teacher/learner relationships, an awareness of including marginalized groups and, not least, the importance of the participants' social and personal growth alongside musical growth (Veblen and Olsson 2002). The term is often used to characterize informal music teaching-learning processes and amateur music-making carried out in non-institutional situations. However, it may also take the form of partnerships between informal and formal contexts (Veblen and Waldron 2013:203). Thus Veblen states that community music activities complement, interface with and extend formal music educational structures (2008). In this context, it is community music's focus upon personal and social well-being which is most interesting.

It is also important to point to the fact that many of the issues which are prominent in the music and health field are already on the educational agenda when it comes to curricula and education acts.⁵ The first paragraph in the *Norwegian Education Act* states that all pupils in primary and secondary schools are entitled to a good physical and psychosocial environment that promotes *health, well-being and learning* [my italics].⁶ Recent educational research also points towards relational aspects and the psychosocial environment as the most important factors for learning (e.g. Hattie 2009; Nordenbo et al. 2008; Plauborg et al. 2010).

Finally, there is already research in the Music Education field which explores the health effects of music learning projects. One example is Ruud's study of the health

consequences of participating in a community music project in a Palestinian refugee camp (2010b). The results show that the participation influenced the children's sense of hope, their feeling of recognition, mastery and self-esteem. Ruud identifies these as health generative mechanisms.

Before moving on to the choral singing examples, I want to sum up the discussion of borders and common ground between music, education and health arguing that the music education field of practice requires extended grounds for reflection in order to meet new challenges and possibilities. There is a need for research and for new theoretical perspectives. Among other considerations, music therapy and the music and health fields bring in perspectives which might develop the music education field of practice further. The concept of *health musicking* is one example of a model which is developed within music therapy, but is relevant beyond the field (Stige 2012). In the discussion from this point forward, I wish to use this term as a point of departure.

Health Musicking

According to Stige, the concept of health musicking can be used as a possible framework for a broader interdisciplinary area of music and health. Central to this is the thought that health effects are not a given, but develop in the actual situation: "What music can afford in relation to health [...] grows out of the relationships established in each case" (2012:184). Health musicking focuses on mobilising musical and paramusical⁷ resources in the service of health. There is also a focus on everyday life, rather than clinical settings, since it is in everyday settings where the majority of health factors exist. If choral singing provides health effects, these are potentially highly accessible considering the many choirs in existence. In Norway, for instance, more than 5% of the population sing in choirs – it is the most widespread musical activity – possibly also in the other Nordic countries.⁸ Stige suggests the following definition of the term: "Health musicking could be defined as the appraisal and appropriation of the health affordances of the arena, agenda, agents, activities, and artefacts of a music practice" (ibid.:186) – in this case choral singing.

Before I present the empirical material, I will account for Stige's analytical categories (2012:186-188):

1. *Arena* refers to musicking as a situated activity. There are several possible analysis levels; person, dyad, group, body, organisation and locality.
2. *Agenda* addresses issues, goals and themes, both conscious and unconscious. Agendas include intrapersonal elements, but are negotiated interpersonally.

Examples include management, treatment, entitlement etc. Negotiations of values belong to this point.

3. *Agents*, denotes the participants in the activity.
4. *Activities* concerns, in this setting, practical engagement with music, which can include elements such as, for example, movement, sound, visual effects in rituals and so forth.
5. *Artefacts* are, in this context, instruments, songs, lyrics and other means which are used in the musical activity.

These different categories are closely related to one another and affect each other intrinsically. The arena in which the musical activity takes place affects both agenda and activity, and vice versa. All of the elements represent both possibilities and limitations. Furthermore, the paramusical features of the situations are as important to investigate as the musical parameters themselves (Stige 2012:186). This aspect is included in the analysis of the three cases.

Choral Singing as Health Musicking

Based on examples from three studies, which investigate the health affordances of different choir practices, I will present an analysis of how choral singing can, in various ways, promote health. With such a small sample, it is of course not possible to draw general conclusions statistically. *Analytical* generality is possible, however, as certain general traits in the case studies can apply in other instances (Yin 1989). The studies were based on qualitative methods, mainly observation and in-depth interviews. The observations were logged and the interviews recorded and subsequently transcribed. The material from all three studies was analysed using thematic coding (Kvale 1997). Ethical guidelines for research have been followed in the implementation of the surveys.

Local community choir

In the first study, a local amateur choir was examined – in other words a quite typical choir practice like those one can find in almost every small hamlet in Norway.⁹ The study was carried out as a case study combining participant observation (2003–2006), interviews with 17 choir members (selected to achieve a variety in terms of age, gender, place of residence and career in the choir) and document analysis (of

meeting protocols, annual reports and newspaper reviews) (See Balsnes 2009 for complementary information on methods). The arena of the choir is the local cultural life of a Norwegian county with 10 000 inhabitants. The choir serves both as a church and local community choir. The following aim forms the basis of the choir's activity: "a choir for everyone who likes song and music".¹⁰ The basis of the agenda was consequently to be together, to have fun and to sing. Simultaneously, the desire was to create a good standard of choral singing. There were often negotiations regarding the relative balance between the musical and the social aspects of the choir practice. The agents were local amateur singers who enjoyed singing. Amongst the choir's activities were weekly practices, regular performances during church services, participation at local events such as celebrations and anniversaries, concerts and performances, annual parties, trips, and Christmas and summer celebrations. The artifacts which were needed to facilitate the musical activities were few and simple: a room with chairs, a piano, and sheet music. Some songs were also learnt by ear. In interviews, the health-carrying effect of the choral singing was consistently mentioned, as exemplified here by one of the singer's (Diana's) observations:

It brings and provides health. The oxygen streams around the whole body. I get lifted. I am quite sure that though everyone is tired when they set off to come to choir practice, when they leave afterwards they almost fly home.¹¹

Diana also explains that she has found a new life after she began in the choir and even characterises herself as "a new human being". The analysis shows that choir practice promotes health by being a tool for developing competency and empowerment, a resource in building social networks, a producer of vitality and a way of providing meaning and coherence in life (Ruud 2010a; Balsnes 2012).

Closer analysis showed that the key to the experience of the choir practice as health promoting, is the repertoire selected – in other words at artefact level. If the repertoire over time was too difficult, the singers lost their sense of mastery and consequently the joy of singing. In one case where an ambitious choirmaster chose a repertoire which was too difficult, several people left the choir. It was also important that social aspects were given their place; the breaks had to be sufficiently long and there had to be sufficient social arrangements separate from the choir practices. The environment had to be inclusive and not given to cliquishness. A choirmaster who prioritised the music alone in such a choir would fail in reaching the intended goal. Both musical and paramusical resources must be facilitated. The health affordances exist as a potential possibility, but sensitivity is needed when assessing how the activities are put together and which artefacts are utilised – such that potential is realised.

Multicultural gospel choir

The second study concerns a "multicultural¹² gospel choir" which has been formed through an organisation working for "more multicultural fellowship, equality, care and friendship between all people in Norway, regardless of their cultural background, language or religion".¹³ In addition to a choir, homework help, collective dinners, a culture cafe, courses and seminars, football training, women's groups, parties, free Norwegian lessons, trips and camps are offered. The choir is, consequently, just one of the activities that the organisation is involved with. The study focussed on members with a refugee background – a group which is often vulnerable both in terms of psychological and physical health (Dalgard et al. 2006). Participant observation of rehearsals and performances was conducted in the Spring Semester of 2012. In the same period, in-depth interviews were carried out with two of the leaders and five singers from different countries, of whom four came to Norway as refugees (see Balsnes and Schuff 2013 for more details of methods).

The choir comprises of "a blessed mixture of foreign students, au-pairs, asylum seekers, foreign workers and ethnic Norwegians who feel that it is a good place to be", to quote one of the leaders.¹⁴ The main agenda for the choir practice is integration. The same leader sums up the aim in the following way: "Gathering somewhere where everybody has something to do, where all are on an equal footing and where one can meet in a warm fellowship – which is what singing is." There is a large turnover of members – something which has a natural explanation: students and au-pairs are often only in Norway for a year or a few months, and asylum seekers are moved back and forth between different reception centres. The following statement characterises the agents from a musical perspective: "The choir is for people who can sing and for people who can't" – in other words the practice has completely "open access" and this is taken into account in the musical work. The leaders are very concerned to create a warm and inclusive "indigenous culture". Everybody is met with a handshake or a hug – "Welcome! So nice to see you! Hope to see you next week." The members often need extra follow up, for example in the form of text messages or transport. The breaks are important for the social aspect. There are often other arrangements besides the rehearsals, such as suppers or football matches.

In terms of artefacts, a piano is needed, but sheet music is never used. Instead, the leader operates a laptop with a projector when he works with the choir. The lyrics are projected onto a wall and the melodies learnt by ear. Audio files are uploaded to the Internet so that the choristers can practice at home. The repertoire consists of three categories of songs: compositions based on immigrants' stories about their experiences,¹⁵ songs from the participants' home countries, and songs which are well-known

throughout the world, such as “Amazing Grace”. The arrangements consist of three parts (soprano, alto and tenor). Each of the groups needs a ‘support singer’ – usually a more experienced Norwegian singer. Many songs have simple choreography.

The analysis showed that the choir forms a positive contrast to many of the challenges that the participants met in their particular situation: fellowship instead of exclusion, an appreciation of the worth of identity and reflection, instead of a loss of identity, power rather than impotence, and meaningful activity as a contrast to days without structure, content, predictability or coherence. One example is Teresa from Chile, who states:

The choir has really eased my burden. Every time I’ve got problems, I can think, ‘no, now I am happy, because we are going to sing’ [...] When I’m sad, I think of the choir, the joy we have, and I tell myself: ‘This helps you to be strong and keep going.’ The choir and KIA is a big part of my life, they are my family. I don’t think I’d survive without it.¹⁶

With an interpretative health term, one can argue that the choir practice in this respect works to promote health. The key is, as it was with the local community choir, on artefact and activity level. One aspect is the emphasis on a warm and inclusive environment, and the social activities connected to the choir’s environment. Another aspect is how the practices are organised and which repertoire is sung. There is a steady and regular exchange of members – something which in turn affects the musical work. A ‘core repertoire’ has followed the choir. Some years ago, this musical practice led to the exit of some of the more experienced Norwegian singers. They became tired of the repetition and wanted greater musical challenges. The leaders were forced to make a choice about whether they would keep to the choir’s agenda – “Anyone can come at any time”. The activities and the artefacts had to be adapted to fit this picture. Here too, it appears that the health affordances of the practice exist as a possibility, but are far from being automatic. Handing out sheet music or introducing four-part singing could easily result in the singers losing their experience of their participation as empowering, and the choir might quickly fall apart. A choirmaster capable of “holding out” the same repertoire year after year is necessary in this context.

Chamber choirs

The third example is from an interview study of choral singers with chronic illnesses. Four singers with different diagnoses (schizophrenia, posttraumatic stress syndrome, rheumatism, and leukaemia) were interviewed during 2012. In reference to

the sample, I knew two of the interviewees from former choir involvement. One was contacted after reading a newspaper article and one was interviewed in connection with another research project, during which I heard a story that encouraged me to ask questions spontaneously in relation to this current project. The interviews lasted between one and two hours, and were conducted in the interviewees' homes so that the surroundings would be as familiar as possible (for more information on methodology, see Balsnes 2014).

Common to these singers is the fact that they have sung in choirs since they were small and all now sing in different choirs at a high standard. All of these choirs have their own concerts but often collaborate with professional musicians including, for example, symphony orchestras. The arena of the choirs is somewhere in the divide between the amateur, semi-professional and professional music life which exists in larger Norwegian towns. The agenda for all of these choirs is to facilitate choral singing at a high level. At the same time, social aspects are valued. The agents are experienced singers and the conductors have higher musical education. The main activity is the rehearsal and performance of traditional choral music of a high standard. A piano, sheet music and a tuning fork are used.

The preliminary analysis shows that choral singing for the interviewees with compromised health is an important resource – individually as an arena for mastery, comfort and emotional work; socially as a 'connection point' and a care centre; and existentially as it is experienced as fundamentally necessary and essential to life. What adjustments are made in order that the different choir practices work to promote health? None! The interviewed singers were typical singers in the choirs in question. Some had informed the conductor about their diagnosis, others not. One of them told the other singers because, as a result of her health problems, she was forced to remain seated at times. However, the interviewees are required to exert themselves in order to take part in the practice. Several of them explain that they need to take extra pain relief medication and rest both before and after practices. One would not have concluded that choral singing was a health promoting activity for these individuals if restricted to a biomedical health term. However, Cristin, diagnosed with leukemia, states:

It has been essential for me to sing in the choir during all these years. If I hadn't had the singing, I don't know how my mental health would be. It has managed to keep me going mentally and it has given me something to look forward to, and something regular to attend. Otherwise I don't think I would have been doing so well mentally [...] I cannot do without the music.¹⁷

And Lisa, who suffers from posttraumatic stress syndrome, explains:

During that time [...] I was feeling horrible – I felt really bad. I couldn't keep it together and struggled to survive. The choir was the golden thread. A source that was indisputable. It wasn't a result of positive thinking, cognitive efforts or expectations. It was in itself a grounding tool, a ray of light, a nerve that helped keep me alive and kept me going.¹⁸

These statements show that choral singing functions as a health promoting and life-supporting activity with real survival value.

The interviewees' backgrounds as experienced choristers *before* they became sick allow these ambitious choirs to function in their cases to promote health. None of them would have thrived in more middle-of-the-road mixed choirs, although these would have been less demanding. They want to be challenged musically. For these individuals, choral singing functions as a self-prescribed remedy. It is the singers themselves who appropriate the health affordances of choral singing – it is not the conductor or others who facilitate the health effects. The choristers operate as lay-therapists on themselves, knowing that they need singing to refuel life. They set aside everything else (family obligations, time, and pain) in order to make it to the rehearsals. All of them are able to mobilise both the musical and paramusical resources which exist in the choir practice in the service of promoting their own health. Choral singing may not cure their illnesses, but it can transform their 'sick identity' and keep them going – thereby contributing to a better life.

Reflections and Implications

Choral singing has contributed to a better life for Diana in the local community choir, for the refugees and asylum seekers in the gospel choir and for the choristers with chronic illnesses in the high standard choirs. The health affordances of the arenas, agendas, agents, activities, and artefacts are in each case appraised and appropriated – although in different ways. It is the participants themselves who *use* the musical practice in the service of health, facilitated to a different degree by the leaders. In the light of these examples, I would argue that choral singing could be described as *health musicking*. Bonde suggests that 'health musicking can be understood as the common core of any use of music experiences to regulate emotional or relational states or to promote wellbeing, be it therapeutic or not, professionally assisted or

self-made' (2011:40). Thus, health musicking can take place in a classroom as well as at choir rehearsal.

All of the choirs in these studies are aimed at adults. Research does exist about senior choirs from a health perspective (Clift et al. 2008, Knardal 2007, Stige 2010), but there is little about children's and youth choirs and school choirs. In general, music, health and well-being has not been extensively researched in relation to children (cf. McPherson and Welch 2013, volume I). Thus, there is a need for more research in this area.

Although the positive effects of choral singing are foregrounded here, it is important to stress that music can of course also be used in a negative sense (cf. Alanne 2010). The health promoting effects only exist as a *potential* in choral singing practices. Music is not a remedy (DeNora 2013). There is nothing of a quick-fix, mechanical or recipe-like in the processes described in this study. One need not look far to find individuals with negative experiences from choral singing. The data from my study of an amateur choir practice (2009) included stories of individuals who had, for a number of reasons, gone on to leave the choir. For some of them, this was a question of external factors such as a change in priorities in relation to time or a new phase of life. Others had problems finding their place in the fellowship or disagreed with the manner in which the choir was led. However, the most prevalent reason was that the singers were uncomfortable with the choir's musical profile or the repertoire's degree of difficulty. Another example is Kreuz and Brünger's large-scale study of long-standing members of choral societies (2012). Among other questions, they asked about the negative associations of choral singing. One out of four singers indicated negative experiences. Content analysis showed that social problems as well as conflicting aesthetic goals dominated these experiences. The two most recurrent themes were identified as those related to the conductor (50%) and to fellow choristers (38%). Nevertheless, Kreuz and Brünger consider choral singing as a very safe activity, both mentally and physically.

I will discuss here further relations between health musicking, education and therapy. In an earlier text, Bonde (2002) explores the similarities and differences between music education and music therapy from the basic perspective that the two fields are not in opposition to one another, but form complimentary fields of learning with music at their centre. Bonde points out two main distinctions between education and therapy whilst simultaneously referring to the problematic aspects of such a simplification. Firstly, both education and therapy will cause changes in behaviour, but where education tends to emphasise musical behaviour, therapy is more concerned with non-musical behaviour. Secondly, the educator tends to emphasize the quality of the musical product (as a linear process, for instance by working towards a

performance), while the therapist emphasizes the quality of the musical process (as a circular movement). In other words, the therapist focuses on the needs of the client while the educator focuses on the development of musical skills. Nevertheless, this is a continuum with smooth transitions. Based on the preceding discussion and the empirical examples, I wish to suggest the following continuum as a model for different choir practices and attempt to place those practices studied in relation to it:

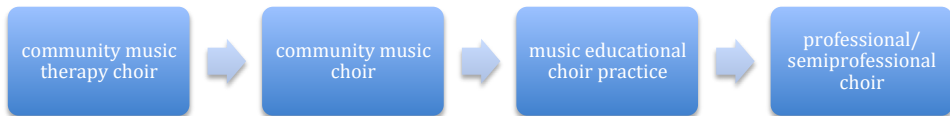


Figure 1: Continuum for various choir practices.

What decides a choir's positioning in this continuum is the degree of emphasis on product or process. The further to the right, the greater the emphasis which is placed on the musical product. Meanwhile, the further to the left one moves, the greater the focus on the needs of the individual.

As I will explore the studied choir practices' positions in the continuum, I will start by looking at the various agendas. The local community choir is neither a (community) therapeutic practice nor a choir where the focus is on musical performance alone. The agenda is, as we have seen, to be together, to sing and to have fun. The access is open to anybody. At the same time the choral leader was trained in music education and expected to develop the choir musically. The choir would find its place somewhere between the community music and the music education category. The gospel choir's agenda is the integration of a marginalized group and is thus a typical community music project. The focus is on teaching music orally, the arrangements are adapted, and the goals are mainly extra-musical. The leaders focus on singing with 'power', involvement, and joy, rather than singing beautifully, as the choir will never sound 'good' compared to traditional standards with singers from so many different backgrounds. The needs of the individuals are to some degree taken into consideration, as when transport is facilitated. However, although they work with refugees, of whom many are traumatized, the leaders are aware that they do not run a therapeutic practice – "the choir just *works* therapeutically," they say. They have found choral singing to be an effective tool for integration and for enhancing the lives of refugees and asylum seekers. The third example of singers in high-standard chamber choirs must be placed in the professional/semi-professional choir category. The performance of high quality choral music is the main objective.

However, as we have seen, although health is not on the agenda in any of the choirs, singing as health musicking seems to be a possible overarching category:

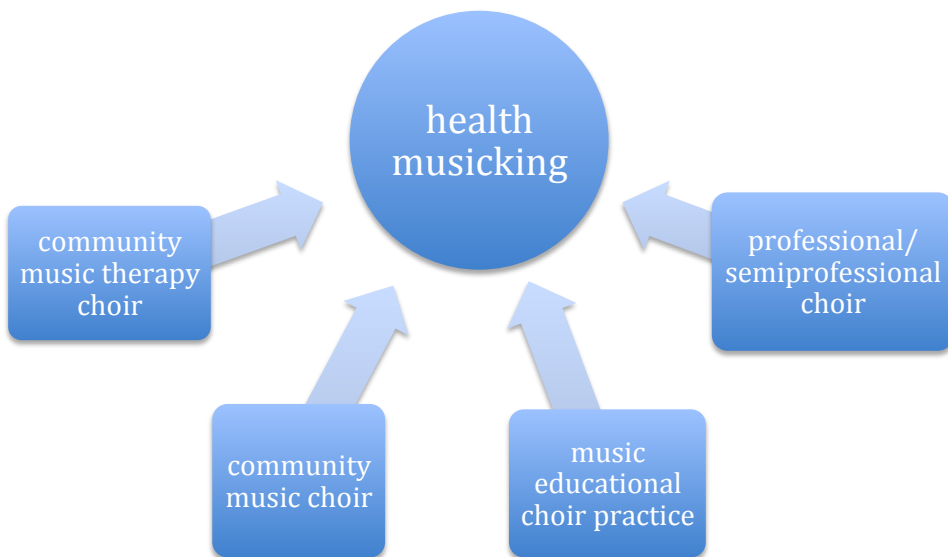


Figure 2: Choral singing as health musicking.

This means that any choir practice can promote health. One implication of this is that we need various choir practices at all levels; high standard choirs, middle-of-the-road community choirs and choirs facilitated for special groups. Choral leaders must be trained to work with choirs at all levels and also have the knowledge, skill and endurance to work with specially adapted choir practices, such as the multicultural gospel choir. Ruud mentions the following competencies for the new health musicians he wishes to see: traditional musical competencies in teaching, performing and arranging music; sensitivity to musical forms of communication; ability to engage participants' interest and create a sense of communal belonging; sensitive and flexible leadership; the ability to adjust to participants' individual skills, pace and comfort levels; the skill to arrange and improvise; additional knowledge about group dynamics, communication skills and participants' backgrounds; communication and social skills to network and collaborate with other agents in the community (2012:94–95). In the gospel choir and also in the community choir, these competencies would have been necessary.

For a further exploration of a 'new' choral pedagogy I will also draw on my own experiences. Being a trained choral conductor, I experienced during my education

that the musical product-side of the training was emphasized. Only the traditional musical competencies Ruud mentions were on the curriculum. As a result, we were trained to lead high-standard choirs. However, very few high-standard choirs exist in Norway compared to the many community-based choirs where the social aims are as important as the musical ones. Consequently, even with the highest possible training in choral conducting, I failed when I first started to conduct a community choir after finishing my education (Balsnes 2009). Among other challenges my choice of repertoire was not wise and I neglected the breaks. Because of this, the choir almost fell apart. I did not realise that the singers had other motivations than purely musical ambitions for being in the choir. For them, the process in itself was more important than the product (although making good music was also desired). Being with music was more important than learning music (Folkestad 2006). I thought they could simply find another choir if they found my repertoire too ambitious. I did not realise that going to rehearsal every week in this particular choir and meeting with their fellow choristers was a matter of existential meaning and essential for a good life for these choir members. Dyndahl and Ellefsen claim that “a music didactics which omits informed knowledge about pupils’ and students’ negotiations of themselves as identities and subjectivities, seems fairly insufficient to deal with today’s educational challenges” (2009:15). Transferred to choral didactics, one could say that the life-world of the choristers must be taken into consideration. This was something I was not taught during the course of my education. Furthermore, in this choir, I would have benefitted from all the other competencies Ruud mentions (2012). Even some knowledge of health issues might have usefully been included in the curriculum for the training of choral conductors in order to prepare me to lead such a choir. Leadership is crucial (Kreuz and Brünger 2012) and as a result, relevant training is a key to develop choir practices which facilitate positive experiences.

Before concluding, I wish to reflect on the following question: is there something about choral singing that is unusually beneficial in relation to health when compared to other cultural activities? We need more research to document this. However, based on my own studies and other research, I would like to point to some characteristics of choral singing.

Bailey (2004) describes the voice as an ontological mechanism for music-making. The voice is the only instrument which is a part of our bodies, and is as such closely connected to body, breath, emotions and self-identity. The singing voice is furthermore a ‘democratic’ instrument, which all human beings are in possession of. Choral singing is a holistic form of participation, which includes bodily, emotional and cognitive aspects in addition to social ones. Thus, the experience of singing affects all human dimensions simultaneously.

Furthermore, the relationships that occur in a musical community are in many ways special. Music seems to be able to unite people in such a way that status and divisions cease to exist or become irrelevant. In addition, everybody is required to submit to one another. Singing together seems simultaneously to create a form of closeness which, nonetheless, does not involve personal intimacy. Thus, a choir can provide a good solution to the relationship between the individual and the group. In the choir one retains the feeling of being an individual contributing to the community, while at the same time experiencing a 'we-feeling' – a feeling of belonging to a larger community (Ruud 2001).

Choral singing is a democratic activity where everybody can take part and all are equally important. Polyphonic song can produce a powerful feeling of being in harmony with other people, vocally, physically and socially (Faulkner and Davidson 2006). It demands a highly developed level of reciprocity, cooperation and coordination. The cooperation which choral singing demands aims to maximize the collective's efforts to best possible effect.

Part-singing seems to fulfil a psychological need to collaborate with others on an intimate and meaningful level. The ideal harmonic fellowship in a choir is at its strongest when the choir "feels like one voice". At the concert, when all the toil is left behind, when tensions and conflicts are irrelevant, when balance is achieved, when everything works, when the audience loves it – at that point the fellowship of the choir is at its best. Choral singing can, in this respect, be regarded as a metaphor for the ideal human relationship. It can, in its best moments, offer deeply meaningful experiences. Thus, choral singing seems, in many ways, to be especially effective in relation to all aspects of an interpretative health concept.

Conclusion

In this article I have discussed the relationship between music, education and health in relation to choral singing. Based on three studies of various choir practices I have shown that choral singing is a good example of health musicking. Furthermore I have suggested a model which can illuminate differences between various choir practices. At the same time, all of them have the potential to promote health. As the borders between the different music professions steadily change, the health perspective has been suggested as a challenge to the future of music education in general, and to choral pedagogy more specifically. Ruud claims that we need, "a new kind of musician, therapist, community musician, and music educator – a health musician, if you will

– with the necessary musical and performative skills, the methodological equipment, and theoretical familiarity, and, not least, the personal, ethical, and political values to best carry out these health-musicking projects” (2012:95). Veblen and Waldron also predict, from a community music perspective, that “in the century to come, it may well be that the roles of CM [community music] workers, music educator, and music therapist begin to merge in significant ways [...], musician-educator-workers will facilitate music-making in multiple situations with all kinds of people” (2013:207). For too long the natural continuum of musical help has been artificially divided and sequestered by professional and disciplinary restrictions, claim Ansdell and DeNora (2012:109). I am not suggesting a ‘therapeutising’ of music education practices. I am also aware that therapists, community musicians, educators and musicians employ different agents with distinct qualifications, educational training and professional identities (Ruud 2012:94). However, the *practices* are often the same. Furthermore, health musicking is a possibility for any music practice. If the people we make music with in our practices as music educational professionals and choral leaders use music as a health promoting activity, we should have the knowledge and skills to include that dimension in our practice. It is my hope that this article can contribute to the debate on where the music education field of practice will go in the future. The discussion shows that new knowledge based on research results is needed to further develop music education practices.

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Notes

- 1 Retrieved 27.4.2013 from <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>.
- 2 I.e. in *Republic*, edited and translated by Chris Emlyn-Jones and William Preddy (2013).
- 3 Dyndahl and Ellingsen write from a music didactic perspective, however, their point of views are relevant in this context.
- 4 Varkøy has since taken this discussion forward by focussing on musical experience as an existential experience, inspired by, among others, Heidegger, Gadamer and the Norwegian philosopher Vetlesen (see e.g. Pio and Varkøy 2012). It would be interesting to discuss such a perspective in relation to a health perspective, but this is outside the scope of this particular article.
- 5 E.g. in “LK06”, curricula for the Norwegian primary and secondary education, the objectives for the school subject *music*, holds forth music experience as an existential experience and musical and human interaction as key elements. Additionally, “the music subject shall balance togetherness and interaction with mastering”. Retrieved 26.4.2013 from <http://www.udir.no/Stottemeny/English/Curriculum-in-English/>.

- 6 "Opplæringslova § 9a-1". Retrieved 26.4.2013 from <http://www.lovdatab.no/all/tl-19980717-061-011.html>
- 7 Stige prefers 'paramusical' to the alternative 'extramusical', "to avoid the misleading impression that things are either 'totally' musical or not musical" (2012:186).
- 8 American reports also document that the highest level of participation in the arts is found in performing choral music (NEA 2009; Chorus America 2009).
- 9 According to the limits of this article, information about methods of the studies etc. is left out. For those interested, see Balsnes 2009 and Balsnes 2012.
- 10 Paragraph one in the Choir Statutes.
- 11 Interview 28.09.2004.
- 12 The use of the term "multicultural" is the agent's own terminology.
- 13 Retrieved 21.6.2011 from www.kianorge.no/om-oss.
- 14 All the quotes in this section (except from Teresa's statement) are from interview with choir leaders 23.1.2012.
- 15 Most of them are composed by one of the leaders in the choir.
- 16 Interview 14.03.2013.
- 17 Interview 20.02.1012.
- 18 Interview 30.08.2012.

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