LIFESPAN SINGING

Working model for therapeutic singing group for the elderly

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Tiivistelmä – Abstract

The objective of this study was to develop a usable working method for therapeutic singing group for the elderly. Since in the near future the amount of the elderly is growing enormously the society has to interact to the changing situation. The therapeutic singing group created in this study is one solution how to offer activities and support for the well being of the elderly.

This study is a participatory action research. The study is based on the researches, which have shown that singing has a possible effect on wellbeing. The data for the study was collected from my clinical training material and questionnaires. The important aspect for the case study was the spiral and cyclic working, through which the method for the model was developed.

The results show that music is a good working tool to explore issues from the present and the past, to share experiences, to do remembering, to connect people from different backgrounds, to have social interaction and to refresh mind and body and to have therapeutic music experiences. The most important consideration is that music affects both biomedical and psychosocial sides of any human being.

Asiasanat – Keywords *ageing*, singing, music therapy

Säilytyspaikka – Depository

Muita tietoja – Additional information

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1 INTRODUCTION

In the near future the amount of the elderly is growing enormously. The society needs to have more capacity to take care of the elderly. The best for all would be, that the elderly could stay at home as long possible. It is important that people could stay in their familiar environment. This way they will feel safer, they would probably need less medication and feel more dignified. In order to stay at home the elderly need a lot of support and activities provided by the society.

The amount of the elderly is growing enormously in the next few years. For example today there are 5.375 million people living in Finland, and the amount of people older than 65 years is 19%. The statistics in Finland have predicted that in the next ten years the amount of the 65 year old will increase to 23%. (Suomen virallinen tilasto, 2010.)

In Finland the age borders of the elderly are ‘young elderly’ from 65-74, over 75 are elderly and over 85 ‘old elderly’ (Helsingin ja Uudenmaan sairaanhoitopiiri, 2008.). Well-being and ability to act are important issues, very important when speaking of the elderly. Today every fourth of the 85 year old are in institutional health care. Nationwide the health promotion of the elderly is defined by the Ministry of Social Affairs and Health in the ‘Terveys 2015’ (Health 2015) – public health program. In each municipality there should be a strategy, which defines and demonstrates the aims of the health care and ability of wellbeing and independent living of the elderly. (Hietanen, & Lyyra, 2003, pp.15-17.)

In Finland the priority in geriatric care is to avoid incessant institutional care and secondly to generate content of the geriatric health care. It is also indicated that domestic health care and social support are the best alternatives for institutional care. (Gernet, 1997.)

World Health Organization (WHO) defines health as follows: 'Health is a state of complete physical, mental and social well- being and not merely the absence of disease or infirmity' (WHO, 1946). The quality of life is defined as: 'A person's perception of his / her position in life within the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns'. (WHOQOL Group, 1994.)

The problems of ageing are various. In the natural ageing the body image will change. There are also physiological changes, for example in vascular system, digestive system and sense perception in eyes and ears. The elderly are in a risk group for basic diseases like flues and they also have longer recovery periods. In the institutional care the serious diseases are cardiac based, ischemia, tumours, respiratory infects and dementia whereas in outpatient treatment the main diseases are pain and ache, arthrosis and common clumsiness. Also arterial hypertension, cardiac problems, lack in memory, which can also be a sign of depression. The elderly at home can suffer from blood pressure, cardiac failure, depression, diabetes, and ischemia and movement difficulties. Based on this knowledge the first solution to aid the elderly is to recognize the diseases early enough to prevent the possible illnesses or at least slow them down. Secondly, to support the independency of the elderly, proving them good quality of life and minimal degenerative diseases and social problems. (Helsingin ja Uudenmaan sairaanhoitopiiri, 2008.)

It is important to offer activities for the elderly so that for example dementia, anxiety, Parkinson's disease, and other neurological based diseases could be prevented or at least minimized. It has been researched that singing can slow down brain ageing. Human brain can be interacted by training, and in that way the grey capacity of the brain can be diminished.

In this study I describe the working model, which was developed for an elderly singing group at Music Therapy Clinic for Research and Training. I examined how singing can be beneficial for the elderly, how attending a singing group is felt, what kind of feelings

the participants have when investigating their life history and daily issues through songs. This study was conducted as part of my clinical training. I analysed the results by clinical training material, WHOQOL – BREF - quality of life indicator, a musical background questionnaire, and an open form feedback. The Finnish version of WHOQOL-BREF (http://www.thl.fi/toimia) was used, and you can see the English version in appendix number two. (WHOQOL Group, 1996.)

2 THEORETICAL BACKGROUND

2.1 Therapeutic use of music

"Music was my first love

And it will be my last

Music of the future

And music of the past

To live without my music

Would be impossible to do

In this world of troubles

My music pulls me through"

John Miles (2007)

What is the assumption, that music heals based on? According to Altenmüller and Schlaug (2012), 'music is probably the richest human emotional, sensomotor, and cognitive experience'. It includes both sensorimotor and cognitive experiences such as listening, watching, feeling, moving and coordination, remembering and expecting. Brain activity gives bio-physiological basis to cognition and emotion. Emotion emergences when limbic system is activated. There are different approaches: biological perspective (body reactions when emotions are born), social perspective (feelings arise by learning previous body reaction), and cognitive perspective (situations and previous experiences create emotion) (Kaikkonen, 2011). In this study of mine all of these perspectives are present.

Bruscia defines music therapy: ‘Music therapy is a systematic process of intervention wherein the therapist helps the client to promote health, by using music experiences. The relationships that develop through them create dynamic forces of change.’ According to Bruscia there are four different types of experience in music: improvising, re-creating (or performance), composing and listening. Each type has its own characteristics and music therapy interventions. (Bruscia, 1998.)

Music making (includes singing) and listening has short and long term effects. Music is engaged to multisensory and motor network and induces changes, links the brain within network. These changes music making has can be beneficial, and can make it easier to enjoy music therapy and to recover from various diseases. Music induces brain plasticity and that may produce advantages for wellbeing in general, and may influence neurohormonal states, cognitive and emotional processes in healthy and diseased people. Music can help us to improve many sensory motor, coordinative, or emotional disabilities. Music has also benefits to brain plasticity. The results are the best when the musical activity has started at an early age. Musicians have enlargements on cortical structure, subcortical structure, and cerebellum. If the training starts later in life, the brain organization can be modified by rewriting neuronal system, and the cells can start working better in specific tasks. Music effects brain plasticity because people find music making fun and it has social effects. (Altenmüller, & Schlaug, 2012.)

There are wide evidences that sensitivity to dopamine in the mesolimbic brain regions is genetically determined. Altenmüller and Schlaug (2012) say, that music induced modulations of neurohormonal states are pleasurable experiences and are connected in transfer effects with music influenced cognitive functions. This is why music therapy has a rich variety of effects that may be related to hormonal central nervous changes. Because music stimulates and regulates activity in these structures, music therapy can be used to help for example depressive people. Music stimulates many psychological functions as well. Altenmüller & Schalug refer to a research by Verghese et al. (2003) that Alzheimer’s dementia is rare in the elderly who are regularly involved in musical activities. Another study showed that musicians over 60 years have less or no

degeneration of grey matter density in the frontal cortex. (Altenmüller, & Schlaug, 2012.)

Long-term music training affects white and grey matter, density increases in frontal brain areas when involved in controlling the practised task, not forgetting the cortical and subcortical structures. Both music making, and listening to music stimulates emotions and emotions can make for example the rehabilitation more enjoyable. (Altenmüller, & Schlaug, 2012.)

A study made with choral singers showed that singing had social and emotional, and physical and spiritual benefits. The participants reported that lung function and breathing improved, mainly because they controlled breathing while singing. Also benefits to relaxation and stress reduction as well as singings ability to forget worries and feel calmer were mentioned. Music made the participants feel energized and gave them moving experiences. The study pointed out the idea that arts can improve health. (Clift, & Hancox, 2001.)

Hays et al. (2002) have examined the role of music in the lives of older people. They argue about the impact of music to positive ageing. In the article it is said that music can help people to release their feelings, transcending everyday experience, resolving hurt and pain, and reviewing significant life events. Music can evoke memories of emotional context of past events and time, and help people to explore issues from a different perspective and so explore events and emotions of their lives. Music makes it possible to share experiences, and makes social interaction easier. They point out that the most important issue how music benefits health, is that music affects both biomedical and psychosocial sides. They say that music is an easy way to treat health; it is painless, nonintrusive, easily accessible, and cost effective. (Hays, Bright, & Minichiello, 2002.)

Koelsch writes that music therapy has effects that improve the psychological and physiological health. In his article ‘A Neuroscientific Perspective on Music Therapy’ he opens up the five factors Thomas Hillecke et al. have presented. These factors are

attention, emotion, cognition, behaviour and communication. Hillecke points out in these factors that music can automatically capture attention. This kind of action can make good use for example of pain reduce. Music can modulate activity of all major limbic- and paralimbic brain structures, memory processes are related to music, music and movement can influence hand in hand, and music can be used to train the skills of communication and is related to social cognition. Koelsch says, that these factors are relevant to music therapy because through those, it is possible to use music to achieve beneficial effects in clients. And further, Koelsch highlights, that music keeps on action related processes such as perception action, 'mirror neuron system'. This is relevant since these mechanisms are part of the learning action, understanding actions, and prediction actions of others. For example, music can be used in the recovery of the stroke patients. Koelsch summarizes that music and music therapy have beneficial effects on the psychological and physiological health of individuals. (Koelsch, 2009.)

Fortunately, the research results have shown that music can slow down brain ageing. If you have practiced musical skills, or if music is used in rehabilitation it is easier to recover. Human brain can be interacted by training, and the capacity of the brain can be influenced. Aldridge says that we will know the benefit of music therapy in neurological rehabilitation by the researches done, but also in our clinical work by watching the reactions and changes the client has. With the clients who suffer from example dementia and who cannot speak well, we are connected through our neurological make-up by the mirror neurons. (Aldridge, 2005.)

Dementia and Alzheimer's disease patients can be helped with music. Daily routines might be difficult for them, but singing or musical activities easy. This can be explained through brain function: musical activities take place on the right brain hemisphere and other activities on the left side. Music and rhythm can help to get sense, and rhythm to daily activities. In these illnesses music can also ease communication and identity. Music wakes up associations and associations wake up emotions. Other sensors start to function at the same time, such as perception of flavour, textures, and temperature. When music is used therapeutically, it makes possible to connect individuals from

different backgrounds. Music can be used in many areas and social programs to help people. For the elderly musical activities can be offered at retirement homes, day centres, at home and so on. (Hays et al., 2003.)

2.2 Emotional impact of music

'Emotion is usually inferred from three kind of evidence – self-reports, expressive behaviour, and physiological behaviour.' Behavioural reaction to music can be for example crying. Physiological reaction is felt when music induces reactions like sad, fearful, happy, and experimental feelings like 'chills' and 'thrills'. Scherer has termed these 'reaction triad' of subjective feeling, expressive behaviour, and physiological reaction. (Juslin, & Sloboda, 2001, pp.84-85.) Bunt and Pavlicevic pointed out that different emotions mentioned above are included in music therapy. They give an example of passive and receptive music therapy, for example one can say 'Darling they're playing our tune'. Music as such contains strong memories and points of contacting surfaces. Pavlicevic found that these associations are individual especially when working with the elderly patients. (Juslin, & Sloboda, 2001, p.184.)

Juslin and Sloboda say, that according to Bruscia, in the improvisational music therapy patient can try out both intrapersonal and interpersonal musical aspects. The psychologically and physically safe space helps these within the self and between people experiences. The authors state, that gradually the group members in free improvisation grow in confidence, release wide range of feelings, feel that there are not right or wrong way of improvisation, and they pass musical messages to one another. (Juslin, & Sloboda, 2001, p.186.)

Juslin and Sloboda comment that: 'in a biological perspective on music and emotion neuropsychological and evolutionary considerations are crucial also for the case of

music.' They also say, that music may represent emotion, so that emotions are perceived by the listener and induce emotion so that the listener feels emotions. (Juslin, & Sloboda, 2001, pp.455-456.)

According to Sloboda, music wakes up deep and significant emotions in us. Music can change our arousal for example from sadness to joy or from boredom to relief. Musical association can make people to understand their feelings and emotions. Through music people can investigate their lives, go back to old times or stay at the moment. (Hays et al., 2002.)

2.3 Overview to literature

A recent article by Clift et al. (2010) is very interesting. It includes 35 researches done of group singing, wellbeing and health. This article has a systematic list of the researches. According to the information found, the finding was that out of 51 papers done approximately 80% were done after the year 2000. This shows that there is a strong interest in the topic. Most of the papers were done in English speaking and Nordic-European countries. The article divides the researches into different categories.

The first is qualitative, and survey studies involving community singing groups / groups established in special settings. The authors point out that in these kinds of researches it is easy to find out positive effects. There is for example a study, which dealt with creating a 'singing and wellbeing' scale by Clift & Hancox (2001). The singing and wellbeing scale analyzes twelve variables: *Helps to make me a happier person, gives a positive attitude to life, helps to improve wellbeing, releases negative feelings, a lot happier afterwards, positively affects to the quality of life, makes the mood more positive, doesn't give me a 'high', doesn't release negative feelings, relaxing and helps with stress, doesn't help emotional wellbeing, no deep significance*. The most important

finding in this study was that women seem to experience more wellbeing effects of singing than men.

The second category in the article is experimental and objective measurement studies. Mood before and after singing has been studied in a wellbeing health study by Houston, et al. 1998 and Cohen 2009. There were positive changes emerged. There are studies that have tried to prove physiological variables with singing. It has been proved that immunoglobulin A in saliva increases after singing (Beck, Cesari, Yousefi, et al., 2000, and Kuhn, 2002, and Kreutz, et al., 2004). Beck also found out that cortisol levels decreased in rehearsal conditions, but increased in performance conditions. This reflects to the stress involved when performing. For my thesis Cohen et al. made the most interesting study in 2006 and 2007. The target group were retired people. That singing group for the elderly met for two years and the aim was to investigate mental and social wellbeing. The data was gathered of health status, health service use and medication. After one year the group had higher ratings of health, fewer doctor visits, less medication, fewer falls and health problems when compared to the comparison group. Clift, Hancox, Staricoff et al. (2008) has done further annotations to this study.

The third category is studies of group singing as a therapeutic intervention for specific health conditions. These studies can prove that choral singing can promote health. For example Di Benedetto et al. (2009) find out that Parkinson's disease patients speech and voice skills were improved after attending to a singing group. The only study that has succeeded in proving physiological changes is made by Grape & Theorell (2009). They investigated how singing in a group reduced pain, and found out that after one-year weekly meetings, there was less pain. There is also an interesting study in natural setting in long-term care home where a singing group met twice a week. The result was that depression decreased notably.

In the fourth category is information about studies of group singing with people affected by dementia / Alzheimer's. Clair & Ebberts (1997), Korb (1997), Brotons & Pickett-Cooper (1994) have compared singing with other musical activities. They found out that

rhythmical activities were more effective, since it is probably that singing ability weakens dementia progresses. For these patients group singing's benefits are in increased social behaviour, singing is an effective tool for participations and group singing reduces anxiety and agitation. Many of the referred authors point out, that more researches of the issues need to be done. (Clift, Nicol, Raisbech, Withmore, & Morrison, 2010a.)

Silver Song clubs in England are meant to promote wellbeing and health with singing. The study began January 2010 and lasted till 2011. There were 200 participants over age 60years of age. They were divided into five singing groups and a control group. Singing group met weekly over a period of twelve weeks, 90 minutes at a time. Before the study started standardized health measurement were done, and three months following-up measurement as well as interviews after the study. The speciality of this study is in the outcome analysis where one point is a cost-effectiveness evaluation. The findings reveal that the project turn out to be 'Sing for your Life Ltd'. Sing for your Life Ltd is a non-profit company, which manages a network of Silver Songs Clubs across the South East of England. The authors wanted to mark out that even though there are music therapeutic nuances, the work does not need music therapeutic justifications, and in the group there are however different kind of needs, which cannot be guided by traditional therapeutic approaches. (Bamford, & Clift, 2006.)

The formative evaluation points out that the findings in the area of participators (for example enjoyment, improved well being and mental health, social interaction, cognitive stimulation and learning) support the previous researches made, and therefore proves that there is a lot of work to be done in this field in the future. One thing the researchers observed was the social exclusion, which correlated with depression and poor health. (Bungay, & Skingley, 2008.)

Clift et al. have examined the causes of the choral singing and wellbeing. Certain arguments were found for the benefit of choral singing. The participants reported of mental wellbeing and that being a member of the choir lifted one's self-esteem. Also family and relationship problems were forgotten for a while when harmonies were

heard. For example one singer told that she felt relieved from worries of relatives who had been taken ill. (Clift et al., 2010.)

There was significant health healing; one singer who had recovered from a stroke felt lifted spirits out of depression. Another said that she felt that these exercises were very good for her lungs. Recently bereaved persons got social and emotional support. They felt that singing was fantastic for their emotional health. Prevalent profits were feeling of happiness and raised spirits, which counteracted feelings of sadness and depression. When singing you can't be sad for long, and singing involves focusing and it makes one forget his troubles. Singing needs focusing on breathing and especially deep breathing. Very often breathing counteracts to anxiety and of course lung activity enlarges and relaxation is involved. Emotional states like anxiety and stress are both decreasing. (Clift et al., 2010.)

An important aspect is also the social support; friendship and social support are offered, and by this way feelings of isolation and loneliness are forgotten. Choral singing includes the aspect of education and learning. This keeps the mind active, and is a credit for cognitive functions. Further effects are in brain activity. The elderly reported that they learned new words and felt the symptoms of dementia repressed. Commitment to regular rehearsals motivates people to avoid being physically inactive. Going to rehearsal can start the daily activities and prevent staying at home for example watching TV as an old lady told. (Clift et al., 2010.)

Singing is not only a social event that stimulates and refreshes, evokes memories and has cultural meanings but also has many physiological effects. Singing has strong physical effect to posture, breathing, blood vessel, and it increases the brain activation. Surely other activities can improve the wellbeing of the elderly as well as singing. Based on the research by Grape et al. (2003), we can believe that singing works effectually, though. This study discovered that heart rate changes were significant for total power, and low and frequency power. This indicates for example cardio-physiological fitness, mainly in the outcomes of professional singers. Serum concentration of TNF-alpha

increased in professional singers but with amateurs the levels decreased. This blood sample indicates the stress level. Here we can point out that singing without a pressure has health promoting effects. In the same study there are more revival findings such as oxytocin concentrations and serum concentration of prolactin and cortisol increased, as well as feelings of joy, energetic and relaxed feelings after singing lessons. Singers felt singing meaningful for self-actualization, self-expression, and a way to release emotional tensions (Grape, Sandgren, Hansson, Ericson, & Theorell, 2003). Again we can read about the benefits of singing, these benefits show us how useful 'medical' singing at its best can be.

There are studies of singing that specified the psychological changes in wellbeing and health. One study was made for elderly people and showed the results of positive health impacts and reduction of anxiety and depression. The other study proves of mental and physical health improvement. (Clift, Hancox, Morrison, Hess, Kreutz, & Stewart, 2010b) Skingley argues that both of these studies have weaknesses both in methodology and analytics. She says that neither of the studies showed sample size in study power, and has lack of cost effectiveness of the intervention. Skingley et al. argue that their study is the first one to investigate the health benefits so, that the study is strictly designed and includes the cost effective evaluation. (Skingley et al., 2011.)

In England 'Sidney De Haan Research Centre for Arts and Health' has done considerably work in this field. The centre researches music and art activities in promoting wellbeing and health of individuals and communities. The current issues of the centre are in scientific research in music, in documenting singing for its wellbeing and health benefits, and in promoting the role of music and arts in healthcare and health promotion. They have established a number of projects such as 'Singing is Good for You', 'Voices foundation', 'Singing Medicine', 'Isle of Wight Singing for the Brain', and 'Silver Song Clubs'. One of the newcomers is 'Singing on Prescription'. My thesis is based on the idea of Silver Song Club. One goal of this study was to be replicated in a standardized form (Skingley, Clift, Coulton, & Rodriquez, 2011).

In Jyväskylä there was a singing group project ‘Laululla elämänlaatua senioreille’ (Improving the quality of life of seniors by singing). It was a pilot project based on the idea of the Silver Song Clubs. This project ended in December 2011. One of the main goals was to find a permanent model to make good use of music in wellbeing of the elderly. The work introduced in this thesis develops the ideas of ‘Laululla elämänlaatua senioreille’ (Improving the quality of life of seniors by singing) project.

3 AIMS

This study is an action research and a pilot research with a goal to develop a working model. The research question is how to create a model for therapeutic singing group for the elderly. An action research gives the opportunity for cyclic working. The main idea is to have a cycle of doing and reflection, and so to have the opportunity to change methods in order to find the best way to serve the group, and to work on the session. The goal is to develop group action, including the experiences of the group members and the leader. An important issue is the health promoting benefits that singing offers. The result of the research is to have a working model for the action, in this case for the therapeutic singing group for the elderly.

As mentioned before, this work is a continuum from the idea of the project ‘Laululla elämänlaatua senioreille’ (Improving the quality of life of seniors by singing). The idea and structure of the previous project was very useful and I saw when visited the group, how the participants enjoyed. When I explored the project more, some new ideas came in to my mind and I wanted to develop the ideas further. One of the most important ideas in my mind was how to get to a deeper and more intimate level with the participants.

I wanted to develop the idea towards more intimate and therapeutic direction. I must say, that the previous project had therapeutic issues included, but those were not visible. I wanted to develop a working model where the therapeutic elements of singing and songs would be consciously present. In this working model the participants are especially acknowledged as individuals, not forgetting the social aspect the group has. In terms of the content of the session the participants have to make their own inputs, not everything is given ready. In my opinion with the healthy elderly simple singing can be developed to a more challenging direction, in this case the goal was to fill up the lack of therapeutic visibility. This happened by given tasks to the participants. The participants

shared their history by introducing an important song of their life and the story behind it.

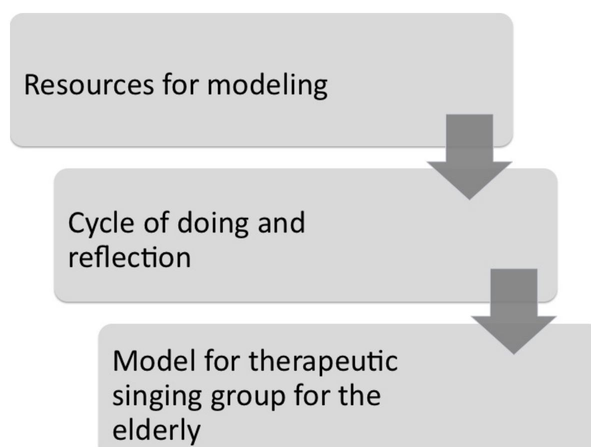

Figure 1. Development of the working model.

Clift and Hancox say, that all kind of arts can provide a way 'directly or indirectly, on one or more component of health broadly conceived' (Clift, & Hancox, 2001). In this thesis the action has a preventing perspective on wellbeing since the participating group had no pathological background. The aim is offer to the elderly activities with music. This way the brain function activates, memory is used and by playing and singing also motoric movement raises. The brain volume will become smaller during aging so activation is needed. There is loss in number of synapses and spines, and the neurons shrink, and that causes changes in the brain structure. Other changes can be seen in memory and functions as well as the myelin level will lower. Activation with musical exercises can reduce the risk of neurotic illnesses, keep the brain health better and improve health and wellbeing. All the functions will work better if the brain is working actively. (Johnson, 2011.)

According to Ahonen, with music therapy it is possible to reveal subjects, aware the subjects and to heal, after the subjects have been worked through. In case of the elderly music therapy goals are in: decreasing depression, increasing social interaction, increasing well-being, and physical functions, helping to reminiscence, helping to

orientate in the day, increasing self-esteem, feeling the life forth while, working through emotions. (Ahonen, 1993.) This working model has notified these matters.

One aim of the songs the participants shared of their life history was to travel in their lifespan. Finnish psychologist Tony Dunderfelt capsulizes life span as follows. Human development can continue through the whole life. Everyone's life is unique and an individual wholeness. Even though everyone's life is different there are some regularities like the phase of development, transition and common challenge in lifespan. Lifespan psychology is orientated in showing that there are potential phases of development through our life. Development phases can be understood better when reflecting to past phases, from childhood to adulthood and again to old age. Dunderfelt points out that older people also want to have the same acceptance as in the other parts of the life span. ‘People need throughout their lives someone or somebody they can ask questions, they need interest and love to touch their inner sides, questions and needs, also those unconscious ones.’ Dunderfelt says, that this interaction creates as a child as well as an adult and old age individually; it strengthens and builds the deepest part of our human dignity. (Dunderfelt, 2011.)

With reference to Dunderfelt's concept the working model used in this study can show caring and respect to the elderly. Also the participants can have the feeling of being heard as well as share and have acceptance. Hopefully, within this concept the participants have an opportunity to perceive their life and accept the events during lifespan and keep their memory functioning well. According to Dunderfelt these matters are important in a life review. Dunderfelt also reminds that remembering can be healing and creating relevance, remembering is not only going to the past since one can also find new matters from the past. (Dunderfelt, 2011.)

4 METHODS

4.1 Research methods

An action research has different kind of approaches. This study is based on the idea of a participatory action research. According to Kemmis and McTaggart (2003), the perspective on practise is to see ‘from the inside’, ‘insider research’. The researcher sees his / her work as an insider as well as an outsider. He / she has the perspective of individuals and of the social, subjective/inside perspective as well as objective / outsider perspective. The researcher also sees ‘ how things are’ and ‘how they come or came to be’. The researcher / participant needs to change him / herself to get changes, understanding and the practise has to change. The change comes through sine qua non of social change, through social movement. (Kemmis, & McTaggart, 2003.)

Kemmis and McTaggart have listed the key features of an action research: the participatory action research is a social process; the participatory action research is participatory, practical and collaborative. It is emancipator, critical, recursive, and aims to transform both theory and practice, including the self-reflective spiral. (Kemmis, & McTaggart, 2003.)

The participants are seen as individuals and as a part of a social structure. The starting point is subjective but it is taken into account that people have a historical way of acting. People are historically, socially, and discursively constituted. Kemmis and McTaggart continue that this kind of research includes a lot of social and moral philosophy, and theology. (Kemmis, & McTaggart, 2003.)

This research has the view of ‘practise as reflective’. This practise connects the thought of an objective and subjective practise. The researcher's role is to be one of the group and ‘a human agent’, as Kemmis and McTaggart say. This means that the researcher takes part in the situations that are already social, historical, discursively formed, and representatives of a tradition. The researcher improves his / her own work and looks at it from the first-person's view. The aim is to change the way of working through his own efforts, participatory and collaborative research. (Kemmis, & McTaggart, 2003.)

The participatory action research, ‘practise reflective’ method has multiple methods, several perspectives. The method has aspects of technical, practical and critical reasoning. (Kemmis, & McTaggart, 2003.)

The main point during this case study was reflection, particularly my own reflection to my work. My task was to realize the hidden matter in the sessions. I had to recognize the underlying themes and dynamics of the emotional content and thus the puzzle over the problem. As Heikkinen, a writer and a researcher of action research, crystallizes (this is a free quotation of what Heikkinen says) ”people live and work in the middle of tacit knowledge, even though they can’t describe, what they are actually doing. Learning will became more effective, when one can consciously think of wordless know-how and discuss it.” (Heikkinen, Rovio, & Syrjälä, 2006, p.34) Secondly, reflection took part after the session in the supervision with the supervisors and the fellow students. The discussions opened different views and interacted my work. According to Heikkinen, a reflective practitioner puzzles her / his work in action and on action. (Heikkinen et al., 2006, p.35.)

My clinical training had the structure of planning, doing, observing and reflecting, and reflection. At the same time working was aiming towards the future (to the next sessions) as well as having reflection backwards (to the important issues there were before), as a typical cyclic spiral in action research. All the parties involved had an impact to each other and thus the action between each of them reflected the process.

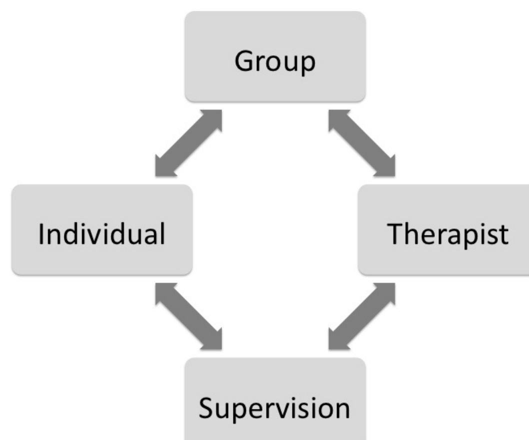

Figure 2. Interrelated reflected processes.

4.2 Methods of data gathering

Research results were collected from the clinical training diary, videos, the supervision of the work from the supervisors and the fellow students, and questionnaires from the participants.

I planned every session and made notes on my clinical training diary. There was always room for changes, a kind of 'carpe diem' attitude. I wrote down my own reflections to the diary and made memos on the feedback given in the supervision. I reflected my feelings and observations of the group and the issues discussed, and also the overall impression and spirit such as I experienced it. I mirrored to my writings and atmosphere, and I did changes concerning the content of sessions and my work. The diary was an important source and a bank for my session planning, especially when I was thinking of the goal to find the most suitable approaches for such group meetings.

The clinical training sessions were every time analyzed with supervisors and fellow students; we tried to find out which part went well and which should been changed. Therefore my clinical work got new forms and had a different direction within some parts of the session, and during the course of process. And, again after such a session, next supervision had an impact on my work. This way of collecting data in the cyclic spiral of action research worked well and helped me gradually find the best structure for the therapeutic singing group model.

Every session was videoed and it created background knowledge for my mind, and for checking important matters. Videoing is a good resource, since you are an active participant in the group sessions it is not possible to observe everything that are going on during the session. Video recordings enable you to do the needed analysis afterwards.

Participants filled the WHOQOL-BREF, quality of life questionnaire, musical background information questionnaire, and after all the sessions they gave free-form written feedback. (http://www.thl.fi/toimia.)

WHOQOL-BREF is the short form of the World Health Organization Quality of Life questionnaire. It measures four dimensions of life quality: physical, psychological, social, and environmental aspects. The participants filled the questionnaire two times, in the beginning and at the end of the process. (http://www.thl.fi/toimia.)

The musical background information questionnaire of Jyväskylä University's Music Therapy Clinic for Research and Training was also used. The questionnaire gives basic information of the clients background and her / his musical interests and favourites. The clients answered questions like, "How often do you listen to music?", "Do you attend some music activity?", "What's your favourite music genre?" etc.

Free form written feedback was asked to be sent to me after the sessions. Clients were asked to give feedback of their feelings and emotions, how they felt during the meetings, and what they liked / disliked, anything they wanted to share. Everyone sent an answer.

5 CASE STUDY

5.1 Starting point

The clinical training was part of my studies at the Master's degree of Music Therapy program. When I started my clinical training, the aim for the group was to have a pleasant environment to share the past and time, have social interaction, have joy, and to explore the benefits of singing. Secondly, there was the fact the researcher knows: singing improves wellbeing.

I was really open minded when I started my work. When I planned my work I thought that there would be a lot of singing. I hoped that my idea to have someone to introduce an important song of her / his life would open conversations. In that way I hoped to get deeper discussions during the sessions. As I have conducted choirs and bands, I was not very concerned how to manage with a group of ten people. Nevertheless, I was strongly conscious of the fact that if the participants open themselves, I have to be ready for the discussion and to the impact it has. I also thought that I have to be careful but ready for musical and verbal interventions. The group cohesion was also a very sensitive issue to me.

There were twelve sessions and the duration of each was an hour with an exception of the last 'close up' session lasting for one and half hours. The structure of the session was divided in to five parts: greeting, relaxation, vocal and rhythmical exercises, life span music and close up.

5.2 Participants

I got the participants for my clinical training came with the help from Taito Aivia, The Crafts Association of Central Finland. I sent an open invitation to the centre through a contact person and got four participants. The rest of the participants came from the singing groups of Kuokkala church. The cantor of the church told people about my study and so I got the missing persons needed. Altogether there were ten participants. Their ages were between 61 and 76, seven women and three men.

Most of the participants were active with music. They sang in the choir or in other scene, one of them took instrument lessons. There seemed to be difficulties with voices especially for those who hadn't been singing for some time. Some of them felt that now, as pensioners, they finally have time and opportunity to do some music. All of them attended concerts and felt that music has an impact to their lives. They commented the meaning of music to be *an important part of life, relaxing, very therapeutic, joyful and pleasant.* They also like singing and listening to music and they hope that music increases wellbeing and encourages to self-expression.

5.3 Through changes towards a working model

The typical cyclic spiral working was very beneficial for my work on this working model. The structure of the sessions stayed the same through time but the elements and time used in episodes of the session changed through the cyclic working. At the beginning of the session it was important to create the group cohesion. It was beneficial to use for example rhythmic exercises for this purpose. In the middle of the sessions the division of time to different elements changed. When people trusted each other, when the atmosphere was cosy, discussions were profound and took a large part of the session. That of course meant that the time had to be taken from some other elements, like from

rhythmic exercises.

Diverse thoughts in the supervision opened up many opinions. After every clinic day there was a supervision session for all the trainers. The structure of this kind of supervision was exceptionally intensive. These opinions made me draw conclusions and decide how to change and improve the session. Some of the exercises caused divided thoughts and made us to discuss them in the supervision. For example, one of the fellow students thought that it would have been impossible for her father to do an exercise like that (for example rhythmic exercise for learning the name of each other), but another said that she thought the group seemed to enjoy doing the exercises. These kinds of contradictions awoke discussion and questions, which made me think every issue thoroughly.

Concerning the sessions I had to do my own reflection and think about the feelings I had. Then after each supervision I had to decide which were the most important issues and who got the essence of the matter. I feel that even though the supervision was excellent and essential, not everything could be felt in the supervision rooms. For example, once there was a complete silence in the middle of the discussion, and someone asked me what had happened. He had an awkward feeling of the silence. But, in fact the silence was permissive and peaceful.

I have thought that these matters were very important for the development of the sessions. The feedback and puzzling over the matter helped crucially in developing the model as it was at the end. The cyclic debate over the session helped us so much that at the end there was nothing to be changed. The start of the sessions was exploratory, searching for the best structure. I can see how the sharing in the group increased towards the end. The first songs broke the ice and helped people to get to know each other. One of the participants said that she felt the genre of the first songs, religion ones, quite rigid. In her opinion the vocal and rhythmic exercises helped to break the ice and then sharing got to another level, it was easier to tell the others about your own history and to comment on the matter when discussing. Of course people have to know

each other, feel comfortable, before they can share life experiences. With the exercises and the first songs shared, group cohesion rapidly grew and the atmosphere was cosy. Through the cyclic working the episodes of the session took a shape of a practical working model.

In conclusion, there has to be participants who are interested in sharing, the atmosphere grows confidential, and participants can be at the same time individuals and members of a group. There were different kinds of problems during the work to be taken care of. Technical problems, with computers and audio, which, were easy to solve but which sometimes, had some functional failure. There were also disability problems like hearing problems, and how to take care of individual disabilities. Participants also had difficulties with their body, there were tensions, hearing and breathing problems, also illnesses. The activity of my verbal interventions and also the musical matters such as the pitch of the song caused difficulties. Research problems of the action research were to be faced, for instance how to present the results.

5.4 Episodes in sessions

The sessions took place in the clinic of the music department at Jyväskylä University. The people who attended the sessions were fairly unknown to each other. First we had to find the time to get to known each other. The members of the group were fairly open and quite soon we felt like being in our own singing group. I made it clear that all the discussion was totally confidential. I was a part of the group, not an outsider. My work was to lead the discussions, to make sure that everyone had a chance to participate, and of course to take response of the musical part. The major subject was to create a confidential and safe environment for the group action.

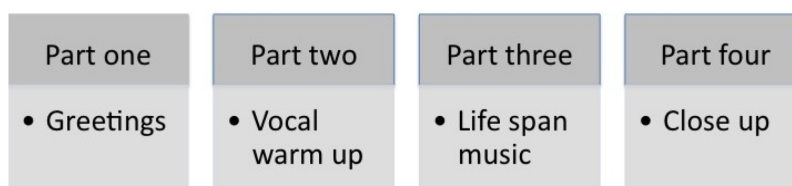

Figure 3. Parts of the episodes in the session.

Part one - greetings

At first everyone had a chance to tell how they were and if they wanted to unburden their hearts to everyone. After the greetings everyone had a moment to settle down. Everyone relaxed either by sitting on the chair or laying on the floor. There was always some background music and the lights were dimmed. Basic relaxation instructions were given, including breathing exercises. Sometimes in the end of this part we were holding hands and breathing at the same time, or standing back to back and breathing. Most of the exercises used in previous sections were meant to increase the group coherent and to give good, grounded basis for the sessions. I selected the background music very carefully and used a lot of time for choosing the most suitable music to be used. I wanted the music to be relaxing but at the same time lifting because the music selected had of course an impact on the action afterwards, and that of course interacted with my decision. The music was recorded, and the relaxation instruction were given to the group, except during the last session when everyone did the relaxation part by her / himself and I played the piano. I wanted the group to notice how they can do the relaxation by themselves and have something to take home, with.

Part two - Vocal warm up

The participants asked me in beforehand and during the first sessions to help them with their vocal difficulties. The basic information of the use of a healthy voice was given and

the participants had a chance to ask about their vocal difficulties. One of the main practises was to search how to breath well and how to get rid of the tensions they felt when using their voice. When the basics were clear the use of voice was freer. Sometimes after the relaxation we started immediately to investigate the voice by using a, o and u vowels. The goal was to use one's own voice freely and to explore where and how the sounds felt in the body. The exercise was made while laying on the floor, standing or sitting. During the last sessions we also had some improvisational parts. Usually improvisation started with the vowels but then every voice and sound was freely sung.

During the first sessions we had some rhythmic exercises, which were mainly used to get to know each other. These exercises helped the participants to remember each other names. There are earlier researches, which have proved that these kinds of exercises can be considered as being related to activating cognitive functions.

Part three - life span music

The idea of lifespan music in the group was organized so that everyone took turns in bringing along a song important to him / her. At first the one whose turn it was explained why the song is so important, what kind of memories and feelings the song brings to her / him. Then the song was sung, and after that there was an open discussion about the matter. The members of the group had a chance to ask questions, express their own feelings, and to compare the life situations discussed. This part was very therapeutic: a lot of memories were risen and they were worked, there was an opportunity of self-reflection. Also associations with everyone's own life experiences and physiological reaction such as crying and laughing were quite common. We were also able to discuss all the current questions in the group. After having the first topic it easily lead to next topic and so on.

Amazingly the therapeutic sharing of the song that was brought to the meeting and the story behind it took the most part of the session. At this point of the sessions only one song to be sung and discussed, maybe one close up song at the end or the sessions song was sung discussed; maybe one close up song at the end was enough or session song was sung again. As I mentioned earlier, I was prepared to have many songs during one session. That could have been therapeutic as well; the other participant could have had same kind of experiences as described before. However, when the participants are active, the sessions can reach the moment of deep conversation and even the allowable quietness. This was possible in this group, because of the trust, commitment, strong caring inside the group and an open mind interest to the matters discussed in the group. There were some absences during the sessions, but it is natural with elderly people who, for example, are willing to help their families. The group cohesion was so strong that even the absences could not harm it.

Part four - close up

At the close up all evoked themes discussed were wrapped together. The scheduled time limited discussions and even when the topics were still on the air, the intensive and intimate discussion had to be finished. Many very personal matters were raised up and several kinds of emotions and emotionally states and feelings were felt as well as physical reactions, such as crying and laughing. Because of that, it was important to make sure that everyone was in a good condition to leave the session.

5.5 Evoked themes

One way to analyse the action and the therapeutic outcomes is to checking the evoked themes and discussions. At the beginning of the session themes were a bit more general and changed to more private ones after the group cohesion and a profound

discussion was reached.

There were lots of memories related to the nature. Through these themes we travelled across Finland and abroad, and memories of childhood, marriage, work, holidays, hiking and beautiful sceneries and soul were shared. Another major issue we dealt were relationships. Topics like differences between women and men, relationships, widowhood, friendship, and social interaction. All these included life experience, which also was one of the topics. There were conversations of evacuee, religion, grandchildren, performances, life's joyful moments like celebrations, and life skills. Physiological wellbeing was an every day matter for the group members. It wasn't only one's own wellbeing, but also a constant concern of their own parents' or family members' life. Evoked themes raised, up from all the periods of participants life. Participants remembered their history and also the new topics in their lives. During the discussions it was often said, that '*it is the right age and time to experience something like this.*

During my internship a lot of evoked themes appeared. My own themes came up from my background as a music teacher. I didn't want to be a teacher, who's leading my clinical training group, but in the beginning the group members had for example vocal matters and they wanted me to help them with those issues. I felt that I was doing my work, though I should have led the process into another direction. In fact, at the same time I thought that it is good for the participants to loose their tensions. After the first couple of sessions I had already forgotten the teacher-aspect and acted like a co-investigator in the group. This change was possible after the group members had got some tips how to use their voice and we were able to move forward.

One issue was the actual working with the elderly. I felt it was comfortable while working with the elderly and luckily I had some experience of that beforehand. Since I have done a lot of work with the kids, I had to modify my work differently. A big issue for me was for example the rhythmic and vocal exercises. I had done most of the rhythmic exercises mainly with the kids. My minor experience with adults of this era made me doubt

whether these exercises we going to work. Although I saw that the participants enjoying the sessions, there were some doubts in my mind. In the feedback during our supervision there were conflicting opinions and debates about this topic. The free form feedback I got from the participants showed my doubts dispensable. The participants had been enjoying a lot the exercises and felt that they were also breaking the ice. I had to defend my view of the right to have fun throughout the life.

Therapeutically the most important task for me was to identify therapeutic elements and to handle musical elements. My pre-understanding of the case was various. I had experienced the benefits and pleasure of singing myself. The moment when you sing with others and you feel the harmony, togetherness and joy of singing is the most valuable result. Secondly, the physical feelings, bodily sensations and breathing you can get with singing, is really important. In these elements it was easy to give guidance and easy to conform myself. Although I did not have any working experience of therapeutic context, I had to learn to identify possible therapeutic elements and concentrate on different kind of methods. For me it was familiar to lead a group and to listen and talk to different kind of people. My attitude towards working with people is open hearted and open minded. However, I was leading a therapeutic group and I had to re-think what group leading actually means. For example musical and verbal interventions had to be thought after very carefully.

The support inside the group was vitally important. I felt that I had to challenge and support the group members at the same time, and to assure that the situation was comfortable for all the participants. The comfortable atmosphere made it easy for the participants to attend the conversations, and secured that every song they introduced was a right one. Not a single song was wrongly chosen. This was the way to successful work with memories, and with other topics as well. This way the participants were accepted as individuals as well as members of the group.

I had to decide what to do when someone was absent. First I thought that I try to recap what we have done, but I soon realized that because of the tight timetable I was not

able to do so. The group lived through session after session. Some remembering of the previous sessions or sharing was done afterwards, but mainly during the very last session when we were talking about all the sessions. The participants were so interested in the life stories / songs of the others that they said that it was a pity not to have an opportunity to be present every time.

It is not common to use your own voice freely, without any boundaries. If one feels difficulties in singing, is she / he ready to use her / his voice freely at all? We are used to singing but even that can make us feel a shamed. I was worried what the participants thought of the vocal improvisation used during the sessions. Vocal improvisation was used to help the participants to explore their own voice. That exercise helped the participants, and they felt it safe to use and were seeking their voice in the group. They also heard the harmonies created in the exercises. Bodily sensation as vibration of the vowels was also experienced and at the same time some mental pictures were seen. Only one person mentioned, that sometimes she felt it ridiculous to lie on the floor and to do the exercise. '*But when sitting, eyes closed the contact to the others was better and there was a feeling of doing together, it was therapeutic'*, she reckoned.

Nature
Travelling
Other countries
Life's joyful moments
Marriage
Christening
Childhood
Work
Life experiences
Evacuee
Life skills

Relationships
Differences between men and women
Friendships
Social interaction and changes
Family worries
Grandchildren
Widowhood
Physiological wellbeing
Illnesses
Performances

Figure 4. Evoked themes.

6 RESULTS

The results of this study are various. In this study, the term ‘life span music’ has been used as a working base. Firstly the result was that life span music, which is many times used as a non-participating model, developed to be an active music making in lifespan singing. Lifespan singing is a therapeutic process, which includes active music making. In this content the client is actively sharing his / her lifespan music by singing. She / he shares a song of his / her life and in that way he / she is an active participator. The participant has an active role as a person who shares and sings and she / he has both mental and physical experiences. Lifespan singing connects the past and the present by activating and evoking memories of one's previous life experiences. In this thesis it has already been said that Hayes et al. (2002) have reported the significant emotions, arousal changes, and associations that music can wake up. Music had the same results in this case study.

Secondly, as a result of my study I have developed a working model with the basic structure for doing music therapeutically and music therapeutic work with the elderly. This is a stabilized model, which includes therapeutic experiences, sharing, social event, association, image working, relaxation, own time, creative work and experiences like improvisation. Improvisation was the part, which I though could be hard for the participants to explore. In the end they found improvisation easy. As mentioned before Bruscia has said that in improvisation music can be both intrapersonal and interpersonal. Juslin and Sloboda also pointed out that group members grow gradually get confidence in free improvisation and in releasing feelings. They also learn that every kind of improvisation is correct, they also pass musical messages to each other. The participants liked the communication through improvisations, they felt it bodily and their imagination started working.

The results of this study have interfaces to earlier studies. Markku K. Hyyppä has researched the importance of cultural activities for wellbeing. The study was done at Ostrobotnia area in Finland. Hyyppä compared the Finnish and Swedish speaking population and found out that the Swedish speaking population lived longer. This population was more active for example in attending choirs. Also a study called 'Mini-Finland' showed that attending cultural activities diminished premature death. Confidential relationships and social relations were shown to be important. Both studies showed that cultural- and art activities are related to wellbeing. These studies also show that cultural activities have the same benefits as physical exercises. This means for ageing population that there are other activities beneficial for wellbeing. (Hyyppä, & Liikanen 2005.)

Hyyppä's research has shown that Swedish-speaking population is more communal, and the traditions from one generation to the next one are tighter than in Finnish speaking tradition. Hyyppä says, that traditions and cultural activities help to have supporting network between people. His studies have shown that singing in the choir has not only the musical but also social interaction good for wellbeing. (Liikanen, 2004) The participants in my study reported of the good feeling that participating, sharing, and singing resulted in them. They also find it beneficial to have new friends, and new social connections in their life.

Liikanen writes that the 'social capital' (from cultural activities) includes confidence. Confidence is needed in keeping the network and reciprocity together. In this case study confidence was a very important issue and appeared at the level of sharing, intimacy and evoked themes. Liikanen further argues, that confidence is an energizing power, which releases resources from defending one's development, target orientation and creativity. Confidence has a positive impact to health, and with the support of friends a strong positive impact against the negative feelings. (Liikanen, 2004) The participants thanked each other for the support they had received from the group. They found it very important to have the opportunity to have people to share their matters and to feel the caring. The participants also felt more confident to use their voice and sing among

others.

Hyyppä sees that when one has ‘social capital’ it has benefits for the health (Hyyppä, 2005). Hyyppä understands ‘social capital’ as the interaction between various levels of culture / history, environment, network and confidence, the circle of acquaintances / social support, pressure of the environment, involvement, contacts and material interests. All these elements are interacting in an individual's wellbeing and health. (Hyyppä, 2002) Participators of this case study had to do mirroring to these different levels. They looked back to their history and shared their memories, they remembered the different social and nature environments, and they had different kind of networks of friends, family, and work history. They remembered the difficult times in their life and the expectations and the pressure of the environment they have had.

6.1 Working model

The aim of the model is to give to the elderly possibilities to activate their brain and body, have emotions and raise up feelings, have a safe place to process life matters, and to have social activities. As told before, the participants found this kind of group important, and in their own opinion they thought it was therapeutic as well. To reach the goal the first element is to achieve group cohesion. Everyone has to be acknowledged as an individual and as a part of the group. For the individual participants the process is to find their own place in the group. After settling to the group there is another process to think how much one can open up him / herself and what matters can be brought to the discussion. The individual processes are going on during the sessions. Everyone's own sharing opens up memories and the sharing of the others opens new paths for investigation.

Because we were working with a small group, the group cohesion grew fairly fast. In the group procession the similarity between participants made it easier to get to know each other and to find a common ground, similarity between participants grew the group cohesion. A small group enables everyone's impact to the group and it is easier to communicate and to get your turn to talk, to participate. The participants were, I could say, at the same situation in life, and this made it also easier to get the group coherent, there was mutual understanding for every one's discussion topics. It is easier to share when the values of life and attitudes are quite similar. People of the same age have a lot of similarities in their lives. This does not mean that they all have similar opinions. They still have different kinds of life histories to share. On the other hand differences brake out the sessions so, that there were different kinds of opinions and lots of thoughts to talk about. Everyone gave his / her own contribution to the discussions and made them therefore more interesting. People usually stick to their habits. People started to sit on the same place every time. In this group we changed the places. That's because there were a couple of hard of hearing and also because I wanted to place the men voices in the vocal exercise evenly in the circle.

Participants	Therapist
Motivated	Takes care of everyone
Open heartedness	Helps people to get to know each other
Committed	Helps to brake the ice
Readiness to explore	Notices participants as group members and individuals
Members of the group	Creates a trustful athmosphere
Individual	Creates a pleasant environment
Willing to share	Carefully plans the opening and closing of the session
Care for the group	Solves timetable issues
	Helps the participants to choose lifespan music
	Acknowledges dissabilities carefully

Figure 5. Keywords.

In the conclusion, the group was as it was. It was not forced to any direction. The group took its time to shape. The advantages of a small group was that it was easy to start

conversations and quite easy to guide. Therefore the true feelings and opinions were easier to sense. The participants were energetic to talk and to listen to. If someone did not understand what the other one meant, it was easy to ask and to correct misunderstandings. My own part was to be a gentle leader, not an authority.

The WHOQOL – BREF, quality of life questionnaire, did not show significant changes. The questionnaire revealed that the state of life quality was good at the beginning and at the end of the sessions. This indicates the fact, that the participants had no pathological difficulties, and in fact the participants assessed their health to be good. The group was concentrated to investigating life span, and succeeded to go deep in personal subjects.

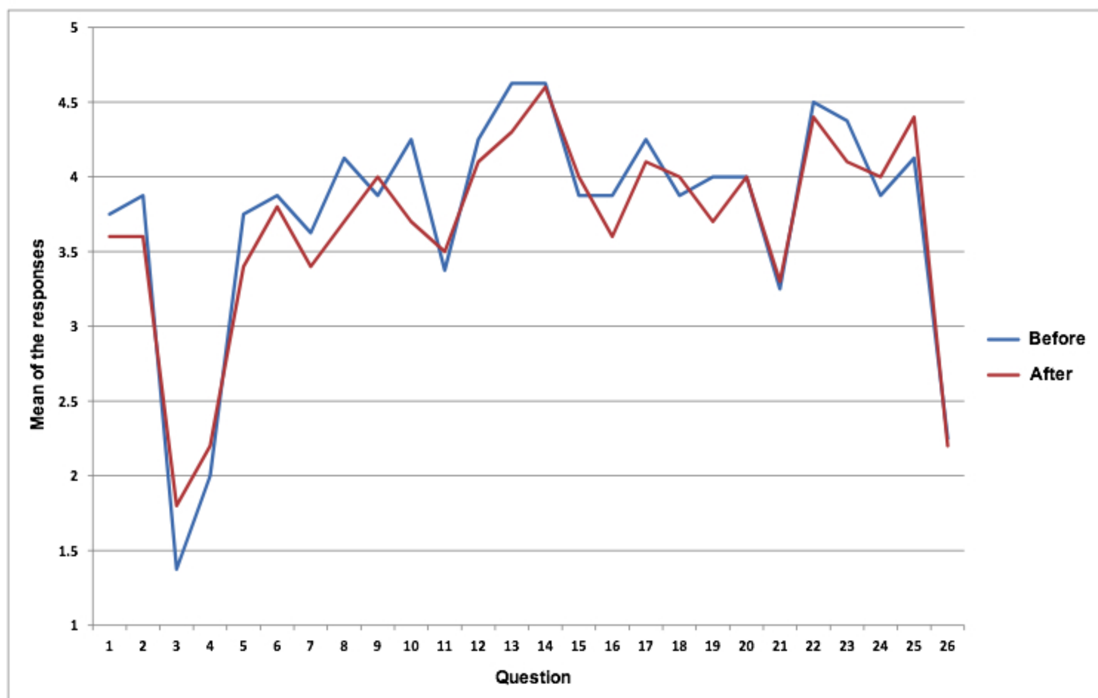

Figure 6. Mean of responses.

6.2 Participants' feedback

At the following the feedback is collected from the participants who attended the sessions at Jyväskylä University's Music Therapy Clinic for Research and Training. The feedback is collected from the free form written feedback and videotaped sessions. Each participant gave her / his own opinion in their personal feedback. Instead of focusing to each individual participant, the feedback is analyzed according to themes evoked. As the videoing was done systematically, it was possible to check the content of each session and to investigate the experiences of the participants.

> *'We were not in need of therapy when we started this group. We have built up trust and started to talk what we have wanted. We are not forced for anything.'*

Indeed, the starting point for the group was that it was not a pathological singing group, yet the group was based on music therapeutic elements. As it turned out, at the end and during the sessions the group was very therapeutic.

> *'Even hard matters, which you have not assimilated as problems, were said aloud.' 'Music, the songs shared, reminded me of the nice old memories, but also the sad ones.'*

One important matter was your 'own song', 'darling they are playing our tune' similarity (look Bunt and Pavilicevic at p. 11). Some of the participants revealed their own song. These songs had different meanings, to remember loved ones or to have a song to a certain moment. The latter one woke up feelings in the participants to find a song, which created strong emotions. The participants reported these feelings:

> *'With this song I always have a rage feeling, but it is a good feeling. With some*

helpful device I can do the dull tasks'. 'I'd be so happy, if I only could find such a strong song to wake up my feelings' so strongly.

Very often a song reminded of someone particular in owns life. All the songs were in a way or another, mirrors of the era. The participants had an opportunity to travel in their different lifetime. They were very interested in the stories shared. They wanted to listen and share people's experiences and thoughts. If someone was absent she / he felt it irritating not to hear the story behind a song and life matter of the storyteller. The group seemed to be harmonious and there was a lot of caring for each other.

Songs helped to get to know each other. At the beginning the sharing was shallow, but deepened hand in hand with the confidence of the group. I can see how a piece of music opened up their minds. Soon after the participants trusted each other and the session grew to a trustful atmosphere, they shared their life history. One of the main factors was the vocal exercise, which pointed out that everything is allowable. The participants reported in the open free form feedback, that the rhythmic exercises broke the ice. They felt that everyone made mistakes, but it was all right. These exercises also helped them to remember every ones names and to get to know each other.

'It is so that when you normally shake hands, you remember the names only for a while. The rhythmic exercise made it easy to remember every one's name.'

Vocal exercises gave courage to try out your own voice. There was quite a lot talking about the issue how, where and when to use your own voice. It seemed to be such a sensitive matter, to listen to your own voice. You needed some extra courage. With other singers it was comfortable to test your own voice. Your own voice combined with the others' voices, was a safe way to investigate how your voice sounds and works. Through the voice exercises there was a joy of voice, timber, harmony and images, which sounds created.

‘I felt the northern lights playing up and down.’ ‘When heard the tone of our mutual voices I was eager to develop my own voice stronger.’

Some of the participants said that they felt it much easier to sing in a public event after attending our sessions. They felt that it was easier to sing and they loved it.

The trust, which was built up, made the atmosphere such that the participants felt no limits in choosing the topics to talk about.

‘Rarely there are seldom situations where one can open yourself like this.’ ‘ I can do things (exercises etc.) that I wouldn't do anywhere else, I put myself on the line.’

The group cohesion was touching. It was so clearly seen how the participants supported each other. There was support and everyone was respected. The participants listened to each other carefully and showed sympathy with words and also bodily for example by touched the shoulder.

The session had a big social value.

‘It is nice to have regular activities.’ ‘It is obvious that we feel now separation anxiety, when the sessions are almost over.’ ‘It is nice to have new acquaintance, when getting older the friends are decreasing.’

The freedom of being yourself was felt very strongly.

‘I felt it therapeutic to use my own voice without boundaries, it was both liberating and had the feeling of doing together.’ ‘I think that all of you are very precious to

me. The atmosphere here, the feelings that you have given to me as a part of the group, is a wonderful thing and extremely valuable for me.'

The group made it possible to share their own artistic outputs, to perform their secrets to the others. It is often impossible to have a change or courage to perform for anyone even though there might be an inner flame for it. There are researched confluences to these matters. Johnson and Louhivuori (2011) reported in their study of retired choir singers, that 50 % of the participant felt that choir singing made them feel as a member of a group. 49% said that the choir singing includes artistic and emotional experiences and 48 % reported of the importance of social contacts. 11% raised up the feeling of the possibility to perform. The choir members who found group support important were culturally active and had therefore better psychological welfare. Johnson and Louhivuori point out the several benefits singing has: *Cognitive effects*, brains are active, for example one has to use words. Brain activity was pointed out earlier in this thesis to give the bio-physiological basis to cognition and emotion (Altenmüller, Schlaug, 2012). *Physical effects*, one has to for example breathe actively and control voice. It was mentioned earlier, that Clift and Hancox (2001) reported about relaxation, and stress reduction, and about the fact that music help to feel calmer, and music gives energation. *Social effects*, one belongs to a group and there it is possible to share memories and life matters. (Clift, & Hancox, 2001; Johnson, & Louhivuori, 2011; pls. see also Louhivuori, Siljander, Luoma, & Johnson, 2012.)

In addition to the study results displayed in participants' responses, there was a useful model to work with the elderly and a good opportunity to test it. During session we found a working structure. Relaxation, vocal and rhythmic exercises, participants' own songs presentation and singing it, conversation, singing, and close-up made the sessions fluent. Little changes to the structure are possible. After exercises there is a possibility to sing a song first and then present the song. In the close-up part it is possible to sing as well the presented song again or a song connected to issues discussed.

7 DISCUSSION

I have truly enjoyed doing this research and developing the working model. First of all, it was very interesting to do all the background work (information retrieval, clarifying the concepts, planning the sessions, finding the participants etc.) I had to make for getting familiar to my subject. The starting point was to do the thesis of the study of singing and to concentrate on the therapeutic scheme choir conductors have. Finally I chose another way of study singing as I dived in to the life of the elderly and to the research made in the Sidney de Haan Research Centre. My supervising professor boosted me to this direction and gave me the information of the similar work done at Jyväskylä, 'Laululla elämänlaatua'-'Improving the quality of life of seniors by singing', which was done with the elderly at Jyväskylä.

It was not easy to find trustful information of the benefits of singing. As a singer and as a leader of choirs, I know in my heart that singing is therapeutic and has benefits. But that is not enough. When I thought that I found an interesting and reliable information, the next finding crashed it. After investigating the researches I found answers and gathered a lot of knowledge on the matter. Even the difficult issue of brain function and research opened up to me understandably. There is a lot I have to study on this area in the future though.

The benefit of singing is an area, which needs to be investigated more in the future. There are reliable researches done on this field, and we can see how music works, but still there are gaps in the research area. Music, health and wellbeing as well as brain research is an interesting area, which undoubtedly will give us answers in near future. Cohen's et al. (2006, 2007) groundwork has shown good results on the well being of elderly and I hope that Lifespan singing could be one way to do such a beneficial work.

In this thesis, it is hard to testify the importance of the working model made. The sample was not big, only ten participants and there was not a follow-up group or other groups to compare the results. It would be interesting to have bigger samplings and to compare the results between groups in the future. As well it would be important and interesting to do individual follow up of the effects on attending a singing group. Since the sample in this study was so small no statistical analyses were done because the test would not have been reliable. The results show however that there are similarities to the earlier studies. The participants reported the same feelings as in some other studies like forgetting worriers, being happy about the new social connection and so on.

I find the developed working model very interesting and I am looking forward to use it in my work. There are interesting issues, which would be good to notice and developed in the future. The participants reported the lack of time in this study. The use of time was of course naturally based on our practising in the clinic, and the time was rationality used based on our study arrangements. With more time, there would have been more changes to discuss of the issues, raised through the songs and if needed to sing more songs.

Another appealing issue is that with a continuum of the session (this is realistic and probable likely) the participants could bring another song. Those who were the first ones to bring their song were not in an easy situation. No one knew exactly in which kind of the group they attended and the expectations were on the air. The participants who were first to share their song would probably take very different kind of song on the second round. Actually, the participants thought that if they had had an opportunity to bring another song the awakened thoughts could have been shared.

Some of the participants also felt that they would need more time to get deeply relaxed at the beginning. They liked the relaxation part and would have liked to have more of that. They reported that after relaxation the movements were better and they felt relaxed to start singing. It was important to keep the clinic’s schedule so I had to shorten the relaxation part to get more time to the discussions at the point when the group started to

be therapeutic and they needed more time for sharing, holding and talking. At the beginning of the sessions, when seeking the nice way of singing, more time would have been useful. These are all minor things inside the working model and thoughts, which can be taken in consideration. More time was needed for the actual sessions too. The model gives the structure within it is easy to do arrangements to that specific group one is working with.

Personally, I learned a lot about the guiding of a music therapeutic group. There are important issues to take care of: how to notice all the group members, when to use different interventions and the timing of intervention, when to interact to conversation, how to turn the conversation to the desired direction, how to grow the croup cohesion, and how to handle your own counter transference feelings. Of course this time my work included basic arrangements linked to the thesis, such as arranging the questionnaires, room, seats, and other basic elements.

I truly believe, that elements of art connected to therapy can bring joy into an elderly person's life. As Hyyppä argues: “If future surveys confirm causes and consequences of social capital in public health, we shall have more ground to argue that our view must be switched from current individualistic biomedicine to social connections and community behavior, or towards a more holistic perspective to better explain inequalities in health.” (Hyyppä, 2001.)

I hope that in this work it has became clear what the elderly living at home may enjoy, and how they can get regular activity which keeps them going, how to give the social aspects to their lives, not forgetting the therapeutic values. I hope that this kind of group activity for elderly could be one answer to support them and it fills the needs society has with growing number of elderly. I find music therapeutic approaches very innovative while working reminiscing and lifespan issues. I feel singing in this context very productive and beneficial.

Life is too short to be wasted, so let's sing it through.

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Figures

Figure 1. Development of the working model.
Figure 2. Interrelated reflected processes.
Figure 3. Parts of the episodes in the session.
Figure 4. Evoked themes.
Figure 5. Keywords.
Figure 6. Mean of responses.

APPENDICES

Appendix 1

Music used in relaxation in sessions

Name of the song	Artist	Album	Time
Sarastus	Lepistö&Lehti	Helsinki	7.03
A Little Child	Annbjørg Lien	Felefeber	5.49
Vihkimarssi	Tsuumi	Risteys	6.57
Haave...	Tsuumi	Hotas	5.48
Amaté Adea	Adiemus & Karl Jenkins	The Platinum Collection	5.21
Any Other Name	Thomas Newman	American Beauty	4.07
Sur Le Fil	Yann Tiersen	Le Fabuleux Destin d'Amélie Poulain	4.24
Satie: Gymnopedie No. 1	Roland Pontinen	Satie: Piano Music	3.57
Lovina	Maria Kalaniemi	Kevään kurjet	3.15
Lappfjard	Maria Kalaniemi & Timo Alakotila	Ambra	2.39
Hofmann: Eventide	Merja Yli-Tepsa	Piano Music	3.15

Appendix 2

The World Health Organization Quality of Life (WHOQOL) - BREF

WHOQOL-BREF

The following questions ask how you feel about your quality of life, health, or other areas of your life. I will read out each question to you, along with the response options. **Please choose the answer that appears most appropriate.** If you are unsure about which response to give to a question, the first response you think of is often the best one.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life **in the last four weeks.**

		Very poor	Poor	Neither poor nor good	Good	Very good
1.	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2.	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the last four weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3.	To what extent do you feel that physical pain prevents you from doing what you need to do?	5	4	3	2	1
4.	How much do you need any medical treatment to function in your daily life?	5	4	3	2	1
5.	How much do you enjoy life?	1	2	3	4	5
6.	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7.	How well are you able to concentrate?	1	2	3	4	5
8.	How safe do you feel in your daily life?	1	2	3	4	5
9.	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about how completely you experience or were able to do certain things in the last four weeks.

		Not at all	A little	Moderately	Mostly	Completely
10.	Do you have enough energy for everyday life?	1	2	3	4	5
11.	Are you able to accept your bodily appearance?	1	2	3	4	5
12.	Have you enough money to meet your needs?	1	2	3	4	5
13.	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14.	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
15.	How well are you able to get around?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16.	How satisfied are you with your sleep?	1	2	3	4	5
17.	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18.	How satisfied are you with your capacity for work?	1	2	3	4	5
19.	How satisfied are you with yourself?	1	2	3	4	5

20.	How satisfied are you with your personal relationships?	1	2	3	4	5
21.	How satisfied are you with your sex life?	1	2	3	4	5
22.	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23.	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24.	How satisfied are you with your access to health services?	1	2	3	4	5
25.	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to how often you have felt or experienced certain things in the last four weeks.

		Never	Seldom	Quite often	Very often	Always
26.	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	5	4	3	2	1

Do you have any comments about the assessment?

____

____

[The following table should be completed after the interview is finished]

		Equations for computing domain scores	Raw score	Transformed scores*	
				4-20	0-100
27.	**Domain 1**	(6-Q3) + (6-Q4) + Q10 + Q15 + Q16 + Q17 + Q18 ☐ + ☐ + ☐ + ☐ + ☐ + ☐ + ☐	a. =	b:	c:
28.	**Domain 2**	Q5 + Q6 + Q7 + Q11 + Q19 + (6-Q26) ☐ + ☐ + ☐ + ☐ + ☐ + ☐	a. =	b:	c:
29.	**Domain 3**	Q20 + Q21 + Q22 ☐ + ☐ + ☐	a. =	b:	c:
30.	**Domain 4**	Q8 + Q9 + Q12 + Q13 + Q14 + Q23 + Q24 + Q25 ☐ + ☐ + ☐ + ☐ + ☐ + ☐ + ☐ + ☐	a. =	b:	c:

* See Procedures Manual, pages 13-15

Appendix 3

The musical background information questionnaire of Jyväskylä University's Music Therapy Clinic for Research and Training

PERUSTIETOLOMAKE

Nimi: ________________________________ **Päiväys:**__________________

Ikä:________ **Sukupuoli:**__________________

I Siviilisääty: 1 naimaton 2 parisuhteessa 3 avioliitossa 4 eronnut

II Suoritettu peruskoulutustaso:

1 kansakoulu 2 keskikoulu 3 peruskoulu 4 lukio

III Suoritettu tutkintotaso:

1 ammatillinen 2 opisto 3 alempi korkeakoulu/AMK 4 yliopisto

5 jatkotutkinto:________________________ **Koulutusvuosia yht.**: _________________

IV Ammatti:___________________________ **Työvuodet:**__________________

V Musiikillinen tausta ja harrastuneisuus:

0 ei kuuntele, laula tai soita musiikkia

1 passiivinen/satunnainen kuuntelija

2 aktiivinen kuuntelija, kuinka paljon?:__________h/viikossa

3 konserteissa kävijä, miten usein?:_____________________(kuukaudessa tai vuodessa)

4 harrastanut laulamista, miten pitkään?:_______________

5 harrastanut soittamista, miten pitkään?:______________, instrumentti?:_________________

6 musiikillista koulutusta, millaista?:________________________, vuosina:________________

7 musiikkialan ammattilainen

8 mielimusiikki:____

9 mitä musiikki merkitsee sinulle:____

____

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