

Health Musicing - Music Therapy or Music and Health? A model, empirical examples and personal reflections

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ABSTRACT

The field of music therapy is expanding rapidly into new areas, practices and interdisciplinary fields, as well as redefining its goals and values. Increasingly "music and health" is used to describe the field when it comes to naming new training programs, new interdisciplinary fields of theory and research and new research centers.

The main purpose of this article is to contribute to the ongoing discussion of empirical and theoretical potentials and problems in the interdisciplinary field of music and health, both in clinical and in everyday life contexts. A theoretical quadrant model, inspired by Ken Wilber and Gary Ansdell, is presented and illustrated by empirical examples and references from the literature. Meta-theoretical reflections include the relevance of interpersonal or relational psychology and vitality dynamics for the theory and practice of health musicing.

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INTRODUCTION

“Health promotion” as a goal is a core element in Bruscia’s well known and comprehensive definition of music therapy (Bruscia, 1998).¹ This definition reflects a salutogenic orientation inspired by Antonovsky’s ideas of health as a personal experience and an ongoing process more than a biomedical state. Aldridge (2004) takes the idea even further and thinks of health as (a) performance: “becoming healthy” is an intentional act aimed at balancing physical, psychological and social elements to create or enhance well-being and quality of life. Ruud (2010) underlines the social aspect of “health as participation” and describes the potential of musicking as, “A provider of vitality; (...) a tool for developing agency and empowerment; a resource or social capital in building social networks; a way of providing meaning and coherence in life” (Ruud, 2010, p. 111).

The concept “Health music(k)ing” embraces all these aspects of how music experiences provide health affordances, also outside the therapy room.² As far as I know, Stige (2002) was the first to link music therapy and health musicking:

Music therapy as a discipline is defined as “the study and learning of the relationship between music and health.” As professional practice it is “situated health musicking in a planned process of collaboration between client and therapist.” (Stige, 2002, p. 198, 200)

The aspect of participation is underlined in the following definition (Stige, 2003):

Community Music Therapy as an area of professional practice is situated health musicking in a community, as a planned process of collaboration between client and therapist with a specific focus upon promotion of sociocultural and communal change through a participatory approach where music as ecology of performed relationships is used in non-clinical and inclusive settings. (Stige, 2003, p. 254)

Thus, health musicking is not limited to a professional therapeutic context. It can be observed in any social or individual practice where people use music experiences to create meaning and coherence in states and times of adversity.

...through these quasi-therapeutic forms of musicking, individuals may construct ontological security, regaining a sense of coherence and community when life is corrupted by illness or disease. (Batt-Rawden and Tellnes, 2005)

In this way, health musicking can be understood as the common core of any use of music experiences to regulate emotional or relational states or to promote well-being, be it therapeutic or not, professionally assisted or self-made. Social science research in recent years has documented some of the many ways in which music is used to promote health by “lay people” in their daily lives.

¹ “Music therapy is a systematic process of intervention wherein the therapist helps the client to promote health, using music experiences and the relationships that develop through them as dynamic forces of change.” (Bruscia, 1989, p. 20)

² The concept “musicking” was developed by C. Small (1998) in a musicological context and D. Elliott (1995) in a music education context. Ansdell (2004) and others have suggested that the ‘k’ is left out in the spelling, and I will follow this line of thought, thus writing “Health musicking” in the rest of the text, except in some quotes.

By considering the often hidden lay-therapeutic functions music serves in everyday life, it is possible to return to music's use in hospital and therapeutic settings with new eyes, focusing on the role of the client/patient and what they bring to the music (therapeutic) event – their “lay craft”. From there, it is also possible to see the craft of the music therapist or health-musician with new eyes as they seek to activate latent health-musicking skills in those with whom they work. (DeNora, 2007, p. 284)

In other words, the field of music and health covers lay-therapeutic musicing in everyday life as well as community musicing and the more specific professional practices of MusicMedicine and music therapy. In MusicMedicine it is the selected and often specially composed music itself which has an effect, while in music therapy the music experience is embedded in the therapeutic relationship.

BUILDING A THEORETICAL MODEL

A DESCRIPTIVE ORIENTATION MAP

In order to describe and understand this vast and somewhat confusing field of health musicing and its potentials I developed a quadrant model (Bonde, 2009) showing how health musicing relates to four major purposes or goals:

1. The development of communities and values through musicing,
2. The shaping and sharing of musical environments,
3. The professional use of music(ing) and sound(ing) to help individuals,
4. The formation and development of identity through musicing.

In this article, the model is re-constructed and developed step by step, quadrant by quadrant. The graphic model is inspired by Ansdell (2001), and the fundamental construction of polarities comes from Wilber (1996; see also Bonde, 2001). The vertical axis is defined by the polarity of Mind and Body and the horizontal axis by Individual vs. Social as overall perspectives. At the center of the model is placed the core concept of “Health Musicing” defined as corrective or affirmative emotional and/or relational experiences created or facilitated by musicing. This definition is elaborated further below.

“Corrective emotional experiences” are hypothesized to be a key factor in therapeutic change (Bernier and Dozier, 2002), especially in psychodynamically oriented psychotherapy. Research in attachment building, mother-infant communication and psychotherapy processes points to the underlying dynamic relationship as the real promoter of these intra- and interpersonal processes (Malloch and Trevarthen, 2009; Stern, 2000), and therefore it is actually more precise to talk about or at least include “corrective relational experiences”. However, this concept of “corrective relational experiences” is not identified in the literature, even if “the relational turn” in psychology, psychoanalysis and social science is a well-established term, referring to the understanding of emotional health as formed through the relational processes

between child and caregiver or between client and therapist (for a discussion, see Ruud, 2010).

Corrective experiences are often facilitated by others, *e.g.*, professional therapists, but in everyday life people use all sorts of music experiences in an affirmative and health promoting way: to confirm values, to mirror aspects of identity, to regulate mood and well-being, to empower and define relationship, to access non-ordinary states of consciousness or spirituality, etc. Both corrective and affirmative experiences can be promoted in therapy as well as in everyday life. This is evident when the emotional or relational experience is fostered through musicing. The simplest event is when a single person relates to music, in an act of singing, playing or listening in order to obtain a physiological or emotional effect. The most complex process is when a group of people with health problems relate to each other through music improvisations. The web of relationship can have many textures, and the emotional context can be highly diverse.

BUILDING THE MODEL (QUADRANT BY QUADRANT).

Musicing provides affordances to persons who may appropriate them in several ways and contexts. The experiences appropriated may be emotional or relational, affirmative or corrective – this depends on the person’s needs and on the context. Each of the model’s four quadrants has its specific characteristics.

In the upper right quadrant (figure 1) the development of communities through musicing is described.

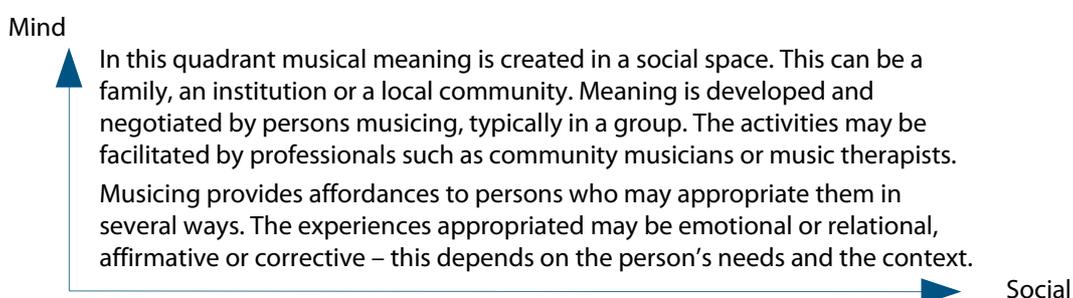


Figure 1: Upper right quadrant. The development of communities and values through musicing

In the lower right quadrant (figure 2) the focus is on how health promoting musical environments can be shaped and shared.

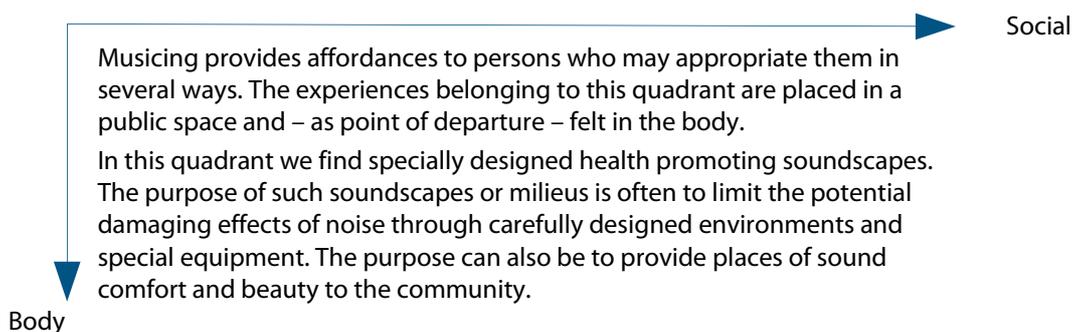


Figure 2: Lower right quadrant. The shaping and sharing of musical environments

In the lower left quadrant (figure 3) it is described how individual health problems may be addressed through music(ing) and sound(ing)

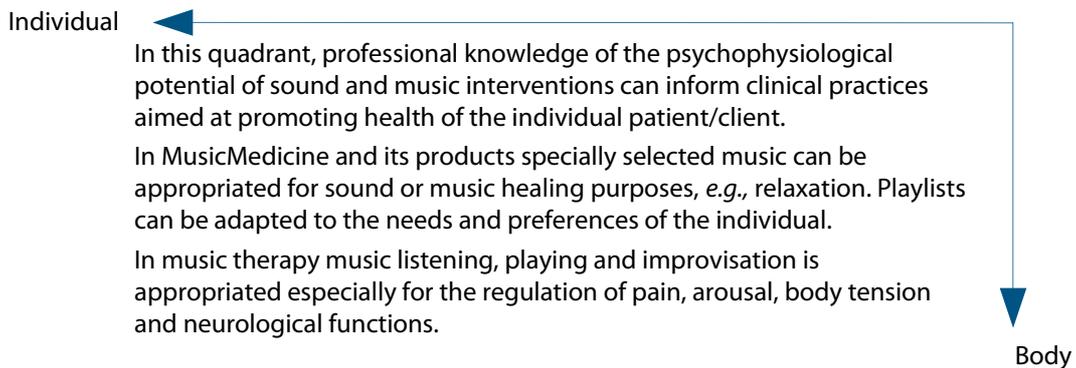


Figure 3: Lower left quadrant. The professional use of music(ing) and sound(ing) to help individuals

And finally, in the upper left quadrant (figure 4), the development of identity through musicing is described.

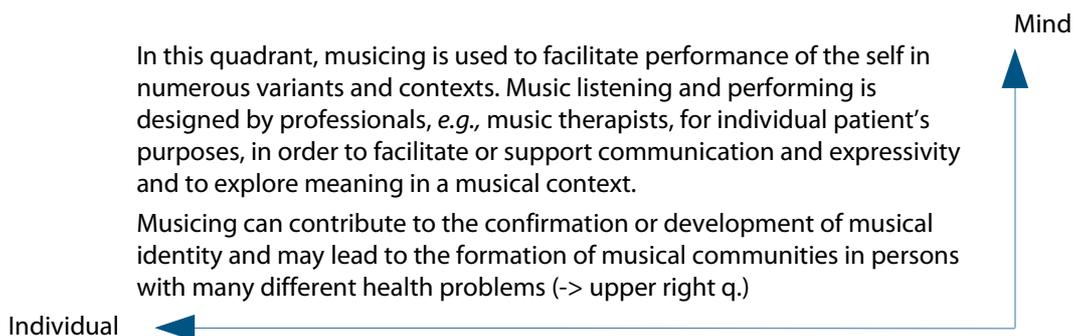
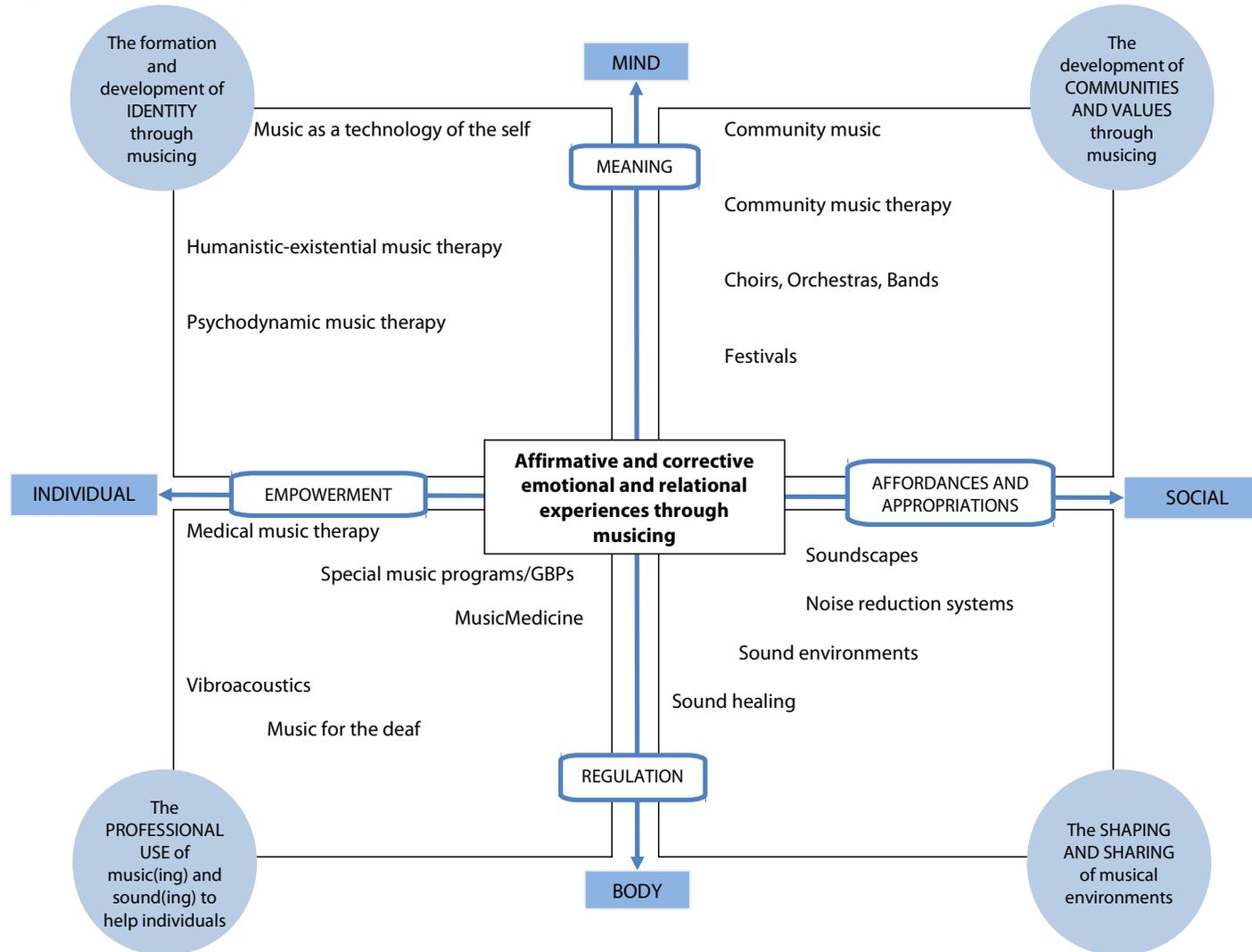


Figure 4: Upper left quadrant. The formation and development of identity through musicing

On the next page we can see how combining the quadrants in one model allows a concentrated mapping of the vast field of Health Musicing.

Figure 5: Health musicing: A theoretical model (Inspired by Gary Ansdell (2001) and Ken Wilber)



EMPIRICAL EXAMPLES

After this short description of basic features of the quadrants I will give empirical examples from each of them, based on my personal experiences as clinician and researcher.³ The examples will be followed by selected references to core literature documenting clinical and other relevant practices in each quadrant.

UPPER RIGHT QUADRANT: DEVELOPING COMMUNITIES AND VALUES THROUGH MUSICING

Example 1: "Baby-chanting" as facilitated parent-child musicing

In Denmark there is a solid and long-lived tradition of community singing, with a large repertoire ranging from very old folk songs and hymns, to secular songs for the community, to contemporary popular music. This repertoire is nurtured (more or less) in the school system and used in private as well as public contexts throughout most people's lives. There is also a strong choral movement in Denmark, ranging from community singing in firms and institutions to elite vocal ensembles. A specific Danish tradition is song writing for specific occasions (contrafact, parody): well-known songs with popular melodies are used as the basis of new texts in social contexts such as weddings, birthdays, anniversaries, meetings, etc. All these traditions have been based on participation in singing communities, especially in schools and churches, and lullabies are often a child's first meeting with music. However, parental singing has become more rare as a partial effect of the overall tendency in Western countries to professionalize singing and playing, accompanied by a deterioration of music education (documented in Denmark by Nielsen, 2010) and the apparently ever-growing focus on supposedly innate (= "non-trained") musical talent exposed in TV shows (X-Factor, etc.). About 10 years ago Danish churches started offering "Baby-chanting" as a community service to members of the congregation: babies (up to one year) and their parents meet with members of the church staff (*e.g.*, the organist and a singer) once a week. They sing and rehearse common and popular hymns, as well as secular songs and game songs, facilitated by movement and dance. The purpose is not only to vitalize congregational singing but also to encourage parents to sing and dance with their children at home and in other communities. This new tradition of community singing has grown to great popularity and is now offered by up to 50% of churches/congregations in Denmark (Riis, 2009).

Example 2: Musicing with a group of people with Alzheimer's dementia

Over the last two years Ellen Thomasen, who is an occupational therapist as well as music therapist, has made regular visits to a small institution where people diagnosed

³ A note on my personal background may explain my familiarity with health musicing in all of these quadrants. My education was in musicology and literature, and my latest funded research project has performative aspects of the Danish composer Bent Lorentzen's operas and chamber music as its focus. During the last 30 years I have worked as high school teacher, university professor (first in musicology, then in music therapy and most recently in music and health), music producer, music journalist (opera, concerts, radio), clinical music therapist and researcher (specializing in psychiatry, oncology and palliative care). I am involved in many different research and dissemination projects, as a clinician, researcher, partner, editor, supervisor or reviewer, and some of these will be mentioned or described below.

with early stages of Alzheimer's disease meet for social interaction and stimulation. She brings song books and a basket of CDs with a variety of music, including popular music from the middle of the 20th century – when the participants were young. Singing and listening to the music brings memories and moods from these peoples' youth, and they can enjoy and share these memories and express aspects of their identity through the music experiences (Thomassen, 2010, personal communication). This is not music therapy, but rather community musicing based primarily on listening to or singing selected or preferred music.

Selected evidence from clinical research

The health benefits of (choral/community) singing have been documented in several studies (Balsnes, 2009; Clift, *et al.*, 2008; Kreutz, *et al.*, 2004), and singing activities are requested by residents and relatives in many homes and institutions for senior citizens.⁴ For people who cannot participate in music activities in their communities under normal conditions, music programmes have been developed to serve, for example, hospital or hospice patients or prisoners in jail. *Live Music Now* in the UK (founded by violinist Yehudi Menuhin) and *Musique Santé* in France are examples of these types of health musicing programmes where professional musicians bring live music into health care institutions. Specially designed music events and festivals for children, adolescents and adults with special needs are well-known in many countries.

During the last decade, community music therapy has been used as a concept to describe a specific type of community music (Ansdell, 2002; 2003; Stige, *et al.*, 2010). Ansdell (2002) describes community music therapy as:

... an approach to working musically with people in context: acknowledging the social and cultural factors of their health, illness, relationships and musics. It reflects the essentially communal reality of musicing.. The aim is to help clients access a variety of musical situations, and to accompany them as they move between 'therapy' and wider social contexts of musicing. (pp. 120-121)

His subsequent revision (2003) described Community Music Therapy as:

... an anti-model that encourages therapists to resist one-size-fits-all-anywhere models (of any kind), and instead to follow where the needs of clients, contexts and music leads. As such, Community Music Therapy involves extending the role, aims and possible sites of work for music therapists. (p. 21)

⁴ A number of issues arise when singing with elderly people including musical competency of staff, difficulty of singing without accompaniment, and the challenge of group sing-a-longs to CDs of familiar music with well-known performers, due to tone range, tempo and interpretation. Based on present research on vocal needs and characteristics of the elderly (Koger, *et al.*, 1999), a group of bachelor students from Aalborg University identified facilitative keys, tempos and timbres of 18 core songs from this repertoire and arranged them in two versions, one purely instrumental and one with vocal lead song included. Through funding, these CDs (Ladegaard, *et al.*, 2010) have been distributed to all Danish homes and institutions for senior citizens. The repertoire represents national values, memories and aesthetic qualities suitable for verbal and non-verbal sharing, and the CDs may facilitate community singing where this is otherwise impossible.

Community Music Therapy projects have been documented particularly in the UK, Norway and South Africa (Stige, *et al.*, 2010). Community oriented musicing within health institutions has also been described as Ecological or Music Milieu therapy (Aasgaard, 1998; 2001; 2005; Ærø and Aasgaard, in press).

LOWER RIGHT QUADRANT: SHAPING AND SHARING MUSICAL ENVIRONMENTS

Example 1: New sound environments for hospitals and ambulances

In recent years, new societies, networks and centers for the study of music and/in medicine or music and health have been created. One example is the [International Association for Music and Medicine](#) (2009) supporting the new international and interdisciplinary journal *Music & Medicine*.

At a macro level, an important working area for such organisations is the creation of healthy sound milieus in (somatic) hospitals. Pioneering work in this area has been done at Rigshospitalet in Copenhagen (Heslet and Dirckinck-Holmfeld, 2007). At a micro level, the development of a more healthy sound environment in ambulances is an ongoing research study by the Danish anaesthesiologist and MusicMedicine pioneer Per Thorgaard and colleagues (Zankel, 2010). The research question is: What can be done technically and musically to change the extremely noisy, high-frequency and high-volume milieu of most ambulances which is counterproductive for the well-being of patients on their way to the hospital? Thorgaard collaborates with two composers to develop specific music programs suited for a situation characterized by a problematic mixture of noise, stress and anxiety. Preliminary results, based on interviews with patients and para-medical personnel on the ambulances, are promising: The music seems to distract the patients from the noise and reduce their anxiety, thus minimizing two critical aspects of the situation.

Example 2: MusiCure and other music soundscapes for hospitals and institutions

The projects and ideas mentioned above originated in a Danish interdisciplinary organisation called *Musica Humana*, engaging doctors, nurses, musicians and music therapists in an interdisciplinary exploration of the potentials of MusicMedicine in hospitals. This organization supported research in the use of specially composed music for patients and staff in Intensive Care Units. An outcome of this research is the music concept and product *MusiCure* – musical environments for hospitals and individuals composed by Niels Eje.

MusiCure is scientifically documented with more than 4000 hospitalized patients over a period of more than eight years, and has been composed and produced especially for this purpose. (www.musicure.com – see also www.musicahumana.org).

Several studies and many conference presentations have been made of *MusiCure*, and they all support it as an appropriate and effective music intervention for hospitals (*e.g.*, Thorgaard, *et al.*, 2005). However, when taking a closer look at the available research protocols initiated by the *Musica Humana* organization it becomes clear that

MusiCure as a music intervention has actually never been compared to other experimental music conditions – only to “nothing” or to “hospital soundspaces”. Both from a scientific and from an ethical point of view this is problematic. The professional production standards of *MusiCure*, its clinical potential and the results of the research so far are not questioned here. However, the importance of respecting and including patients’ music preferences cannot be dismissed (Schou, 2007; Short and Ahern, 2009). When *MusiCure* or other forms of MusicMedicine are used with individual patients (which belong to the lower left quadrant of the model proposed here), each patient should have access to either using self-selected music or choosing among carefully developed playlists, created by experts in the field. Short and Ahern (2009) present the concept of a Genre-Based Playlist (GRP) study, and many other studies underline the importance of participants’ choice as a major influence on the outcome of music interventions (Bonde, 2009; Dileo and Bradt, 2005).

Selected evidence from community and clinical research

The concept “soundscape” was coined by the composer Murray Shaffer (1994), the first well-known advocate of acoustic ecology. His ideas have been developed both in theory and practice, e.g., in *The World Forum for Acoustic Ecology* (WFAE) which was founded in 1993 as an international association of affiliated organizations and individuals with a common concern with the state of the world’s soundscapes. The members represent a multi-disciplinary spectrum of individuals engaged in the study of the social, cultural and ecological aspects of the sonic environment. (See also Ruud, 2005 for an introduction to soundscape research and projects; and Raimbault and Dubois, 2005 for an introduction to soundscapes as a core concept in urban planning). Three contemporary tendencies can be observed: (1) Society’s responsible response to people’s needs for acoustic defences, such as noise reduction systems, (2) Public, private and artistic initiatives to design specific hospital or city environments and soundscapes to meet the needs of patients and citizens, and (3) A more artistic directed research in sound and music as multimedia soundscapes. All three areas are documented in the work of the Swedish Urban Sound Institute (www.usit.nu/). A quite spectacular example is the project *Nordic Walk 59°N* at Arlanda Airport (near Stockholm). Architects and sound designers have created a 250 meter long light and sound installation inspired by natural light and sound environments in the Nordic countries, in order to transform the normally boring movement through a transit area into a healthy, inspiring, multisensory experience.

All the projects and studies mentioned in this quadrant include planned regulations of music and sound as physical vibrations, related to the direct physical experience of sound in the body. The fact that this direct effect is also at the core of ancient and modern traditions of sound healing for groups and individuals must be mentioned (Aldridge and Fachner, 2006; Gouk, 2000; Horden, 2000; Tucek, 2005).

LOWER LEFT QUADRANT: HELPING INDIVIDUALS THROUGH MUSIC(ING) AND SOUND(ING)

Example 1: Music experiences and music therapy for the deaf

It may seem paradoxical to work musically with deaf persons, but nowadays cochlear implants (CI) are used worldwide as an early intervention for deaf-born children. However, even children with cochlear implants need support and even therapy (Kerem, 2008). Before the CI era many music therapists worked with deaf children and adults, using their capacity to feel musical vibrations in the body for purposes such as speech improvement, self expression and social interaction. The Danish pioneer Claus Bang video-recorded his work with this population from the 1960s, and this lifelong effort to help deaf individuals through musicing is now documented as an open internet resource (www.clausbang.com). In these recordings the health benefit of singing, dancing and playing activities, and of specific music-based training and clinical interventions, is obvious – both for the individual deaf child or adolescent, and for the group.

Example 2: Sound pillows for psychiatric patients

Music therapy is a well documented intervention for psychiatric in- and out-patients (Gold, *et al.* 2009). Expressive and receptive individual and group music therapy interventions are used and modified to the specific needs and preferences of the patient (or group). The therapeutic relationship develops through musicing and is considered the most important factor in the healing process (Austin, 2003; Pedersen and Wigram, *in press*; Turry, 2005). However, music and music experiences can also be used with psychiatric patients without a music therapist being present, *i.e.*, as a MusicMedicine intervention. For highly agitated and anxious patients at Aalborg Psychiatric Hospital genre-based playlists (see above) were developed for patients in special custody. This intervention enables a nurse or other caregiver on the ward to offer the anxious and highly agitated patient the choice between five different music programs, administered through an mp3 player connected to a “sound pillow” with tiny built-in loudspeakers. Pilot projects so far have been successful (Schou, *et al.*, 2010; Sørensen, 2005). This is a low-cost and fairly easily administered MusicMedicine intervention meeting the needs and preferences of individual patients in an ethically sound way.

Selected evidence from clinical research

The research literature presents evidence for the effects of different music interventions on the physiological well-being of persons with many different medical diagnoses. Hanser (2010) gives a comprehensive overview of research documenting how music experiences – in MusicMedicine as well as in medical music therapy – can promote and facilitate health and well-being. She reviews the reported effects of music on stress, pain, immune and neurologic functions with special attention to four conditions: childbirth, depression, coronary heart disease and cancer. Hanser’s theoretical framework is an integrative mind-body medicine emphasizing “the

interactions between emotions, thoughts, relationships, behaviour, and spirituality in determining good health” (Hanser, 2010 p. 852, referring to Harrington’s, 2008, history of mind-body medicine). Pelletier (2004) made a meta-analysis of the effect of music on arousal due to stress. Based on 22 quantitative studies he concluded that “both music alone and music-facilitated relaxation were instrumental in decreasing arousal, with a statistically significant effect size ($d = .67$)”. Other meta/analyses can be found in the Cochrane Library. This library is administered by the Cochrane Collaboration, overseeing the quality of health care interventions research using strict criteria for experimental methodology but not including qualitative or mixed methods studies. A specific music intervention directed towards the body is the example of vibroacoustics, where the patient senses music vibrations directly on the body through loudspeakers built into chairs or beds (Wigram and Dileo, 1997).

UPPER LEFT QUADRANT: DEVELOPING IDENTITY THROUGH MUSICING

Example 1: Group Music and Imagery for psychiatric outpatients

The experience of music can be very private, even within the public sphere of the concert hall. Verbal exchanges at concert or festival intermissions rarely mention deep personal experiences. In group music therapy it is possible to arrange an intensive exchange of experiences. This can be done both in active, improvisation based group music therapy and in receptive groups based on music listening. So far, research has documented the effects of supportive music in Group Music and Imagery (GrpMI) sessions with psychiatric patients (*e.g.*, Moe, 2002; Summer, 2002). A more recent study (Bonde, 2010) study examines the effects of classical music including both supportive and challenging features with relatively well functioning psychiatric outpatients. Patients with a score of 50 or higher on the Global Assessment of Function (GAF) scale came together in groups of 3-4 participants. In 90 minute sessions they would discuss life world issues (such as isolation/social anxiety and how to deal with it) and then listen to therapist selected classical music pieces followed by mandala drawing and a final verbal round. Preliminary results show that social anxiety is reduced in all participants, and that imagery stimulated by classical music including challenging features is effective in promoting health and quality of life for these patients.

Example 2: Strong music experiences in Guided Imagery and Music

Music experiences can have profound and long-lasting effects, and transpersonal experiences are part of such deeply transformative health musicing. This has been documented not only in biographical and anecdotal form, but also with scientific evidence (Gabrielsson, 2008). In the receptive music therapy model Guided Imagery and Music (GIM), selected classical music and a listening mode including deep relaxation (leading to an altered state of consciousness) is combined to facilitate potentially transformative experiences for persons ready for and psychologically strong enough to enter this special musical space (Bonny, 2002; Summer, 2009). An ongoing study of the transformative potential of individual GIM sessions with selected music programs aims at documenting the health potential of such musical-

relational experiences (Bonde, 2010a). The theoretical basis for the study is interpersonal psychology focusing on the concept of “surrender” (Blom, 2010). The basic idea is that if a person can give in (surrender) to beautiful, powerful music, this may transform the person’s experience of self-in-relation to include not-me experiences as non-threatening, expansive and even peak experiences (Blom, 2010). This again may facilitate the potential letting go/forgiveness of highly charged life wounds caused by abuse, neglect, trauma, etc.⁵

Selected evidence from clinical research

There is a vast research literature documenting the effect of different music therapy models on the physiological, psychological, social, existential and spiritual well-being of persons with many different psychiatric or medical diagnoses.⁶ The Cochrane Library includes meta-analyses/systematic reviews of the effect of music interventions (*i.e.*, MusicMedicine as well as music therapy) on pain relief, autistic spectrum disorders, schizophrenia, dementia, depression, mechanically ventilated patients, acquired brain injury and coronary heart disease patients, while studies of cancer patients and individuals suffering from other illnesses are forthcoming (www.cochrane.org).

It is not possible in this context to give a closer description of these experimental studies and reviews. I find it more important to point to complementary evidence from qualitative research.

Outside of a music therapy context, the processes of creating and negotiating meaning through musicing have been studied by researchers such as Batt-Rawden (2010; Batt-Rawden, *et al.*, 2007) and DeNora (2000; 2007). Batt-Rawden studied how people with long-term illnesses and diseases could use recorded music, structured in a novel “Participatory CD Design”, as a “technology” of self towards health, healing and recovery. The concept “music as a technology of the self” was coined by DeNora (2000), as a result of several case studies examining how music was used in everyday life for recovery of self-identity, reminiscence and regulation of emotions and physiological states. In clinical music therapy contexts researchers such as Pedersen (Pedersen and Wigram, 2010), Turry (2005) and Austin (2003; Austin and Dvorkin, 1998) have explored how different aspects of the therapeutic relationship in music, such as transference and countertransference, community sharing and resistance, may contribute to therapeutic change.

Thus, “relational experiences” are at the core of the presented model of health musicing, and this is closely related to Daniel Stern and the Boston Change Process Study Group’s basic ideas on therapeutic change. In Stern’s new book on *Forms of Vitality* it is formulated very clearly:

⁵ Music and Imagery can also be administered as a self-help resource, based on individual or group listening to selected music played from a CD with or without verbal guidance (Bush, 1995, Röcker, 2005).

⁶ In Wigram, Pedersen and Bonde (2002) some international and well-known models of music therapy are described: cognitive-behavioral (*e.g.*, medical music therapy), psychodynamic (*e.g.*, analytically oriented music therapy), humanistic-existential (*e.g.*, Nordoff-Robbins music therapy) and humanistic-transpersonal (*e.g.*, Guided Imagery and Music). Community music therapy could be added to this list today.

It is crucial to remember that the most transforming and curative element in psychotherapy is the experience of the therapeutic relationship, not the theoretical approach or the technical manoeuvres. Most evidence leads to that conclusion. (Stern, 2010, p. 149)

If we see musicing not as a “theoretical approach” or a “technical maneuver” but as a descriptive term, Stern’s (2010) concept of “dynamic forms of vitality” (including “the fundamental dynamic pentad of movement, time, force, space, and intention”, p. 6) and the matching and sharing of these forms through “affect attunement” is at the core of understanding how musicing as a relational experience in all four quadrants of the model may contribute to health promotion.

Affect attunement through musicing is described by many music therapy researchers (Trollaldalen, 1997; Wigram, 2004), and there is also evidence of how corrective and affirmative emotional experiences are promoted through musicing (Bonde, 2006; Trondalen, 2008). The term “corrective and affirmative relational experiences”, suggested in this essay, is an attempt to stress the interactive, intersubjective, interpersonal dimension in health musicing. The music means a lot in itself, and it can influence a person directly, as seen, for example, in MusicMedicine and Sound healing. However, the therapeutic relationship (or the musical relationship in a non-therapeutic context) is the most effective transformer. When a sharing or performance in the community can be added, we can talk about “coming full circle in the (music) therapy relationship” (Turry, 2005).

DISCUSSION AND SUMMARY

When drafts of the model described here have been presented in international symposia or seminars, part of the discussion time has been used to address two questions: (1) Do we need such definitions and models? Maybe normative definitions do more harm than good in clarifying the situation. Is it more ‘exclusive’ than ‘inclusive’? – (2) If “Health musicing” is such a broad concept, will it not sacrifice the evidence-based competencies of music therapists and leave the field open to “harp therapists” or other less qualified professionals?

The proposed model is not an attempt to give normative definitions of “music therapy” vs. “music and health” or “community music”. Mapping a territory in this way is more a descriptive and metaphorical endeavour than an attempt to obtain exact denotations of areas or traditions. However, I think we need some orientation tools, as the field of music, culture and health is rapidly growing and becoming potentially confusing. Music therapists have fine qualifications to work in the field, including the areas outlined outside the left quadrants, but the field – all four quadrants – is notoriously open to anyone who wants to contribute to musicing for health purposes.

“Musicing” is a relational term. Even when there is no music therapist, community musician or music educator present, a person will establish a physical, psychological or spiritual relationship with the music chosen or offered. Therefore (just to give one

example), music is recognized as a “co-therapist” in the receptive music therapy model Guided Imagery and Music (Bonde, 2006; Bonny, 2002).

Stern (2010) writes that “the dynamic aspects of experience are what ‘aliveness’ is about” (p. 35); “The dynamic flow of music (sound in motion), dance, theatre, and cinema sweeps us up at moments and then releases us, only to sweep us up again quickly just downstream” (p. 6). In health musicing the dynamic flow of music is used, more or less consciously, to influence body and mind, and to facilitate corrective emotional and/or relational experiences.

Since antiquity music has been used in most cultures, not only as an aesthetic experience in its own right, but also as a means to regulate physical and psychological health (Gouk, 2000; Horden, 2000). Hanser (2010) describes how contemporary health services are slowly evolving from a disease/symptom model into one of prevention and wellness. In such a lifestyle-based paradigm music interventions can be part of lifestyle enhancement programmes that not only teach strategies for coping with stress and pain, but also support strategies for breaking insufficient cognitive, emotional and relational patterns. Hanser refers to Benson and Proctor (2003) when she describes “the breakout principle” as

a four-stage process that takes advantage of the innate ability to heal oneself. It leads to creative solutions to problems or optimal performance through (1) a mental or physical struggle, (2) a letting go or release from the struggle, (3) a peak experience, and (4) a new state of improved performance and body-mind patterns.

Hanser adds that: “*The principle explains how a peak experience with music is capable of transforming a person’s state of mind, body, and spirit*” (Hanser, 2010, p. 872).

I have already referred to some of the evidence for this transformative potential of musicing. In conclusion, I will summarize my description of “health musicing” as a modern interdisciplinary field of theory and practice with eight statements related to the model (to be read clockwise from “3 p.m.” in fig. 5):

1. Musicing provides affordances to persons who may appropriate them in numerable ways. The experiences appropriated may be physiological or psychological, emotional or relational, affirmative or corrective – this depends on the person’s needs and the context.
2. It is possible to design large-scale health promoting soundscapes and limit the potential damaging effects of noise through carefully designed environments and equipment.
3. At an individual level music and sound can be appropriated for sound or music healing purposes.
4. Knowledge of the psychophysiological potential of sound and music interventions can inform and may be appropriated in MusicMedicine and its products.

5. Musicing is appropriated by professionals for individual and social purposes in music therapy practices within different contexts, in order to regulate pain, arousal, bodily tension and neurological functions, and to facilitate or support communication and expressivity.
6. Musicing can contribute to the development of musical identity and to the formation of musical communities in persons with many different health problems.
7. Musical meaning is created, developed and negotiated by persons musicing.
8. Musicing facilitates performance of the self in numerous variants and contexts.

“Health musicing” cannot be monopolized by “music therapists”, “community musicians” or “music and health workers”. It is an interdisciplinary field, including specific disciplines like “Music therapy”, “MusicMedicine”, “Community music (therapy)”, and professionals with many different backgrounds and qualifications can work – alone, or better: together – in one or more or even all of the quadrants described in this essay.

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