Exploration of the effectiveness and transferability of an English model of health promotion based on participation in singing groups for older adults (Silver Song Clubs) in Italy

by

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Declaration

I hereby declare that this thesis, whether in the same or different form, has not been and will not be submitted in whole or in part to another University for the award of any other degree.

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Abstract

Background
There is growing interest in the idea that arts and singing have effects on health, wellbeing and quality of life in older individuals. This study assesses the effectiveness and transferability to Italy of an English model of health promotion which promotes wellbeing and quality of life in older people through participation in singing groups (Silver Song Clubs). The model developed in the South East of England has proved to be successful.
A recently completed randomized controlled trial (Coulton, et al. in press) demonstrated a significant improvement in mental health with a reduction in measured anxiety and depression for older people living independently. The current study adopted the same measures.

Method
A mixed method approach was adopted with research divided into two parts; Part A was focused on exploring the status of older people living in Rome, their interest in music and singing today and in the past and in taking part in a singing experience. It also explored how local politicians and social workers see the status of older people. Part B was focused on setting up and evaluating singing groups and gathering information from participants on their experiences of singing. The primary outcome measure was an Italian version of the York SF-12 which provides scores for physical and mental wellbeing. The Italian version of the EQ-5D-3L questionnaire was also employed.

Results
Results from Part A revealed a highly fragmented Italian family, with widespread poverty and social isolation and a need for emotional support and leisure activities among older people. In Part B, three singing groups were established in different areas of Rome with weekly sessions over a period of three months. Participants completed the standardized measures of health and wellbeing at baseline (n=62), after the singing experience (n=45) and three months later (n=41). After the singing experience, older people showed a statistically significant decrease in their levels of anxiety and depression, but this was not maintained over the three month follow up period. However, a significant improvement was found from baseline to follow up in reported performance of ‘usual activities’.

Conclusions
Silver Song Clubs provide a health promotion model which was successfully transferred from England to the different cultural setting of Italy. Singing can be widely used because it is grounded in a fundamental human ability to engage with music. The present study had a number of limitations, primarily a lack of a control group and small sample size. However it provides a good foundation for the development of further research on singing and the wellbeing of older people in Italy.

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Preamble

This thesis describes the exploration of the effectiveness and transferability of community singing groups for older people in Rome, Italy. The initiative was based on a model of community singing for older people developed in England by the charity 'Sing for your Life' (Silver Song Clubs) and evaluated for their health and wellbeing benefits in a series of studies by researchers in the Sidney De Haan Research Centre for Arts and Health, Canterbury Christ Church University. The reasons that have led me to develop this study are manifold. First, my background, I studied music, at amateur level, for many years (from 10 to 17 years old), my first degree is in Law, I am particularly interested social justice in health policies and especially in health promotion and I have worked in Italy in the development of health promotion projects for older people. In addition to that I have known the Silver Songs Club Project from its real beginning and first development. In 2005, I carried out its first evaluation for my MSc dissertation and, during that time, I realized that the model was suitable for older people. The participants came from both the community and some nursing homes; furthermore some of them were in the early stages of mental decline and were experiencing memory loss problems.

One aspect that has been crucial in choosing this topic in the light of my professional experience was that many health promotion interventions focused on older people are concerned with those who are suffering from some disease, while little space is given, especially in Italy, to those who are still healthy. In my opinion, from a health promotion point of view, this is inappropriate. Interventions for the promotion of health care and the health of the population should be focused on all citizens and, in particular, on those who are more likely to develop disease, or represent a future concern from a public health point of view, such as older people are. Communities are often forgotten, older people in their homes have few occasions to make connections and to take advantage of their time in an appropriate way, health promotion interventions are focused on screening rather than on cultural and leisure activities. This was confirmed during my visit to the Italian Centri Anziani, venues set up in the 1970s as places where older people can socialize and meet. Their origin was driven by the growing demand of older people themselves for a venue where they could stay during the day. They were mainly set up by the local governments of each Italian city or village. The building is usually provided by the local government, which is also responsible for the payment of the main bills. At the same time, the local governments provide a little budget to satisfy the everyday needs of life at the Centro Anziani. During my visits to the Centri Anziani, I found there were many advertisements about medical check-ups on blood pressure or hearing impairment but none of them was focused on pleasurable activities (apart from those organized by the participants of the Centri Anziani who, of

course, know very well what is interesting and good for them). Bearing in mind that all health promotion strategies are important, my opinion is that older people in good health condition should be one of the main concerns and interests of health and social care policy.

The Sidney De Haan Research Centre has been engaged in a progressive programme of research evaluating the contribution of the Silver Song Clubs model in promoting the health of older people. A survey conducted in 2009 (Bungay, Clift and Skingley, 2010) provided a profile of clubs (n=26) and participants at that time. Findings revealed that average club attendance was 25 participants with 77% female and a mean age of 78.7 years (range 60-99 years). A qualitative evaluation, conducted around the same time (Skingley and Bungay, 2010) sought the views of a sample of participants (n= 17) in relation to their experiences of Silver Song Clubs, particularly in relation to the potential benefits on health and wellbeing. Themes emerging supported the value of the singing groups in terms of enjoyment, wellbeing and mental health, social interaction, physical improvement, cognitive stimulation and learning, and memory and recall.
The study explores the effectiveness and transferability of the model both in terms of transferability and of improvement of health and wellbeing. It will compare its results with both literature on the topic and a randomised controlled trial (RCT) which was undertaken to assess the effectiveness and cost-effectiveness of participative singing groups for older people more rigorously (Coulton et al., in press). Findings of the RCT showed a significant difference on mental health between the singing and non-singing groups at three and six months and, after three months, also on specific anxiety and depression measures. This is why I thought it would be interesting to explore the effectiveness and transferability of this well-constructed model of health promotion and to assess its application in such a different context as the Italian one.

Furthermore, the objective of this research is to add some knowledge to the study of singing and health, as a model of health promotion and health care. Some action can be taken on policies and social care to improve the quality of life and the health of individuals as a result of the implementation of the knowledge and study of new models of health promotion. New tools of health and social promotion which are low cost and have easy executive feasibility in different social and cultural contexts should be a concern of public health and international politics, especially when studies are focused on a topic as important as the health of the older people in an ageing society.

Therefore two main considerations have driven this study - the first is that in our ageing society healthy older people should be given more consideration and, for the second, good practices should be spread as much as possible.

1. Presently, there is great concern about older people with major diseases such as Alzheimer's or Parkinson's disease but little attention is given to those who live in the community, sometimes alone and, although healthy, have poor wellbeing.

   The social isolation experienced by older people is associated with the loss of the concept of community as conceptualized by Tönnies (2011). He dichotomizes the concept of a group of people into two distinct aspects - community and society. According to Tönnies (2011), the community is made up of people who share beliefs, strong personal relationships and strong family ties where the family is the first and perfect community. Instead, society is something mechanical and the authenticity of the relationships of the community no longer exists. The individual becomes more detached, first of all from the family; coexistence in society is based on the division of labour, by rational norms, efficiency and the clear distribution of tasks. In addition to the claims of the above scholar, it can be said that there is a loss of the community concept, stated as a form of coexistence constituted of relations, in which each individual is recognized, recognizes the other and implements supportive behaviours in modern societies. In this study, particular emphasis will be given to the role of the family in modern society in general and Italian society in particular, since the first community, as stated by Tönnies (2011), really is the family. Observing that, in Italian society, the family, conceived just as described by Tönnies (2011), with all its corollary in terms of support, reciprocity and help, is disappearing is an important aspect which should be taken into account. This scholar classifies three different kinds of communities - kinship (blood community), neighbourhood (community place) and friendship (community spirit). Older people have lost (or are losing) all three kinds of communities.

   Beyond the concept of family, the source of real informal welfare in Italy, older people experience worldwide problems of social isolation, poor wellbeing and health; their condition may deteriorate, on the one hand because the social isolation and lack of relationships have a negative effect on their health status and, on the other, because the absence of a diagnosed health condition eliminates them from many health promotion activities which are devised for specific problems.
2. The second point refers to those instruments of health promotion that have a demonstrated ability to improve the health level of the people who are involved. On this point, there is growing interest in sharing policies and good practices at European and worldwide level.

As far as the concept of good practices is concerned, this can be defined as a set of actions, projects, policies, initiatives and innovative experiences which can help improve the quality of the performance of a subject. More specifically, best practices in health promotion allow actors of health promotion to learn from the positive experience of others, looking at key aspects at once and identifying the reasons for the success of an intervention to promote health.

As said above, one aspect that should be mentioned is that not all expertise or good practices are transferable. More specifically, there are some tools which can be transferred almost entirely from one country to another without actually losing their essence and/or efficacy, and others which cannot. In the case of health promotion policies, the socio-cultural aspects and political structure (i.e. how health and social care works) of each country should be taken into account because health promotion cannot ignore the context and must be compatible with it to operate properly.

However, starting from the fact that there is a need to share best practices as much as possible in all areas, it should be underlined that this is not always possible. There are a number of barriers (technological, legislative, cultural and social) that make the transferability of good practice difficult, if not impossible. Notwithstanding the above, an attempt to transfer what has worked in another context seems necessary. The WHO (2012a) clearly makes the point about the need to circulate not only the evidence in Europe, but the knowledge and best practices in order to implement and better address actions and interventions on social determinants of health. All this without forgetting the inherent difficulties that may be encountered in transfers and "The need to address different cultural, historical, political and social contexts" (WHO, 2012a, p. 43); social policy and practical problems should be properly taken into account (Azarmina et al. 2008). The report "Addressing the social determinants of health: the urban dimension and the role of local government" (WHO, 2012a), considers the role of local government in the social determinants of health and once more stresses the problem of evidence and transferability.

In the case of this research, the model of health promotion that has been transferred is deeply connected to the culture as it is based on singing and songs. While important, culture is a difficult concept to define. Culture is a set of so many heterogeneous elements that it makes it difficult to decide what is predominant over the other. The cultural aspect was therefore held in high regard during the development of the study, at different levels, and therefore not only in choosing the songs, but also and above all in the approach to the institutions and participants to the experience and research.

One aspect that must be considered before proceeding with the description of the work presented here is that Italy is not a country where the choir was started and developed, but it is much more focused on an individual 'virtuoso' singer around which Italian opera has rotated from the18th century onwards. In agreement with the view taken by Surian (1988, p. 107), the focal point of reference in a work setting or Opera "was [...] the interpretation that the virtuoso singers gave to the drama". The stereotype that all Italians are good singers interested in music probably started with opera which, originally, as mentioned above, was mainly structured around a single singer and not a choir or chorus.

This is in stark contrast to Protestant nations. In the 16th century, there was the schism between Catholicism and Protestantism which had strong repercussions on music. After the break with the Church of Rome in 1519, Martin Luther wanted to create a new liturgical way to involve believers during the service, more than occurred during the Catholic service. This view was distant from that of the Church of Rome, which delegated music only to ecclesiastical musicians; indeed from an architectural point of view, the choir in a Catholic church was an area separated from worshippers. Martin Luther undertook a very important task - to give access to all religious texts, translating liturgical books and endeavouring to create a wide repertoire of religious songs that would involve worshippers more during religious services (Surian, 1988).

Structure of the thesis

A brief outline of the thesis is drafted in this section. The first four chapters aim to build a framework into which the research subject of the thesis is inserted more specifically, the first two chapters will give a wide range of data and an analysis of social and health policies about ageing at English, Italian and European level. These two chapters are aimed at giving a scenario into which the study will be inserted. The third chapter is focused on the analysis of a number of key concepts related to health. Concepts such as health, wellbeing and quality of life should be clarified, as these are all important and crucial as well as being difficult to classify due to their multi-factoriality. The fourth chapter is focused on the concept of arts, health and wellbeing and, more specifically, on music, singing and wellbeing. The use of these tools for health improvements at both community and individual levels is analysed, especially taking into consideration the research on singing and older people.

The fifth chapter mainly describes the method with a small section of the practical process of translating the project from the UK (England) to Italy. The study was conducted using a mixed approach - qualitative and quantitative, and dividing research into two parts namely Part A and Part B. Part A aimed at informing Part B, and Part B develops the model in the Italian context. Part A used qualitative research tools and was conducted through the use of

semi-structured interviews with professionals (politicians and social workers) involved in management of the older population, as well as interviews with older people in order to assess their daily lives, the relationship with music during their life and to identify interest in participating in singing groups. The second part of the study (Part B) was constructed in the light of the findings of Part A and consisted of setting up and organisation of the singing groups. Both qualitative and quantitative methods were chosen in this second part of the study in order to assess the effectiveness and transferability of the health promotion model analysed.

Chapters six and seven describe the results first of Part A of the research and successively Part B. The results of Parts A and B are discussed separately and then reconnected in order to have a general picture of the study (Chapter eight). Implications, recommendation and future research, limitations, reflection on methods and overall conclusion are also included. The conclusions drawn throughout the study and from the experience of the researcher are highlighted in the final section.

Chapter 1.

The Challenges of an Ageing Society

1.1. Introduction

This chapter is aimed at addressing two main issues - on one hand figures and data which show current demographics trends worldwide particularly at European level, in Italy and the UK, on the other, it is concerned with highlighting current theories which trace how people age and perhaps how they should age. Data on ageing deserves attention because a clear and complete picture of the ageing phenomenon can be obtained in the most appropriate way through its analysis.

There has been growing interest in understanding and drawing the delicate passage between adult life and older life since the 1960s. The main question is how an individual should approach older life, should s/he stay at home and withdraw from society or should s/he stay engaged and enjoy life? Clarifying the right approach to older people is not only important for individuals but also for policy-makers and researchers into health promotion and public health as well as social care. This is so that interventions can be developed which both make sense for the targeted population and have a positive effect. Another important issue to have a clear picture of older people's lives is the analysis of retirement, a real milestone of every individual's life. It has an intense effect on individuals' lives and this must be analyzed at both social and economic levels. This discussion will provide part of the context for justifying the value of setting up singing groups for older people in Italy.

1.2. Ageing society: A global perspective

One of the most important demographic changes on a European and worldwide level has been the ageing population. The World Health Organization defines ageing as a "process of progressive change in the biological, psychological and social structure of individuals" (WHO, 1999 p. 4). Ageing can be seen in two different ways - on the one hand, it is certainly an immense achievement of medicine and society (Kinsella and He, 2009) and, on the other, it can be seen as an enormous problem in terms of provisions for health or social care services. An ageing population, such as that of Europe and more specifically Italy and the UK, is a severe social, health and economic issue.

There are distinct groups into which older people should be sub-divided. One suggestion is a distinction between 'young-old' (from 60 to 85 years old) and 'oldest old' (85 and over) (Kinsella and He, 2009). This is an approach but older people can be divided into other

categories - those for whom there is, for instance, multi-pathology, depression and non-self-sufficiency, and the older people in good health condition who live this part of their life without such serious challenges. Obviously, the concern of the scientific world is with the first group and the risk of depression, social isolation, poor quality of life and all the related costs for the social and health system. This growing group significantly affects the level of health expenditure because spending is considerably higher for older people than for other age groups. Besides that, the phenomenon of single-person households made up of older people is a very important feature of our age and our society, because these individuals experience poor quality of life and health.

As a preliminary consideration, it should be underlined that the so-called 'health transition' exists worldwide and includes, on one hand, demographic changes and, on the other, epidemiological changes. The world and Europe, in particular, are ageing for a number of reasons – among them the growth in the number of people aged over 65, and the decrease in the number of children together with the improvement in health conditions (Goll, 2010).
There has been a shift worldwide from high birth rates, high mortality and short life expectancy to a very different situation i.e. low birth rates, low mortality and longer life expectancy. In other words, nowadays the patterns are exactly the opposite to those of the past when there was a strong relationship between fertility and mortality - they were both high, generating equilibrium in the shape of the population. The process underlying global population ageing is known as the "demographic transition", a process whereby "reductions in mortality, particularly at young ages, are followed by reductions in fertility" (United Nations 2009, p. 4). The patterns, as seen, have changed radically due to a number of cultural, medical and sociological variations; at first, mortality rates decline but fertility rates remain high and, as a consequence, the population starts to increase. Successively, there is an inversion and fertility rates firstly stop growing and successively start to decrease. In the meantime, the continuing improvements in life expectancy (e.g. due to improved medical care and quality of life) make life longer and the population begins to age.

The above is the starting point for looking at 'epidemiologic transition', the theory first developed by Omran (1971), which shows that when rates of mortality decrease and income increases, the existence and significance of communicable disease decreases compared to other causes (Salomon and Murray, 2002). Omran's theory (1971) is related to a number of conditions such as improvements in nutrition, housing and living conditions, hygiene and medicine. In the light of this, epidemiologic transition leads the population to have chronic degenerative non-communicable diseases in both developed and developing countries (Kinsella and He, 2009) as one of the major causes of death. Such diseases progress over a

very long period of time, leading, as a consequence, to governments concentrating a considerable amount of resources on the support of these people throughout the course of the disease until death. Furthermore, this situation leads to a rise in the old-age dependency ratio; in other words, there is an increase in the number of people (mainly older ones) supported by the working population.

As has been seen, fertility levels are one of the key factors determining the current situation. It is important to underline that is highly unlikely that fertility rates in the E.U. will rise again in the future, therefore population ageing is an irreversible trend in progress for the 21st century at least (United Nations, 2009). In other words, the total fertility rate is at present below the so-called replacement level, which means that the number of babies born is insufficient to replace the number of people dying, and this leads to a reshaping of the age structure of a country. According to Kinsella and He (2009), projections made (at the time of writing) indicated that "in fewer than ten years, older people will outnumber children for the first time in history" (p. 6).

Certainly, it should be noted that not all countries are experiencing the same problems and that, in developing or less developed countries, the population is still young, just 9% is 60 years old or more; therefore, at the moment, these countries have to deal with the problem of ageing to a lesser extent (United Nations, 2011a). However, Marmot said, "It is convenient, but quite wrong, to think that the growth of the world's population is an issue only for the richest countries" (Marmot 2005, p. 1101); although population ageing is, as said, currently less, nevertheless, a number of countries "are poised to enter a period of rapid population ageing" (United Nations, 2011a p. XX).

The graph below displays the trend in life expectancy at birth worldwide, in more, less and least developed Regions according the United Nations definitions (2001) (Figure 1.1). This shows a gradual rise in life expectancy all over the world where higher values can be found in the more developed regions over the whole period.

In addition to all the above, this process appears very rapid. According to the United Nations Report World Population Ageing 1950-2050, the number of older people tripled from 1950 and will more than triple again in the next 50 years (United Nations, 2001). Up to this point, two main factors (low birth rates and longer life expectancy) have been underlined to understand the process of ageing. In partial contrast to the claims so far, Blangiardo (2008) believes there is a third factor in addition to those already mentioned which leads to an ageing society. This is the fact that, with the succession of generations that gradually reach the threshold for entry into the older group, considered as a normal and logical consequence with so many being born in the past, there will be many older people in the future.

One aspect that usually tends to be underestimated when dealing with the issue of ageing population is that the inputs in the older group, will however, and for a long time, be more than the outputs. In other words, all those who were born immediately after the Second World War entered the older people group in 2010; there will then be a stable situation that will change when the baby boomers become 65-year-olds.

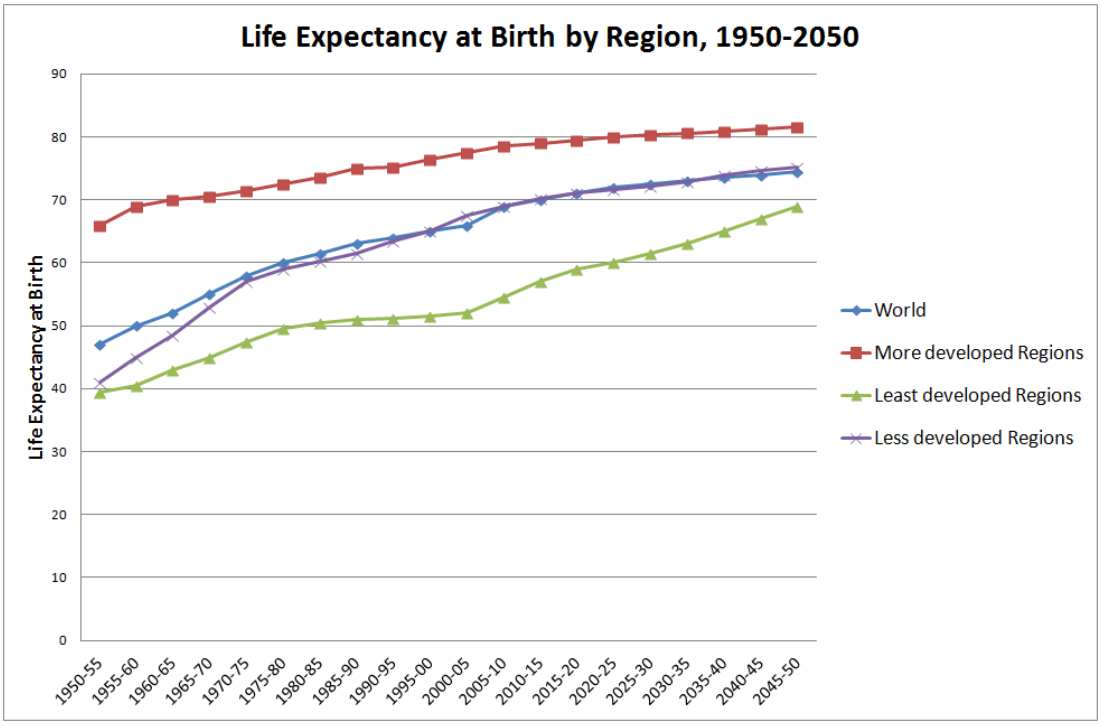


Figure 1.1 Life expectancy at birth by region, 1950-2050

Source: U.N. World Population Ageing 1950-2050- elaborated (United Nations, 2001)

The Report of the United Nations, World Population Ageing 1950-2050, provides an overview of the process of population ageing, focusing on the many aspects of the process itself according to geographical differences where this phenomenon arises (United Nations, 2001). The patterns of Europe – the oldest world region with the highest ageing index (Kinsella and He, 2009) - show "the highest proportions of older people, projected to remain so for at least the next 50 years" (United Nations, 2001). In Italy, for instance, more than 20% of the population is aged 65+ with 33% projected for 2050 (United Nations, 2001).

Moreover, within the group of older people the proportion of 'oldest old' (individuals 85 years old and over) has increased significantly. Kinsella and He (2009) report that the section group of oldest old group will increase, according to the projections, by 233% between 2008 and 2040. Furthermore, according to the demographic data of the World Population Prospectus (United Nations, 2011a), the 'oldest old' form 14% of the age group of 60 years old and over.

In addition according to the report World Population Ageing, 2009 "about one in every seven older people, over 100 million people, live alone" (p. 30) (United Nations, 2009). Starting from the point that the assessment of an ageing population is a key aspect for economic, social and health policies around the world, the projections that have been made should certainly be taken into consideration. It appears crucial to understand how projections are calculated, in other words there should be clearly defined factors that have been considered in making projections. Projections are mainly based on the level of fertility; Lutz, Sanderson and Scherbov (2008) point out that population projections only based on the level of fertility may be sufficient to determine the general level of world population but are, however, insufficient to determine the level of increase in the numbers of older people, as the projections do not also consider longevity. Therefore, Lutz, Sanderson and Scherbov (2008) take into account not only fertility but also longevity (life expectancy) and make a comparison between the usual projections and those calculated with their method. Interestingly, the study shows worthy aspects - the patterns of median age of world population are clearly of growth for both methods but there is a significant different in values (Table 1.1).

Table 1.1 Ageing Population according to UN Report 2007 and Lutz, Sanderson and Scherbov Calculations (2008)

Year	UN Report Median Age World's Pop.	Lutz calculations Median Age World's Pop.
2000	26.6	26.6
2050	37.3	31.1
2100	45.6	32.9

According to the Lutz, Sanderson and Scherbov (2008) projections, the number of older people will therefore increase but to a lesser extent.

1.3. Ageing society: The European picture

Up to this point, the account has been concerned with population trends in the world; now it is appropriate to look at Europe and, more specifically, Italy and the United Kingdom in order to clarify both their ageing level and to compare it. As a preliminary, an aspect that should be emphasized is that Europe is certainly an older continent in comparison with the whole world. In Europe, few countries boast a high level of fertility (Eurostat, 2012); moreover, the level of dependency ratio (which is an age population ratio indicating the part not in the labour force [the part is made up of two groups, 0-14 years old and over 65 years old] and those in the labour force [the part between 15 and 64 years old]) in Europe in comparison with the rest of the world is certainly connected with the above. According to the Eurostat 2012 data, "the Eu-27 old age dependency is projected to reach 29.5% by 2060,

higher than the 7.3 point average of the world" (p. 43). This will have serious repercussions on the resources of governments.

As far as the Italian situation is concerned, Italy is perfectly in line with the data mentioned so far, as illustrated by Figure 1.2. Italy, in common with the rest of Europe and the world, is facing an increasing number of older people in the population. In the light of the above, according to Blangiardo (2008), the ageing population in Italy will tend to stop, because when the generations with low birth rates (from the 1980s onwards) enter the older age group, there will be more output than input and this will lead to a population balance.

Eurostat (2012) data (Table 1.2) indicates that Italy is the oldest country in Europe with the highest percentage of people over 80 (6%) while the UK has a percentage of 4.7%, exactly that of the European average (EU 27 states). As far as the level of individuals between 65 and 80 is concerned, Italy is above the European average while the UK is below it. This is connected with low fertility rates in Italy, which are a consequence of the lack of relevant, significant pro-family policies (Gal, 2010). Figure 1.2 shows estimates and projections of the population aged 65 in Italy displaying the high, medium and low variants of 2010. According to the 2010 Revision of the World Population Prospects, the projections are based on fertility projections (United Nations, 2011a). Looking at the red line, the average of the projections, there is a peak around 2045, after a stable consistent rise, then there will be a decline, until mid-2070, before reaching a stable line.

Table 1.2 Main socio-demographic indicator Europe 2011 (elaboration on Eurostat data)

Nations	% >65 <80	%>80
EU (27 Nations)	12.7	4.7
Belgium	13.4	4.9
Germany	15.3	5.3
Greece	14.2	5.1
Spain	12.1	5.0
France	11.4	5.4
Italy	14.3	6.0
Netherlands	11.6	4.0
Austria	12.7	4.9
Portugal	13.6	4.6
Finland	12.7	4.8
Sweden	13.2	5.3
United Kingdom	11.9	4.7

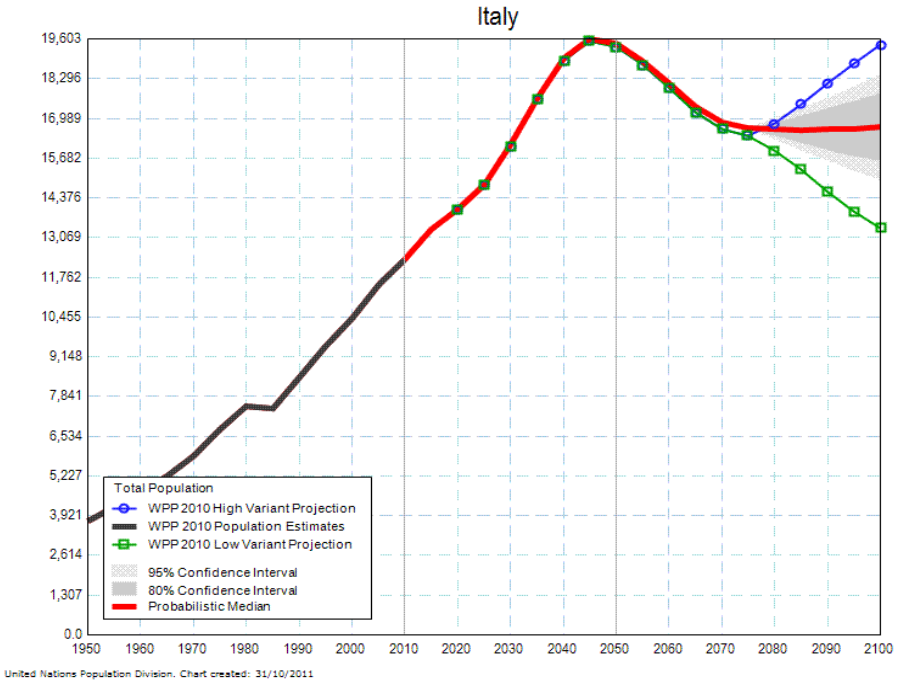


Figure 1.2 Population aged 65 in Italy 1950-2100

Source: United Nations, Department of Economic and Social Affairs, Population Division (2010): Population projections using probabilistic projections of total fertility and life expectancy at birth, based on a Bayesian Hierarchical Model (BHM), New York (United Nations, 2011b)

Figure 1.3 shows estimates and projections for the population aged 65 in the UK displaying the high, medium and low variants of 2010. In Italy, it can be seen that the projections show a dizzying marked climb to 2045 with a subsequent fall to mid-2070 while the UK shows a different pattern, with more constant and steady growth that does not reach a peak and continues after 2070. In numerical terms, Italy will have a greater number of 65-year-olds in 2050 compared with the UK, and then there will be a reversal of patterns with a greater number of over-65-year-olds in the UK.

In the light of what has been said, Europe should worry about this section of growing population in the near future, especially in the so-called old Europe, which will lead to radical changes in society and in the social health of the nations concerned - older member states and new ones - where lesser growth of the older population can be observed (Goll, 2010).

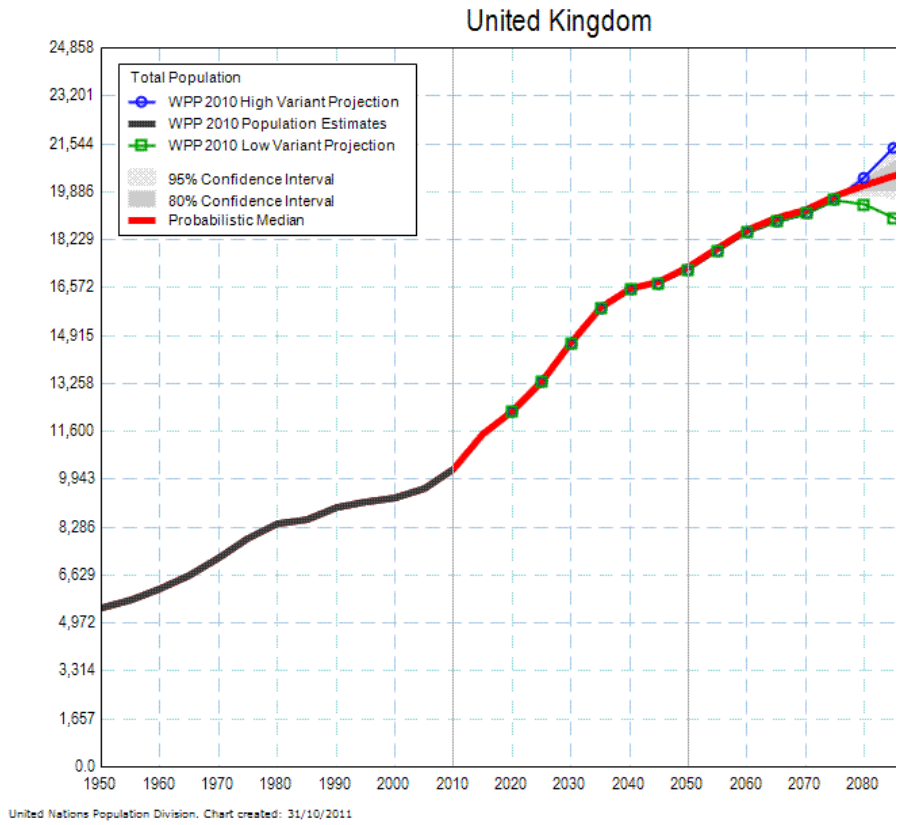


Figure 1.3 Population aged 65 in the UK 1950-2100

Source: United Nations, Department of Economic and Social Affairs, Population Division (2010): Population projections using probabilistic projections of total fertility and life expectancy at birth, based on a Bayesian Hierarchical Model (BHM), New York (United Nations, 2011b)

1.4. Theories of ageing

In the light of the above, older people live longer and it is therefore convenient to mention a number of theories which trace how people age and perhaps how they should age.

According to the literature (Franklin and Tate, 2009; Agahi, Ahacic and Parker, 2006), there are three major social theories of ageing - the disengagement, activity and continuity theories. In the 1960s, the theory of successful ageing was formulated by Havighurst (1961), in definite contrast with the disengagement theory (developed in the 1950s). The latter argues that ageing is accompanied by a gradual and inevitable tendency to retreat from and abandon social roles and, basically, to prepare for death. In addition, this relocation is not carried out only by older people but also by society, which takes older people out of the job market. In other words, there is a mutual estrangement - the individual from society and society from the individual. This theory was subjected to strong criticism (Franklin and Tate, 2009). First, it was pointed out that there are many older people able to successfully adapt to new conditions; further, theories should not be developed in a generic way as there are a huge number of variables which play an important role, not least being the person's character

or gender, for instance. Certainly, it can be said that the disengagement theory was largely based on a stereotyped view of older people, and because of this could be weak and open to attack.

The successful ageing theory claims that it is essential for older people to lead a life as active as possible to have be healthier in old age. The designation ‘successful ageing’ coined in the 1960s was the starting point for the development of a number of theories about this section of the population that, more than 40 years later, include biomedical and psychological points of view. More recently, Atchley (1989) developed the theory of continuity which better illustrates the arguments made by Havighurst - starting from the fact that one of the essential aspects for good ageing is the level of activity of the individual just prior to ageing. In other words, there must be continuity between pre-ageing and ageing so that there is not a fracture ‘before’ and ‘after’. More specifically, Atchley (1989) argues that, in old age, the individual maintains more or less the same habits, in terms of preferences, relationships and behaviour, the more the individual maintains his/her habits, the more he/she will experience successful ageing. According to Franklin and Tate (2009), the two theories mentioned above highlight that “any declines in social interaction among ageing adults might be attributed to decreased health and physical function as opposed to an intrinsic need to withdraw from society” (Franklin and Tate, 2009 p. 7). In other words, older individuals do not want to leave society but it is more likely that the decline of physical or mental condition leads to less participation in life.

In the early 1990s, there was a further shift in theories of ageing. Baltes and Baltes (1993) argued that optimal ageing actually consists of two elements - maximizing gains and minimizing losses. Therefore, the ageing process comprises a parallel development of losses and gains, which is why good ageing passes through the maximization of gains and minimization of losses. In other words, the individual adapts to the new situation in ageing, changing their life to mirror the changes that ageing itself imposes.

Notwithstanding the above, taking into account that the said theories have a clear and reliable foundation and their main aim is to build a clear framework, it seems necessary to note that there is a main point that must be reiterated while accepting, in the main, what the scholars mentioned above have expressed. The issue is stereotyping. Victor, Scambler and Bond (2009) state that older people should not be treated as a problem or consider only the most negative aspects of their lives; it is important to underline that ‘older’ is neither an archetype nor a stereotype. On the contrary, it is made up of a plethora of different nuances and, more specifically, two of prime importance - health and economic level. These theories

clearly suggest that healthy ageing requires good levels of health and social integration and, even if the older person wants to pursue an active life, he/she would be in great difficulty in the absence of these two elements.

The stereotyping of the older is largely dependent on the type of social construction of the society of old age - ageing is an individual process, as said, there are differences that must be taken into account based on gender, race and ethnic origin (Walker, 2004). There are many factors influencing the ageing process, while genetic factors and the occurrence of disabling diseases can speed up mental and physical decline, other factors may favour the older. These include education and cultural level, which offer excellent tools for the adaptation to life after retirement, thus allowing the creation of transformation strategies, economic wellbeing and high levels of interaction and communication also lead to this.
The main point is that older people should not be placed in a homogeneous group.

Victor, Scambler and Bond (2009) point out another important fact, older individuals today live a different life than the older people of yesterday and have had to adapt to something completely new. If, on one hand, older people are more active in life and have generally better health status, living longer than their grandparents and developing as a consequence expectations about the number of years they have to live. It is equally true that they have had to absorb very significant social changes which have profoundly changed the structure of the whole society. The authors take Britain into account but those underlined are social changes that also touched (perhaps more deeply) Italy. The changing role of women, who are now much more integrated in society, laws on divorce and abortion that have greatly changed the social structure of the family, and, of course, also the economic welfare of years ago has diminished family ties instead of increasing the external ones. What these authors have developed is easy to share, especially considering the last point; economic welfare has made families more distant. Conversely, at a time of economic crisis, there is more probability of feeling the need for family ties as well as aid from the connection with the family. On the other hand, the family is fragmented, as will be explained later; furthermore, it is affected by the economic crisis and is unable to reconstruct itself in order to support all the members of the family and especially the older people.

1.5. The challenges of retirement

As stated above, retirement is of great significance in the older person's life, partly because after the first signs of physical ageing, it is the first real separation from active people, at least in job market terms. Starting from the fact that job satisfaction and employment have a

positive value, and that, according to Diener (2000), 'job satisfaction' is one of the elements which make up wellbeing, when individuals stop working, they not only lose one of the activities that primarily fill their day, but they also lose an important part of their wellbeing. Considered in this light, retirement could be seen as a very sensitive moment in an individual's life, in accordance with what Drentea (2002) claimed, "retirement is associated with lower levels of wellbeing because retirees are missing the benefits of employed work" (p. 169). Further, there is a strong distortion of routines with retirement; spouses accustomed to seeing each other only in the evening and at weekends are forced to share the day, days which are often quite empty, especially at the beginning. This can certainly lead to frustration and lack of wellbeing, but it must be remembered that retirement can also be seen as a time of relief from all job-related stresses. The ageing of the population has been and, in the years to come, will once more be the main factor leading governments to change social security systems in the direction of strengthening their financial sustainability. The attempts across Europe at raising the age limit for access to pension benefits serve both as a functional response to the increase in life expectancy and a strategy to counter the drastic reduction in the average age at retirement and thus eliminating the reduction in the participation rates of older age groups.

Further, an aspect that should certainly be considered is that retirement is not always voluntary, especially recently. There are growing numbers of older people who are driven to early retirement to make room for younger workers or to decrease the job related costs for public and private companies, and this has a very different effect on the individual in terms of acceptance and coping. Forced retirement is similar to unemployment; the individual wants to work but cannot (Bonsang and Klein, 2011). Beyond the psychosocial effects of retirement on the individual, it is important to stress the intense effects on the economic level.

Satisfaction with income after retirement has a fluctuating trend in quite a complex way. According to the study conducted by Bonsang and Klein (2011), satisfaction with household income increases after the first five years of retirement and the authors suggest, borrowing to some extent Baltes and Baltes's (1993) theory, older people adjust to the new situation, i.e. the new economic entry level and therefore do not experience great discomfort. However, contrary to the view expressed by these authors, older people experience great poverty in the UK and Italy with very intense consequences on their psychological wellbeing. There is general agreement in the literature (Kim and Moen, 2002; Montizaan and Vendrik, 2010, and Wang, Henkens and Van Solinge, 2011) that research on the combination of retirement-psychological wellbeing has given mixed results. Halvorsrud and Kalfoss (2007) report "a paucity of attention [...] to assessing important areas such as transition from employment to

retirement" (p. 230), with pieces of research showing on one hand an increase in depression after retirement while on the other not finding any relation between depression and retirement.

This leads to a wide range of considerations connected to the above, once again the older people are not a homogeneous entity and that the individual aspects and characteristics have a strong influence. Therefore, retirement can be experienced in different ways, in consideration of gender differences, but also, and above all, professional position with economic capacity and so on. More specifically, according to Wang, Henkens and Van Solinge (2011), there are five major factors which can contribute to retirement adjustment, "individual attributes, pre-retirement job related variables, family related variables, retirement-transition-related variables and post retirement activities" (p. 209). Reichert and Weidekamp-Maicher (2005) quoted by Walker (2005) maintain that the key factors influencing positive wellbeing in retirement are "a positive attitude towards entering retirement, a high degree of achievement in previous employment, conflict-free, entirely voluntary transition and a high level of wellbeing before retirement (optimism, emotion stability and a positive view of old age) as predictors of subjective wellbeing after retirement" (p. 16). This aligns with the theory developed by Atchley (1989). Further, retirement can lead to great disappointment, it is perfectly possible that the idea the individual had about their time as a retired person will, in reality, be completely different leading to the said disappointment, due to a number of reasons such as the change in their physical and psychological state, social engagement and economic level.

1.5.1. Mental decline and memory loss problems

As a preliminary, in this study it was decided not to use the term dementia but use 'mental decline and memory loss problems' in order to avoid any stigmatization, nevertheless all quotations from the literature report the term dementia.

An important issue that should be mentioned within the broader concept of 'ageing society' is that of mental decline and memory loss problems. The increase in the rates of individuals with mental decline and memory loss problems should be mentioned, and also that long term diseases which afflict mainly older people have a significant weight on social and health policy as well as health spending (Bernard, 2000). In the last 30 years there has been growing interest in it, seeing the number of people affected and the socio-economic impact that those diseases have on global health spending. Given the fact that "research identifying modifiable risk factors of dementia is in its infancy" (WHO, 2012b p. 2), health promotion on the issue should be focused on mitigating and on delaying the effects of these diseases..

One aspect that should be taken into particular consideration is the impact of mental decline

and memory loss problems on this section of population; the rates of individuals affected by these problems increase with the rise in the number of older people worldwide, “dementia is the major cause of disability in later life” (WHO, 2012b p. 8). Among all social and health related problems which can affect older people, these disease have a strong economic impact and can be defined as a real health and social care emergency encompassing the entire society. According to WHO (2012b), there are currently 35.6 million individuals living with mental decline and memory loss problems; this number will double by 2030 and more than triple by 2050. According to WHO (2012b), the costs of mental decline and memory loss problems amount to US$ 604 billion, which represents 1% of Gross Domestic Product in the world. Further, there are 7.7 million new cases worldwide each year. In the light of statistical data and projections, the Report encourages countries not only to take care of the most eminently practical aspects of mental decline and memory loss problems but explicitly pushes nations to "improve the social wellbeing and quality of life of those living with dementia" (WHO, 2012b p. vi). Older people who have to take care of their partners with mental decline and memory loss problems are in real danger at physical and emotional level.

Considering the above, the scientific arena has focused its attention on assessing the impact of social engagement on mental decline and memory loss problems. Several pieces of research have shown that having social contacts and meaningful relationships, as well as participating in cognitively stimulating activities, are associated with a reduced risk of mental decline and memory loss problems(Fabrigoule et al., 1995; Fratiglioni et al., 2000; Wang et al., 2002; Saczynski et al., 2006; Akbaraly et al., 2009). According to Saczynski and colleagues (2006), people between middle and older age who have a lower level of social engagement have a higher risk of mental decline and memory loss problems. This is in some way connected with what Atchley (1989) claimed, i.e. that the period immediately before the ageing process is a crucial one, and where the fracture between before and after is significant, the individual can experience a lower level of wellbeing and quality of life. Akbaraly and colleagues (2009) are even more specific in their study - “persons [older people] engaging in stimulating activities [...] had 50% reduced risk of developing dementia over the 4-year follow up compared to a person who engaged in such activities less than once per week” (p. 858); Hao (2008), for instance, said that being active and taking care has beneficial effects on the wellbeing of older people. “Activities in general and interpersonal activities in particular are beneficial for psychological wellbeing because they offer channels for role acquiring that supports sustaining one's self concept” (Hao, 2008 p. S64).

To sum up, the stereotype of older people as a section of the population leading issues and problems should certainly be avoided, taking into account that these people are still ‘useful’ to society; retired people should not be expunged by society because of the idea that they cannot

make any contribution to it, mainly because an older person who moves out of society and whose quality of life is impoverished effectively becomes a problem for that society.

In 2008, Kanström and colleagues highlighted on how many levels older people are an important resource within a community, giving the examples of education, family and society, work, taxes and wealth. The older section of the population can be a resource in all these different labels - "the older have accumulated resources both human and social capital" (p. 24). In addition to this, the authors underline that older people still contribute with money (through taxes) as well as "non market resources (such as social capital) to family, friends and society" (p. 24). Life expectancy has certainly improved, but it is crucial to keep in mind the significant difference between life expectancy and healthy life expectancy; HALE, health life expectancy is a "population health indicator that combines mortality and health state utility score" (He, Muenchrath and Kowal, 2012 p. 4). HALE then measures how many years of life an individual can live without disabilities. Starting from the fact that the task of health promotion is to improve health rather than lengthen it, the tools of health promotion, especially those focused on older people, should be developed bearing in mind this perspective.

1.6. Chapter summary

The number of older people is growing steadily; therefore, this is a section of the population that health promotion should be concerned about. The assessment of ageing is not a linear extension, i.e. it is important to evaluate and analyse how individuals grow old and which aspects of health promotion should be addressed by policy makers. One aspect to be emphasized is that old age essentially consists of three levels: biological-physical, psychological and social. Therefore, all three aspects should be taken into consideration in understanding it (=ageing). Ageing is a progressive situation featuring progressive decline in physiological and biological system over time. In addition to physical and mental decline, the older person experiences a very large number of changes in priorities, retirement, economic conditions and social contacts, all of which have a strong influence on their lives. Retirement should be considered a real milestone in a person's life - a radical change of life and habits. When individuals retire, they are easily put aside, the world in which he/she starred as a worker, even in the short term, becomes one to which he/she belongs less and less; the metamorphosis completes its cycle, regardless of the geographic location of the individual. Italy and the UK are not markedly different, and both have a growing number of older, with needs that are at least comparable if not identical.

Older age, especially at a historical time in which older people is generally healthier than their predecessors, should be lived actively, with older people integrated into the community

as much as possible. As a consequence, the theory developed by Havinghurst (1961) perfectly fits the present context in both Italy and Britain. In the light of this, the next chapter will analyse and critically evaluate the policies of the two countries and Europe as a whole to clarify whether these policies are appropriate and how these are addressed.

Chapter 2.

Health Promotion Policies: Europe, Italy and England

This chapter aims to review the main policies to support older people, both at the national level, in Italy and England, and at European level, pursued by the European Union. As noted in the preceding chapter, the number of older people is increasing and therefore it is necessary for a large number of policies to be activated to help this section of the population to enjoy the best health status possible. Policies should be focused on health promotion as well as the treatment of pathologies, in the light of the fact that public funds are finite. The demand for care in the older section of the population is an incisive, particular challenge in both Italy and the UK as the number of dependent older people is growing.

Hoff (2008) displays the diamond of welfare, adding to the state, the market, the family and the voluntary sector (Figure 2.1).

According to Figure 2.1, welfare production is the result of the outcome of these four elements; the loss or weakening of one or more of these elements leads to correlated weaknesses in welfare production and a number of negative consequences.

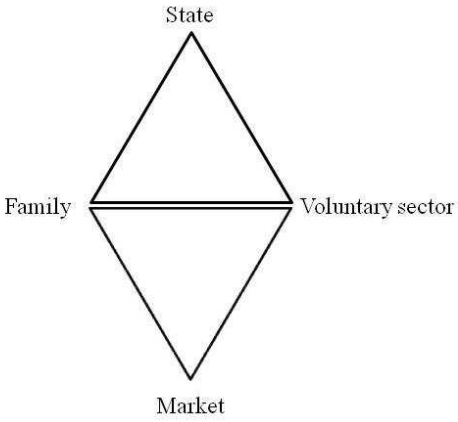


Figure 2.1 The division of labour in welfare production ('welfare diamond') (Pijl 1994 quoted by Hoff, 2008)

2.1. Health policy: General

Firstly, and in the light of the above, policies focused on older people are particularly difficult to develop because older people, as has been said, are not a homogeneous group but vary widely. Furthermore, in the light of the scarcity of economic resources, the most crucial point from a policy perspective, and even more from an economic one, is to identify effective health promotion and health care interventions. Russell and Schofield (1999) argued that public policies, programs and services for older people are often not designed in

consultation with them but more often thought up by professionals who state what the right solution for this target group is. Therefore, one of the key concerns of health promotion is designing interventions which are effective and actually respond to the needs and desires of the users; in other words, which are not just effective and well-constructed in the minds of those who create them but are effective, welcomed and give results among those who are destined to receive them.

The growing number of the oldest old and the rising percentage of older people living alone entails concern for public policy in terms of providing assistance and care because these people have the greatest need for social care. It is essential for governments to consider the above-mentioned trends and their projections because older people are the largest single group of patients using health services. In addition, it is worth considering the consequence of the growth in the number of this section of the population in terms of funding not only health care, social support and health promotion for older people but also in terms of retirement rates. Thus, the growing number of older people and the theory of successful ageing are the starting points for stating that policies which promote social inclusion are as crucial as those that promote physical health. Countries across the world face the need for more targeted provision for this social group, particularly those enjoying good health for their age but socially isolated due to the social-cultural changes in the family structure that will be analysed later in this chapter. This has had, and will have, important social and health policy repercussions. The growth of the older population and its implications for public finances and health policy raises the question of whether health promotion "influences the underlying aetiology of intrinsic disease processes (e.g. delaying the age of onset) or only modifies the expression of intrinsic disease (i.e. delays the age of death)" (Carnes and Olshansky, 2007 p. 370). This is an important consideration that should be borne in mind, especially for older people. However, the most appropriate answer is to say that health promotion deals with both aspects. By analysing the two concepts, both contribute in different ways to adding to both quantity and quality to life, delaying the outbreak of a disease or absorbing the worst effects of disease on quality of life.

At a time of global economic crisis, it is more likely that policy in Europe, and particularly in Italy and the UK, is targeted towards financing services considered fundamental (medical and pharmacological treatment) and not towards the older population's other needs that may appear less pressing. In this regard, it is important to consider whether the economic crisis in Europe could reinforce a medical perspective on health. This is because, on one hand, there are conditions where pharmacological intervention is crucial and it is impossible to use alternatives, but there are also important aspects which affect wellbeing and the perceived

quality of life, such as opportunities for physical, mental, social and creative activity needs to be promoted.

2.2. International health policy

This section is aimed at highlighting both the role and thinking of international organizations and their policies on older people. Analyzing international organizations is important because are independent bodies that develop a significant role on Public Health and Health Promotion at European and worldwide level drawing up guidelines as well as focusing on and drawing attention to different issues. These bodies are able to look at the issues in the most neutral way and can show Member States how health promotion and care should be developed.

In keeping with the above, the first time the United Nation focused on the problem of ageing was in 1982 during the First World Assembly on Ageing held in Vienna. Twenty years later, the Second World Assembly on Ageing, held in Madrid, reaffirmed the principles stated in Vienna (United Nations, no date). The Assembly of Madrid produced more than 100 recommendations (political declaration and the Madrid International Plan of Action on Ageing), which focused their attention on three main themes:

1. older people and development,
2. advancing health and wellbeing into old age,
3. ensuring and enabling, and supportive environments.

More than 10 years ago, the above themes referred to a wide range of activities which should be developed in Member States in terms of social and health policies with respect to their demography, economy and culture. The idea was to give guidelines which should then be adapted to the context of the individual country starting from the fact that all Member States were experiencing problems, although at different levels, with the growing number of older people. In the last 20 years, a number of initiatives have contributed to growth in the international proposal; in the 1990s, several resolutions addressed issues, problems and projects for older people (United Nations, no date).

The European Union also has an important role in giving guidelines and plans to improve the life condition of older people. Article 25 of the European Union Charter of Fundamental Rights (2000/C 364/01) states that, "The Union recognizes and respects the rights of the older to lead a life of dignity and independence and to participate in social and cultural life"

(European Union, 2000). This article says a lot about the interests and concerns that member states have towards the older population of Europe and, interestingly, it sums up a wide range of messages, dignity, independence and participation in social and culture life.

First, there is the need to age with dignity, a concept that can be seen from many points of view - philosophical, social, legal and so on (European Union, 2000). Immanuel Kant (1991) made a distinction between value and goods, dignity not being goods but a human value; goods are subject to economic evaluation, and therefore, dignity, which is not subject to economic valuation, is undoubtedly not goods but a value. Beyond the philosophical thinking, law protects dignity; human rights (life, health and dignity) have been a central concern of law since the firsts attempt by mankind to frame it. The growing interest of mankind and governments at national and international level is evident from laws developed in history which have flourished, in particular, since World War II.

Continuing the analysis of the Article, the European Union shows that it is concerned about the independence of older people, which is an aspect that should be one of the main aims of health and social policies of European Member States. The Article in analysis states that older people have "to participate in social and cultural life" in other words, the European Union is worried about social isolation and its consequences as well as recognizing the contribution that social life and participation in culture, in its broadest sense, can make to older people.

In 2008, the Parliament and European Council designated 2010 as the Year for Combating Poverty and Social Exclusion with Decision No. 1098/2008/EC. The European Commission implemented the decision, calling on each Member State to develop their own national programme, to be submitted for evaluation and approval by the European Commission with the Strategic Framework Document on 'Priorities and guidelines for the activities of European Year 2010' (European Commission, 2008). Although the onset of the crisis was in its infancy in 2009, the WHO Regional Committee for Europe adopted a decision (EUR/RC59/R3) to encourage health systems across Europe to continue to maintain free and universal access to health for citizens of the various member states (WHO, 2009). In 2011, the European Parliament and European Union took Decision No. 940/2011/EU of the European Parliament and Council on the European Year for Active Ageing and Solidarity between Generations (European Union, 2011). A number of common concerns motivated this decision: a) increasing ageing as a challenge for society and all generations (points 6 and 7 of the decision), b) the need to promote active ageing in order to "realize their [older people] potential for physical, social and mental wellbeing" (point 9), c) the European Union

had been concerned about these problems for a long time (points 12, 14, 15, 16, 17 and 19), and d) issues on the achievement of the objectives of the European Year [for Active Ageing and Solidarity between Generations] must be addressed by common policies and strategies (point 30). A series of documents relating to this decision was produced such as, for instance, a brochure listing funds as well as policies, activities and projects in Europe so that there could be the greatest possible access to funds and also knowledge between Member States (European Union, 2011).

2.3. Italian health policy

2.3.1. Italian social structure

Before analysing health and social policy in Italy, it would be appropriate to give a preliminary outline of Italian social structure and how older people are part of this. As has been seen, Italy and the UK are experiencing the growth of the older population, and both have to deal with the problems indicated above in terms of social care and health care spending. The two countries have a number of aspects in common, as seen previously with respect to the growing number of older people, but they have a very different cultural context and one of the main elements of this is the structure of the family and its role. Cultural differences in family structure have a significant part in all research, especially with regard to the way of life of older Italians and this will be discuss in deep later. According to Dalla Zuanna (2001) and Tommasini (et al., 2004), there is significant diversity in the family structure and living arrangements of older people in Europe "with generally higher proportions of older people living with a child in southern Europe" (p. 54); moreover, their study shows that parents in Italy have more contact with their children than those in the UK.

Bordone (2009) claims that the role of the family has changed in modern societies; it has "either been replaced or reduced" (p. 361). However, the family plays a fundamental role in society, especially in an ageing society because the first support for the older person is his/her family, partner or children, both when they are in good health and even more when the individual is experiencing poor health. This is especially true in countries where welfare and social care are less developed or where the family still has an important social role as Italy is. According to Gesano (2008) just 250,000 older individuals live in nursing homes in Italy. In addition, Italy has a low level of fertility yet, as claimed by Tommasini, Glaser and Stuchbury 2007, this has not affected the behaviour of the family structure. Italy still has considerable availability of family care support. This is because families in Italy tend to be 'physically' close, which means that in Italian culture, if parents can afford it, they help their children in the purchase of a house and this is often as close as possible to their own (Dalla

Zuanna, 2001; Bordone, 2009). This is with the idea of mutual help, on one hand the older people help the new family in the management of grandchildren and, on the other, children will help their parents, they will be their informal carers throughout the period of old age. This is what mainly happens in wealthy families but, of course, in families with a low income, it does not and there are a number of consequences; further, it should be borne in mind that the above is what Italian families of all economic levels would like to happen or, even better, what happened until the last decade. Today, at a time when the economic crisis is ravaging the middle class, this happens less and less. According to Tomassini, Glaser and Stuchbury (2007), "the availability, quality and cost of formal services are likely to have a significant effect on the use of formal or informal support" (p. 849). Conversely, in the light of Böhnke's statement (2008), this consideration is far from true - according to empirical studies, "welfare state support does not necessarily prevent private solidarity" (p. 134). Despite this, and especially in the light of the analysis carried out by Gal (2010), it can be stated that Mediterranean area nations, including Italy, have similar socio-political characteristics (strong religious feelings and family presence, and a strong patronage relationship in politics) and this leads to a series of choices and effects including "fewer resources, relatively low level of expenditure, and weak support for the poor where there is a major role for the family and religious organizations in the provision of welfare" (p. 296).
According to Kinsella and Velkoff (2001), the UK and northern European countries generally have a more developed system of health care in comparison to Italy. In addition, in the last 15 years in Italy, there has been a growing number of foreigners (mostly female) taking care of older people at home (particularly those suffering from mental decline and memory loss problems or chronic disease).

The problem of supporting older people is not negligible, and seems central in this discussion starting from the fact that national health systems are limiting more and more resources (Glaser, Tomassini and Agree, 2009), although the older population will grow and grow alongside the number of older people with chronic degenerative disease. Family solidarity in Europe, in agreement with the results shown by Böhnke (2008), is good, more developed and stronger in the Mediterranean area and new members of the European Union; interestingly, confirming what has so far been established, support outside the family has an important role in Baltic countries but also in France and Denmark but, in Italy, Malta and Greece, it plays a very residual role. In addition to this, Britain and Italy are also different in the use of support outside the family by individuals with a precarious economic situation. In Italy, if there is a problem, the individual turns to the family, whereas in the UK support outside the family acquires more importance for those with economic difficulties.

2.3.2. Italian policies

Italy is divided into 20 regions and each region has its own government which depends on the central government. Five regions continue to depend directly on central government but have more defined legislative autonomy. Although Italy is based on a centralized government, recent reforms have increased the legislative and administrative power of the regions and this has led to a marked difference in the health and social care offer from region to region, mainly due to economic differences among regions. In the light of the above, welfare policies in Italy are highly irregular and there may be substantial differences, not only from region to region but also between cities in the same region. Despite this, the central government remains the major point of reference through laws and decrees giving directions which regional and local governments must follow.

More specifically, the institutions with a role in health and social care are the Ministries of Health and Employment and Social Policy at central level in Italy. (It should be highlighted that each government has the possibility to give each department a different area of interest and name, therefore, the name of the Ministry of Health may be slightly different according to its area of interest under each legislation.) Regional governments at the local provinces and municipalities, Azienda Sanitaria Locale (ASL - Local Health Agency) and GPs. Furthermore, the tertiary sector (voluntary organizations and charities) is also involved at an informal level, although there are some interesting changes on that in the last years (Astra Ricerche, 2011). The national prevention plan signed by the Ministro della Salute (Ministry of Health) with the Italian regions refers to the period 2010-2012 (Ministero della Salute, 2010). This plan takes into consideration health issues of the Italian population with particular attention on the problem of longevity, called "a triumph and a challenge" (p. 49). This Law addresses a general increase in primary, secondary and tertiary health promotion. The document stresses the need to increase tertiary prevention as much as possible, not to mention the centrality and importance of the first two types. There are no references to social inclusion, social isolation, wellbeing and quality of life in the plan. The current Italian National Health Plan takes the period 2011-2013 into account, and its main objective is the improvement and strengthening of prevention and health promotion. In the paragraph dealing with older life, the document emphasizes the importance of the need to implement positive action to promote healthy lifestyles, including "the participation of older people in society" (p. 87), above all clinical aspects. It also recognizes and emphasizes the need to "conduct an active lifestyle that reduces the reasons for psycho-physical stress, maintaining constant intellectual activity" (p. 88) as a means of promoting health and decreasing the onset of chronic diseases (Ministero della Salute, 2011).

In 2009, the White Paper on Welfare (Ministero del Lavoro, della Salute e delle Politiche Sociali, 2009), the last, to the author's best knowledge, indicated that older people are at risk of social exclusion, especially those living with a partner with a severe disability and also in poor economic circumstances. It stresses the centrality of the family as the primary source of social help for the older population, despite taking into account all the social aspects that are changing the 'typical Italian' structure of the family, which was ready in the past to make up for the deficiencies of the country. In some ways, the paper address the problem connected with older age however there is no properly defined policy, as Dirindin suggests (2009). In the light of these considerations, the White Paper focuses its attention on health promotion and active ageing of older people, urging a greater number of Centri Anziani for them in Italy. The document makes rather daunting reading, as many subjects are dealt with but few solutions and policies are suggested and there is a lack of clear, specific explanations to address the issues raised in a timely manner. Dirindin (2009) notes that the White Paper is quite silent on how those issues could be resolved. Furthermore, data from the Istituto Nazionale di Statistica (ISTAT – National Agency for Statistical Data and Analysis) (2011) demonstrates a decrease in the use of informal care (in 2011, only 16.7% of households could take advantage of informal care) due to the fragmentation of families, which is beginning to increase in Italy. This, given the financial and political crisis which has struck Italy, means that requests for assistance from older people without family help will grow but these may be not addressed due to the lack of well-targeted social and health policies.

As mentioned above, regions and even municipalities play a key role in addressing health and social policy in Italy. The Second Report on Social Services in Lazio (the region which includes Rome) shows that the following are a major source of discomfort for older citizens: economic issues, loneliness, and lack of self sufficiency (Regione Lazio, 2010a). According to ISTAT 2011, the incidence of relative poverty in Lazio is 21.8%, equivalent to about one family in five. The Regione Lazio Regional Prevention Plan for 2010-2012 implements the directives in the National Prevention Plan analysed above (Regione Lazio, 2010b). The focus of the paper is on the prevention of disabilities in older people, but nothing is said with respect to social inclusion of the older, maintenance of cognitive abilities or the quality of life and wellbeing. Not only are there no policies specifically aimed at promoting health, but there are also none focused on active ageing or cultural participation of older people.

In the above, considering poverty and the role and impact that poverty has in today's society, it is interesting to note how the social-political and cultural influences can, in turn, influence an individual and to what extent they can actually count on social integration and support. In the light of the above, there are many differences between countries in and out of Europe,

stressing the need for the strong ability of European policy makers to develop policies which should have a substantial impact on nations even if culturally socially and politically diverse; a detailed and critical evaluation of these differences can make the difference between a well addressed policy and a nonsensical one.

As has been said, the Italian family and social structure are changing; they have been modified by a number of elements already stressed above. Further, they are unlikely to return to what they were. Thus family support and health promotion for older people, carried out informally by the Italian family so far, is declining a little more every day. In the light of this, the Italian health and social care policies analysed briefly above are worrying. As pointed out by Dirindin (2009), the current Italian National Health Plan (2011-2013) shows "minimal vision of social policy where there are no rights of citizenship but only extreme situations worthy of attention" (p. 3). There is still insufficient integration between health and social policies, economics and politics in Italy, and the notion that 'health is everybody's business' has not yet been acquired. Policies are still fragmentary and focus more on screening and health problems (disability, disease and so on) than prevention and prevention policies or the causes and consequences of social isolation and exclusion, quality of life and wellbeing.

To sum up there are a number of considerations which should be made. Local government, cities and the tertiary sector certainly have a major role in the development of policies on the older, but it is equally clear that central government should be dictating sufficiently precise guidelines for local governments to be able to develop more effective health and social policies. The Ottawa Charter (WHO, 1986) has not yet been absorbed into Italian policy, which fails to translate its principles into effective policies across the country, however the fact that there are many interesting and effective health promotion projects across Italy although, as yet, there is not enough dissemination should be taken into account.

In November 2012, three Italian charities focused on health promotion in the older asked for a law about active ageing in a national government conference "giving various forms of incentives for those who work for the benefit of their community, and also payment, through social benefits consisting of credits, for the use of cultural, recreational, sporting and artistic opportunities and/or vouchers for access to goods and services paid by the municipalities" (Anteas, 2012). This means that older Italians are well aware of what they want and what they need but institutions are still greatly confused with respect to the most important targets to follow and, of course, the serious crisis which has invested all sectors of Italian life does not help the proper development of a coherent policy. Further, as has been seen, policies or

aspects of social inclusion are not generally prerogatives of the Ministry of Health in Italy, meaning as focused on the biological aspects of human health, but to the Ministry of Employment and Social Policy and this may lead to some considerations; this shows that there is still a separation between health and social care (I say social policy) in Italy and this separation involves a failure of interconnection between the two policies which should be co-ordinated.

Recently (June 2013), the new Italian Health Minister's new programme that the new Italian Government intends to develop (Ministero della Salute, 2013) was presented. Bearing in mind that this is just a planning document and should be understood as a declaration of intent, therefore neither legislative nor a real programme, there are, nevertheless, some interesting changes towards a more integrated approach on individual and community health. The document makes references to the WHO guidelines in terms of Health in all policies considering the involvement in public health also of other professionals, which is rather something new in Italy, as well as an enlarged account on prevention. Despite these improvements, which have considerable impact with respect to the Italian policies analysed above, there are two main concerns/criticisms, in the author opinion, that arise quite strongly in the analysis of this Plan. The first relates to the lack of an approach and/or mention of wellbeing; more specifically, mental and physical wellbeing is mentioned (p. 6), but there is no mention of the concept of wellbeing encoded as will be discussed in the next chapter (Ministero della Salute, 2013). The other concern relates to a list of instruments to promote health focused almost exclusively on biological/medical purposes (e.g. cardiovascular disease, diseases of the respiratory and central nervous systems, cancer, serious organ failure, diabetes, prevention of forms of psychiatric disorders, the prevention of addiction to alcohol and drugs as well as gambling, the number and severity of workplace accidents and so on). The perception on reading these lists is that not only is there no description of how the Italian government will operate, which can be justified by the nature of the document, but that there is also a decisive step backwards in terms of what was just been said above in the plan about the new way of Public Health in Italy (Ministero della Salute, 2013). This attitude is even stronger with regard to older people because the text mention older people in the following terms, "Today, the NHS is involved with other major healthcare challenges, such as supporting issues of social and health care related to long-term care, the high numbers of older people and oldest old, treatment availability/high cost diagnosis [...]" (Ministero della Salute, 2013 p. 1). The fact that the plan recognizes that there is a growing number of older people is absolutely insignificant as there are many reports that show this. It would be much more important to touch on the problem of ageing well or social isolation, poverty and social exclusion which are not even mentioned. This clearly confirms what has been said above

about governments which are more interested in the practical issues of public health than health promotion in the long term.

2.4. English health policy

First of all, it should be borne in mind that the focus of this discussion will be on English policies. The starting point for the analysis of health and social care policy in England is certainly the 'National Service Framework for Older People' (2001) published by the Department of Health. This document set national standards to be developed over 10 years. It focused on providing for and encouraging older people to stay as healthy as possible in their own home to avoid the onset of disease, especially long term disease or mental decline and memory loss problems. Recently the Department for Communities and Local Government has decided to support older (and disabled) people in remaining independent in their homes in order to avoid collapse into homelessness (Department for Communities and Local Governments, 2013).

In 2010, the White Paper 'Healthy lives, healthy people: Our strategy for public health in England' was published setting a series of targets for the maintenance and improvement of health (Department of Health, 2010). There is an 'ageing well' section (Points 1.41 to 1.45) which outlines the situation for the older, emphasizing the increasing number of older people, the growing rates of depression, and the increased prevalence of mental decline and memory loss problems. Section 3.4 of the document stresses that action should occur at local level to "help people improve their mental and physical health, wellbeing and resilience and tailor support to the different needs of individuals and families" (p. 32). The document (paragraph 3.67) emphasizes the need to create opportunities for older people "to become active, remain socially connected, and play an active part in communities" (p. 50), all with the ultimate goal of removing social isolation and loneliness (Department of Health, 2010).

In 2011, the Department of Health prepared a report entitled 'No Health without Mental Health' which emphasizes how mental wellbeing is important in the health of individuals of all ages; in particular, paragraph 1.7 states "improving mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds" (p. 7) (Department of Health, 2011). In addition to what has been said, there are a number of documents from institutions close to the government (Arts Council of England, 2005; Department of Health 2007) which show the tremendous impact that art and participation in art has on the health and wellbeing of the individual and, in particular, the older, and that encourage the use of these tools in the health and social care environment in government policies in favour of older people. In 2007, the Department of Health and Arts Council of

England published the 'Prospectus for Arts and Health' which underlined and emphasized the positive effect of art on health, and reviewed the growing literature in the field; however, the use of arts is also encouraged in the widest sense in the NHS and the community.

2.5. The European economic crisis and its consequence on household and policies

As recalled, the economic crisis encompassing the whole of Europe can have effects on health policies across that area. It is, therefore, worth giving a brief account of this. Starting from the fact that social exclusion, deprivation and poor health are all consequences and causes of poverty, the economic crisis which has struck Europe (including Italy and the UK) should be considered. It seems clear that a profound crisis affecting primarily basic needs such as health-related ones erodes wellbeing and quality of life, firstly of the country and then of individuals. Suhrcke and Stuckler (2012) pose an interesting point, saying that the articles reviewed in their study demonstrate that economic crises are not always precursors of a decrease in the health levels or rise in mortality rates at a population level since the decrease in car accidents exceeds the number of suicides. The authors take into account the level of life expectancy and mortality as parameters in evaluating a population's health, which is a point of view.

Like the UK, Italy has a health system financed from public taxation and, therefore, the government has not cut the most important treatments despite the very serious crisis. Nevertheless, the Italian government has recently had to make a series of highly unpopular choices to deal with the crisis which, on one hand, have tried to contain health costs and, on the other, have had a severe impact on the pension system and the level of pensions. Both elements have had a considerable impact on the older population, leaving many in a serious financial state and this, in turn, has had a significant impact on their wellbeing and quality of life. According to de Belvis et al. (2012), "the national government has cut central transfers to regional and local governments for disability, childhood, migrants and other welfare policies" (p. 13); this has led to a greater use of co-payments for health care with serious effects on household income. The crisis has led to some households choosing not to care for themselves (De Belvis et al., 2012), as there were other, more important and urgent family expenses. In agreement with De Belvis et al. (2012), comparisons between Italy and the rest of Europe show that Italy is a nation that is experiencing the worst effects of the crisis and this has been compounded by the fact that it had very low economic growth, even before the crisis. Furthermore, according to the data from Italy Report 2012 Eurispes, it is the older people who suffer more because of the effects of the crisis in Italy; in 2010, 74.8% of the

older indicated a deterioration in their economic status while in 2011, this figure had risen to 81.5% (Eurispes, 2012).

The economic crisis that has affected the whole of Europe is an aspect that should be taken into account when looking both at policy choices on health spending and the reactions of individuals. According to Kaplan (2011), several crucial determinants of health have been affected by the economic crisis, including health care, housing, income and wealth; however "social and economic policies have the potential to mitigate at least some of the potential negative health effects of economic crises" (Kaplan, 2011 p. 646). However as Lloyd-Sherlock (2002) points out that "rather than driving up health spending, the main impact on health services…" of the growth of the older population, "…may be a shifting of priorities" (p. 755). The economic crisis should focus politicians' minds on the need to invest more in health promotion and try and avoid the costs of expensive health and social care.

2.6. Chapter summary

The chapter provides a short overview of social and health policies in Europe, Italy and England related to the needs of older people. One of the most interesting aspects is that the concept of health promotion and public health in Italy is still profoundly related to the medical and biomedical fields. Health promotion for older people is not addressed sufficiently and is poorly developed when compared with England. Furthermore, public health is still focused on help given by families. The lack of policy and practical initiatives in Italy has been criticised by associations which deal with the older population. It is clear that the more physical healthcare needs of older people must be addressed but, in addition, more attention is needed on the quality of life and social wellbeing of older people. The economic condition in which Italy and, to a lesser extent, England and the UK are positioned, makes the need for a change in priorities all the more pressing.

Chapter 3.

The Multifactoral Concepts of Health, Wellbeing and Quality of Life

3.1. Introduction

This chapter will discuss a number of key concepts central to this thesis. The concept of health itself and approaches to definition have been a subject of debate and have developed in important ways over time. The further multi-dimensional notion of wellbeing is related to the concept of health. That of the quality of life will also be analysed, trying to frame this for individuals and, more specifically, older people. Quality of life is important for this section of the population, especially in the context of the lengthening of life and it certainly has a different aspect in comparison to adults or young individuals. A number of approaches to defining and categorising this idea are explored. The last section of the chapter is focused on social capital, social exclusion, social isolation and poverty and their connection with older age.

3.2. Health

The concept of health is complex and has developed over time, adapting and changing as society, economics and medicine changes. The definition of health proposed in the constitution of the World Health Organisation was something new and important at that time. Health is said to be: "a state of complete physical, mental and social wellbeing and not merely the absence of illness or infirmity" (WHO, 1946, p.2). For the first time, the health/disease dyad was broken. As Jadad and O'Grady (2008) note: "This definition invited nations to expand the conceptual framework of their health systems beyond the traditional boundaries set by the physical condition of individuals and their diseases, and it forced us to pay attention to what we now call social determinants of health" (p. 337).

In recent years there has continued to be some debate in the literature about the definition (Huber et al., 2011). Saracci (1997) argues that the WHO definition of health is much closer to the concept of happiness than to health and having good health status does not automatically involve being happy. The exception raised has a high value since there are a number of difficulties in life which do not involve health but which can make life difficult. Saracci (1997) is particularly specific in demonstrating that the definition of health is not so

straightforward, also through a significant paradox - health can be considered a human right, but happiness he suggests cannot. In their review, Jadad and O'Grady (2008) underline that a number of problems had been emphasised in the scientific literature, focusing in particular on the use of the term 'complete', showing that its meaning is difficult and complex.
In agreement with what was said by Huber (et al., 2011), the term 'complete' is misleading because it has led to an excess of medicalization. In other words, a healthy individual is somebody who experiences a complete sense of health (emotional, mental, physical and social), this is a difficult objective to achieve. In addition, Huber and colleagues (2011) highlight another important aspect - the demography of the population. In 1948, demographic patterns all over the world were not as they are now, as seen above; health can no longer be seen and measured in relation to that definition, because of the growth in the number of older people and connected diseases (long term/chronic). According to the WHO definition, an enormous number of people over 60 cannot be considered healthy; further, the definition does not take into account coping abilities, both at a mental and physical level.

The definition of health, and therefore its measurability, has serious implications. A definition as close as possible to the social-economic-political context has significant effects on policy choices and health promotion interventions. Buchman et al. (2009) underline that the most recent literature on ageing and the condition of the older population recognises that physical health is "only one of the components of an active and healthy lifestyle" (p. 1143).

The use of a single definition to describe a concept is misleading, because there are so many components or related issues that the sense would be distorted. As Huber et al. (2011) argue it is therefore probable that the need today is not so much to focus on a definition of health but more to have a more comprehensive conceptual framework covering the whole field of issues relevant to 'health'. Social changes are so fast and scenarios differ in such a short time that encapsulating such a complex concept in a single sentence is deceptive.

Despite the above, the WHO definition of health (WHO, 1946) was an important starting point for developing health promotion strategies which may not have emerged without that definition. In other words, it can be said, that the definition was a revolutionary approach to individual health, and overcoming the concept of disease was instrumental in the development of an extensive range of considerations and theoretical frameworks which have led to a widening of the boundaries of health, including wellbeing and social aspects. Health promotion has taken the definition of health given by the WHO as something to strive for rather than a closed definition health being a resource for living not a goal. The operations implemented by health promotion and social policy have to be addressed to achieve a status

that could be as close as possible to a complete sense of mental, physical and social wellbeing, despite the fact that it is impossible to achieve, as explained above.

3.3. Social determinants of health

As seen, health is, on one hand, a status which includes several aspects and, on the other, determined by a wide range of factors – the so-called social determinants of health. These have been defined by the WHO as "the conditions in which people are born, grow, live, work and age" (CSDH, 2008 p. 1), therefore how a person ages can determine their health. In accordance with this definition, "the human health span could be considered as how long an individual can maintain good health" (Franklin and Tate, 2009 p. 8). Some social determinants of health cannot be modified, such as gender and age, but there are also those which are under the control of the individual (lifestyle/health behaviour). Lastly, there are social determinants that affect defined sections of the population such as poverty, access to health care, housing conditions and lack of supportive and close relationships. Hoff (2008) reports that the two strongest determinants of health in older age are educational level and income (poverty). In the European Union, "the proportion of the population who are at risk of poverty, one of the strongest determinants of health (defined as having an income of less than 60 per cent of the national average) was 15 per cent in the EU as a whole," (Mackenbach, 2006 p. 31). A life of poverty, and low economic circumstances, profoundly affect individual health, and social determinants of health such as poor education, housing, relationships and income exert important effects on health status (Benezeval, Judge and Whitehead, 1995; Anderson, 1999; Cattel, 2001; Dunn, 2002). According to Judge (et al., 2006), "health inequality is very much related to the numbers of people disadvantaged by different forms of social exclusion" (p. 5). Social exclusion has been defined as "a complex and multi-dimensional process" which impacts on both mental and physical wellbeing (Levitas, et al., 2007, p. 25). Marmot (2005) claims that social determinants in health are relevant both for communicable and non-communicable disease, therefore tackling health inequalities is crucial for health promotion as a whole. In the light of this, if social determinants influence health, they also influence social wellbeing and the connected concept of quality of life.

In 2008, the Commission on Social Determinants of Health presented its final report to the WHO, once again emphasizing that health is everybody's business since a growing number of organizations were concerned with individual health, "the whole government, civil society, local communities, business, global flora and international agencies" (p. 1) (CSDH, 2008). The Commission made three main recommendations:

- improve daily living conditions,

- tackle the inequitable distribution of power, money and resources,
- measure and understand the problem and assess the impact of action.

The three recommendations emerging from the report are crucial and have a huge impact on public health and health promotion. As a preliminary, it is important to develop a better quality of life/health of citizens every day rather than a very punchy operation which has little long-term effect, as well as the importance of improving the distribution of power, money and resources as a pre-condition to living better. Emphasis will be placed on poverty and all its consequences in paragraph 3.9.

The aspect that is probably most incisive in the light of the work presented here is that expressed by bullet point 3, i.e. that focused on identifying and measuring the problem and consequently assessing the impact of action. In agreement with what Bambra (et al., 2010) describe, measuring social determinants of health is extremely difficult "public health systematic review evidence base is weak in terms of how to tackle the social determinants" (p. 290); furthermore, "there are specific areas that appear especially sparsely populated" (p. 290) in terms of research. The study (Bambra et al., 2010) is very clear in highlighting how difficult it is to develop effective tools and interventions, how hard covering all the aspects of the 'social determinants of health' problem is and what the consequences of these difficulties, which literally fall back onto the health status of citizens, are. Addressing the social determinants of health, the urban dimension and the role of local government (WHO, 2012a), the report, which analyzes the 'behaviour' of 5 European countries (including the UK but not Italy), assesses how these nations are concerned about socially determinant issues and how they differ from each other (some countries consider it a priority and others less).

3.4. Wellbeing

The World Health Organization defines health as "a state of complete physical, mental, and social wellbeing and not merely the absence of illness or infirmity" (WHO, 1946 p. 2); it is therefore important to carry out an analysis of the concept of wellbeing. Wellbeing, just like health, is a very difficult concept to define. In February and June 2012, the WHO Regional Office for Europe created a group to answer a number of questions connected with the definition of wellbeing (WHO, 2012c; WHO, 2012d). The fact that the WHO feels the need to define or build a framework to highlight what wellbeing is clarifies two aspects - one is the inherent difficulty in defining the concept, and the other is its importance.

Despite the comments below about research into health and wellbeing, and starting from the fact that there are several tools for measuring wellbeing, there remains a profound difficulty in measuring it, according to the literature (Bambra et al., 2010) and the WHO (2013). This is mainly due to the fact that tools often focus their attention (the author would say their measurement) on one or two dimensions of wellbeing rather than giving an overall assessment. This aspect, and the problem of defining wellbeing, is essential because a clear definition and measurement indicate the most correct way to create intervention on health promotion and social and health care. Moreover, another important and not negligible aspect is that of having a measurement that could be valid for all; in other words, taking into consideration that Europe is becoming more and more extensive, connecting countries with completely different cultural and historical backgrounds and features, there is a need to develop a tool with common indicators. This is mainly in the light of the need, as stated in the Preamble, to transfer tools and good practice in health promotion at European level.

According to WHO 2013 (p. 141), "well-being exists in two dimensions - subjective and objective. It comprises an individual's experience of their life and a comparison of life circumstances with social norms and values". Illustrative examples of the objective elements are those that affect the living conditions (housing, income, and so on) while the other are those related to the subjective experiences that each of us has in his life (WHO, 2013). The fact is much more complex, the comment above is too simplistic because it is difficult to draw a clear line between an 'objective' aspect of wellbeing, such as income, and how this aspect is also reflected on the condition of the individual taking into consideration that each individual reacts differently to the stressors of life.

In the literature, there are two main concepts of wellbeing - hedonic wellbeing identified as the pursuit of pleasure and avoidance of pain or "as the presence of positive affect and the absence of negative affect" (Vázquez et al., 2009 p. 17), and eudaimonic wellbeing, which focuses on self-realization and can be defined "in terms of the degree to which a person is fully functioning" (Ryan and Deci, 2001 p.141). Hedonic wellbeing is connected not simply to happiness but to the idea of gaining the highest amount of pleasure in life. The eudaimonic theory goes back to Aristotle (1999) who, in the first book of Ethics, developed the concept of *εὐδαιμονία*, arguing that true happiness comes and builds a virtuous life based on developing the potential of each individual and not only pandering to his desires and avoiding pain. In agreement with what is said by Deci and Ryan (2008), life satisfaction cannot be evaluated accepting the hedonic model, because it is made up of many elements which affect not only happiness itself and the absence of unhappiness but includes others aspects which the eudaimonic perspective takes into account. Furthermore, the complexity of

the elements making up eudaimonic wellbeing could lead to a more lasting feeling of happiness because it includes personal growth and meaningfulness, compared to the pure and simple happiness in hedonic wellbeing.

In 1984, Diener elaborated the theory of subjective wellbeing as that feeling that each individual can self-evaluate. Later, in 2000, Diener suggested that there are several separable components of subjective wellbeing such as "life satisfaction (personal judgment of one's life), satisfaction with important domains (e.g. work satisfaction), positive affect (experiencing many pleasant emotions and moods) and low levels of negative affect (experiencing few unpleasant emotions and moods)" (p. 34). Ryff (1989) advocated that psychological wellbeing instead consists of six components: self-acceptance (positive evaluation of oneself and one's life), personal growth, purpose in life, positive relations with others, environmental mastery (the ability to effectively manage one's life and the surrounding environment) and autonomy. In addition, it has been found that "psychological well-being is more strongly associated with survival in older healthy populations (>60 years old) than in healthy populations in general" (Chida and Steptoe, 2008, p. 754). According to Sarvimaki and Stenbock-Hult (2000), the factors affecting the wellbeing of a person are both internal and external. Illustrative examples of internal factors in old age may be health, physical ability or coping mechanisms and the external ones are home, social relationships, and the living environment. In addition, several pieces of research show that eudaimonic wellbeing is influenced by a number of variables such as social-demographic factors, age, gender, race, social-economic status and also the adversities in life (Ryff, Singer and Love, 2004). As a result, eudaimonic wellbeing changes during the life due to specific adversities but also normal changes. Wellbeing like health and quality of life, is a dynamic process.

There is a general agreement in literature that both hedonic and eudaimonic wellbeing have positive connections with physical health (Ryff, Singer and Love, 2004; Pressman and Cohen, 2005; Howell, Kern and Lyubomirsky, 2007; Chida and Steptoe, 2008; Vázquez et al., 2009 and Krijthe et al., 2011). According to Vázquez et al. (2009), there is a connection between negative affect and health. They report a number of studies which show that a high level of negative emotions "may weaken the response of the immune system" (p. 19). According to the quantitative review carried out by Chida and Steptoe (2008), psychological wellbeing is positively correlated with a decrease in mortality, both in healthy people and those with chronic disease. More specifically several pieces of research on older people show that wellbeing has a number of positive effects on them.

The pioneering study, carried out by Ryff, Singer an Love (2004), is of particular interest. It was aimed at assessing whether wellbeing is associated with reduced biological risk in older women. The results of the study show that there is a link between 'biological' health and wellbeing, which contributes to the effective functioning of various biological systems – women with higher levels of eudaimonic wellbeing had lower levels of cortisol, pro-inflammatory cytokines, cardiovascular risk and better sleep in comparison with participants who had a lower level. Further, positive affect has been shown to predict survival in older adults in univariate analyses (Krijthe et al., 2011). According to this, promoting wellbeing is an important fact from a health promotion point of view, even more so for older people who have to deal with a number of negative aspects with respect to their health and their position within society (Vázquez et al., 2009). Thus, there is a close interconnection between health and wellbeing and it is equally possible that there are reciprocal influences.

3.5. Quality of life

The concept of the 'quality of life' is widely used in the scientific arena, but is not often clarified and defined. A starting point for its analysis is provided by the WHO definition "an individual's perception of their position in life in the context of the culture and value systems they live in and in relation to their goals, expectations, standards and concerns" (WHOQOL Group, 1997, p. 1). This definition is certainly exhaustive but only because it is very generic. According to Alesii (et al., 2006), the concept of quality of life has had a fluctuating number of definitions starting from an idea of equality with the definition of health, to detachment from health and becoming a concept with a wide range of different nuances.

According to Lawton (1991), quality of life is a multi-factor concept involving four main areas - objective condition, behavioural aspects (including health), subjective perception and psychological wellbeing (including the sense of satisfaction). It would be interesting to evaluate whether there is a hierarchy among these levels, in other words, is there an element which has greater importance in determining the quality of life in the older person's life? Consequently, if so, a hierarchy of policies would be necessary, addressing social and health care policies firstly in terms of one aspect and subsequently another. Conversely, the multi-factor nature of the concept of quality of life could be understood not so much as a layering of different levels but rather as elements making up a whole. In which case it would be more difficult to assess what the most appropriate tools are to improve the quality of life of older people involving multiple elements. Interestingly, the review carried out by Smith, Avis and Assmann (1999) showed that quality of life and health status in patients with chronic disease are "two distinct constructs" (p. 450); furthermore, according to their review, mental health has a greater impact in assessing quality of life in comparison with physical health.

Defining quality of life is challenging and this is even truer if the definition is focused on defining older people's quality of life. This is mainly because the older group covers a long period of time of about 40 years (from 60 to 100) and the physical and mental challenges experienced, as well as the aims and desires, are certainly different. Despite this, the literature has attempted a conceptualization in which the first principle is to assess the quality of life in the older population in a different way from that of the rest of the population; if, as has been said, the concept of quality of life changes in time both at the individual level (the events of life affect our needs) and group level (the adult group has a rating of the quality of life different from that of adolescents or older people).

The starting point for analysis of the concept of quality of life in the older person's life is raised by Netuveli and Blane (2008) when they state, "although there is a plethora of statements about quality of life, they tend to be descriptive rather than definitive" (p. 114). The start of any discussion of this concept should conveniently consider that quality of life is a dynamic element which changes in time and adapts to the conditions that the individual is experiencing at the time, so it is possible to say that the quality of life is an individual and changeable feeling. Notwithstanding this, certain aspects can be indicated as common with possible validity in time. As suggested by Halvorsud and Kalfoss (2007), in their review "Quality of Life is influenced by intra-individual characteristics such as health, functional capacity and the coping mechanism, and external conditions including environment, work, housing conditions and social network" (p. 234). Quality of life is thus closely linked to the period in which an individual lives and ages. In the light of this, quality of life in the older touches and affects very specific aspects that are certainly not found in other age groups.

According to Age UK (2013) physical conditions are not taken into account by oldest old people in rating their health while "aspects of mental wellbeing such as mood, personality and lifelong intellectual ability are the most important factors" (p. 21) in assessing their quality of life. This is recalled also by literature, there is general agreement that, in older age (like all older sections), it is crucial to take into account aspects that go beyond strict functionality and explore more concepts such as life satisfaction, social interaction, wellbeing and similar situations to improve their health (Fernandez-Ballesteros, Zamaron and Ruiz, 2001; Gabriel and Bowling, 2004; Smith et al., 2004; Halvorsud and Kalfoss, 2007; Netuveli and Blane, 2008). Some research illustrates that the older population particularly values several aspects of life and, in particular, social contact with family and relatives, financial circumstances and independence. As Netuveli and Blane (2008) state, "Family, activities and social contacts were the factors which they thought gave their life quality" (p. 116).

Housing is a central facet of the quality of life in older age, according to the final report of the ENABLE-AGE (2005) study, which explores the home environment as a determinant for autonomy, participation and wellbeing in very old age in five European countries, including the United Kingdom. At a general level, the study indicates that "healthy ageing at home is linked to action, identity, dignity and survival in very old age" (p. 3). Starting from this fact, it is interesting to see what home means for older people; for the older, the home is certainly not only a place but a world, their world, built over time, consisting of habits and routines. The concept of identity with the area, connected with that of their 'world', should also be emphasized and the need for most older people not to change too many aspects of their life. This is because their life has already really changed with retirement and emerging health conditions, and the home is an important cornerstone of their world.

The report further suggests that the word 'dignity', mentioned above by the European Union in Article 25 of the European Union Charter of Fundamental Rights, is one of the most words used in the collection of data through interviews. Five facets of dignity emerge - functionality, activity preference, privacy (at different levels, i.e. physical, social and psychological), financial dignity and embodied dignity. These cover all facets of the individual - from his physical wellbeing to that of economics, finishing with having aesthetic respectability (being happy about one's appearance). In the light of this report, it can be seen how society has a very stereotyped idea of older people whereas this section of the population is specific in recognizing their needs and desires. This discrepancy between how the older perceive themselves and how they are perceived by society is something to which attention should be paid because identifying the real needs of this section of the population could help to address social policies more specifically. The older in good health condition with access to free medical care and a good financial level are now, in Italy, in a better position than younger people, and appear satisfied, in stark contrast with the stereotype that we have of them.

Beyond the problem of having a series of stereotypes of the idea of the older person, resulting from the non consideration of Victor, Scambler and Bond (2009) i.e. that the older of today cannot be compared with those of yesterday, the link between these results and what Baltes and Baltes (1993) developed, i.e. the minimization of losses and maximization of gains, should be underlined. In other words, it can be argued that these results demonstrate that the older person can adapt to the passage of time. In the light of this, it appears easier to highlight factors which enhance the levels of the older person's quality of life as well as highlighting the premise necessary and sufficient for them to have a good quality of life.

3.6. Social capital

Firstly, it is important to underline that the concept of social capital is not a recent one, and has already been analysed but not extensively theorized. Social capital is a term that summarizes a wide range of elements such as number and quality of interactions and connections among individuals or groups of the population but also the outcome of those interactions. As Ferlander (2007) points out, social capital has been used to explain a wide range of aspects of civil society such as educational achievement, democracy and level of crime. As said, social capital appeared in the studies of several authors, including Durkheim in his studies on solidarity, in those on the community and society of Tönnies and also Weber in the studies about religious communities (Di Giacomo, 2006).

Despite the above, the main authors who have explored the concept of social capital in depth are Bordieu (1980), Coleman (1988) and Putnam (1994 and 2000). Bourdieu and Wacquant (1992) quoted by Lesser (2000 p. 91) define social capital as the "sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of networks or less institutionalized relationships of mutual acquaintance and recognition"; in the Bourdieu's view, each individual is moved by its interest in pursuing its aims. Social capital is therefore an individual resource "which is partly developed by the individual's own past and present activities, but is also contingent on the attitudes of others" (Gray 2009, p. 7).

Coleman (1988) states that social capital is not "a single entity but a variety of different entities with two elements in common. They, too, consist of some aspects of social structures and facilitate certain actions of actors [...] within the structure" (p. S98). As noted by Coleman's (1988) starting point in the definition and analysis of social capital, individual's actions were analysed from two different points of view - one purely economic and the other sociological. Both have their own strengths and weaknesses and their analysis takes important factors into account (the economic one only considers the individual while the sociological point of view only social relations). This scholar claims that social capital can go beyond these divisions and give a more complete point of view of concept of capital (in terms of amount of resources). Coleman (1988) divides the dyad 'social capital', saying that social means 'relationship between people' while capital means the 'relationships that constitute the resource'. He maintains there are three basic forms of social capital - obligations and expectations, information flow and laws accompanied by penalties. The most interesting aspect underlined by the author is that social capital is far from other forms of capital (= material resources) used, such as physical and human because "the actor or the

actors who generate social capital ordinarily only capture a small part of its benefits" (p. S119) while the remainder becomes a public good.

In pursuing two empirical studies with a similar methodology, Putnam focused the first on Italy (Putnam and Leonardi, 1994), on differences between north and south, while the other focused on the United States. Putnam's book "Bowling Alone" (2000) focuses its attention on social capital analysing differences among states in the U.S., developing a number of theories and statements. According to Putnam, social capital is a means of improving the general welfare of a country, and when social capital decreases, the general welfare of a country automatically decreases as well (Berger-Schmitt, 2000). Putnam defines social capital as "features of social organization such as networks, norms, and social trust" (1995, quoted in Ferlander, 2007, p. 116).

Social capital can be divided into three different dimensions - bonding, bridging and linking social capital; in turn, these dimensions can be weak or strong. Bonding social capital is described as involving social networks of people with similar characteristics, in other words connections among family members or of individuals of the same ethnic or religious group, whereas bridging is characterized by more cross ties, and also relationships among dissimilar individuals (Ferlander, 2007). Linking social capital, by contrast with the first two forms connects individuals at a vertical level while bridging and bonding connect individual at a horizontal level (Ferlander, 2007).

As will be discussed later, social exclusion and isolation are harmful for health; the opportunity of having social relationships and connections with other individuals automatically has a good effect on health. D'Hombres (et al., 2007) indicates that this influence could be seen at very different levels, such as macro, micro and individual. In other words, social capital has different paths to influence the health status of the population seen as a whole as well as at individual level. Ferlander (2007) reviews research which shows the many ways in which health is linked with social capital, for instance through a decrease in mortality and better self-reported health. More specifically, the literature recognises a strong connection between higher social capital and social cohesion and a corresponding higher level of health.

In the light of the above, the role of social capital and its connection with old age and the theory of successful ageing appears clear, as it emphasises the importance of having relationships and connections with other individuals in order to have a more satisfying and qualitatively better life. According to Gray (2009) social support is a direct outcome of social

capital; social support and good relations make an important contribution to the health not only of the individual but also the community. In discussing social capital and one of its most direct and major outputs i.e. social support, the decline of family support particularly strong in Italy, but also in other situations such as that in England, should be emphasized. The lack of social support within families brings older people to look outside for the support they need and they also turn to other support networks such as friends. The lack of this kind of support has direct consequences and therefore creates the possibility of an increase in loneliness in older people (Gray 2009). The above strongly reconnects to what is claimed by Putnam (2000), describing the overall importance of place of aggregation and socialization as the best place to finding social networks such new friends.

3.7. Social exclusion

Over the last 15-20 years, there has been growing interest in social exclusion and the correlated situation of poverty. The problem of social exclusion touches more than one section of the population and is the complete or partial absence of relationships and social interaction with either family or friends. Mililband (2006) quoted by Levitas (et al., 2007) underlines that social exclusion has to be considered in three ways - wide, deep and concentrated exclusion. More precisely, the author defines wide exclusion as arising where a large number of people are excluded by a single or small number of indicator(s), deep exclusion is where people are excluded by multiple and overlapping dimensions, and concentrated exclusion is where there is a concentration of the problem in a specific geographical area.
In 2010, with validity until 2020, the European Union formed the "The European Platform against Poverty and Social Exclusion: A European framework for social and territorial cohesion" the aim was to carry out policies that decrease social exclusion and poverty in the different member states (European Commission, 2010).

It should be borne in mind that social exclusion is not the result of low income or more generally of poor material conditions but is something broader. Social exclusion is both a cause and a consequence of poverty. Poverty tends to exclude the individual from many activities; those who cannot afford to take advantage of activities that may relieve loneliness and solitude are excluded, also because their experience is poor. Therefore, poverty is not simply a matter of low income but people can also be impoverished in terms of social support. In addition to this, poverty seems to be seen as something touching individuals while social exclusion is a broader concept including, on one hand, entire sub-groups of the population and, on the other, several different aspects of individual lives (Berger–Schmitt, 2000). Poverty is often the main cause of exclusion from access to a series of recreational

activities for these layers of the population, as they do not effectively have the economic resources to spend on 'unnecessary' things, as recreational activities may appear (Huxley and Thornicroft, 2003; Böhnke, 2008). On the contrary, these people see recreational activities as a real possibility of leaving the routine of everyday-life behind and as a way of feeling less isolated and having the chance to form and build relationships which would influence their perception of wellbeing. In addition, it is important to underline the strong connection between one or more dimensions of social exclusion and the quality of life of an individual.

There has been a heated debate (Tsakloglou and Papadopoulos, 2002) around the concept of social exclusion which is not easily to assess. Currently, however, there is agreement in the scientific literature that the concept does not have just one distinctive element but contains several components. Therefore, social exclusion is something difficult to conceptualize and, once again, multifactoral. The question is not an academic one; it is not just a case of finding a label for a concept but defining it as precisely as possible to develop solutions to address significant social issues.

According to Jehoel-Gijseberg and Vrooman (2008), there are four elements which make and/or are related to social exclusion - deprivation, lack of social rights, integration and social participation. Results of the study show that "Social exclusion among the older is generally much higher in terms of social participation than in terms of the two other dimensions [deprivation and lack of social rights]" (p. 48). Looking at Europe, Tsakloglou and Papadopoulos (2002) suggest that social exclusion appears to be more widespread in southern Europe (including Italy) and countries such as the UK or Ireland. Again according to the above study, "elderly citizens living alone and elderly couples face an increased risk of social exclusion" (p. 223) in southern European countries.

3.8. Social isolation

According to Berger-Schmitt (2000), social isolation is a status where the individual feels both a lack of social contacts and subjective feelings of loneliness. Social isolation is another difficult and multifactoral concept which is hard to define. However, following Nicholson's (2009) taxonomy, a number of aspects should be taken into account such as "number of contacts, feeling of belonging, fulfilling relationships, engagement with others and quality of network members" (p. 9) while the author indicates lack of relationships, psychological and physical barriers, low financial/resource exchange and an unsafe environment due to crimes rates, for instance, as antecedents. Van Gelder (et al., 2006) quoted by Victor, Scambler and Bond (2009) claims that living alone is linked to physical and mental outcomes including "anxiety, depression, cognitive decline and psychological distress" (p. 27). Victor (et al.,

2005), stated that socio-demographical attributes, material circumstances, health resources, social resources and life events have been associated with social isolation. In other words, the causes and consequences of social isolation may be related, leading to the consideration that all the above elements may lead to a vicious circle, where the existence of one element is connected to the start of another and another is, in turn, worsened.

Victor and colleagues (2005) noted that 'being alone', 'living alone' and 'social isolation' are three different concepts, remaining distinct even though they sometimes overlap. Being alone is the time spent alone, living alone is the fact of living by yourself while social isolation is something deeper and concerns the level of integration with individuals or groups. It seems clear that even if an individual lives alone they may not necessarily be socially isolated and, in some cases also vice versa, since there are people who take care of a sick family member (for example spouses where one of the two is suffering from mental decline and memory loss problems) and so the individual does not live alone but is effectively socially isolated because of the lack of contacts.

Social isolation is deeply affected by age and therefore social isolation among older people can differ from that of other age groups or sectors of the population. Furthermore, it should be borne in mind that the health status of the older and their motor function problems may be elements significantly influencing the social contacts of older people. In addition, older people have already experienced a number of losses during their lives - partners, relatives and friends leading to a certain social isolation.
Social isolation has repercussions on individual wellbeing; therefore, in the light of the above, it has a negative effect on individuals' physical and mental health. Social isolation among older people is one of the issues which policy makers and health care professionals should take into account more in terms of health promotion. For this section of the population, isolation is not just the inability to have a meaningful relationship or the possibility of social contacts but, as Nicholson (2009) highlights, social isolation causes a number of physical ailments such as poor nutrition, rehospitalisation, cognitive decline and increased consumption of alcohol and these ailments are a cost to society and national health systems. Several pieces of research show the importance of social relations in old age for both health and quality of life (Scharf et al., 2001; Beland et al., 2005; Wilson et al., 2007; Gallegos-Carrilo et al., 2009). Furthermore, there is a good body of research which has established the connections between leisure activity and health and the quality of life.

As far as the concept of very low income (or poverty) is concerned, a part of the literature notes that income is not the only or the strongest determinant of health (White, 2003) and that the term 'poverty' has been, to some extent, replaced by the term and concept of social

exclusion. In socially deprived areas, social isolation and exclusion are, therefore, often connected to a state of poverty which can profoundly influence individual and community health and wellbeing.

3.9. Poverty

Any consideration with respect to poverty must start from the fact that income plays a significant role in the quality of life and wellbeing in all age groups and, in particular, in older people. This is related to two factors, i.e. having a good economic level gives a feeling of safety and, more materially, the individual is able to deal with a greater number of adversities. Poverty among older people is a problem which exists on a universal level, partly due to the economic crisis, although of course in some countries the situation looks worse, probably because those countries experienced economic problems among older people even before the outbreak of the economic crisis, as is the case in Italy (de Belvis et al., 2012). In the later section of life, individuals are vulnerable to changes in their income; furthermore (Hoff, 2008) older people living alone are the most vulnerable group in this section of the population.

Relative and absolute poverty are two measurements essential for outlining and highlighting the socio-economic status of the older population. Relative poverty consists of the number of families and individuals out of the total number of households living below a conventional threshold (poverty line) identifying the value of income below which a family is defined as poor in relative terms. Absolute poverty has a number of variables (e.g. number of members of the family, the city of residence and so on) and identifies those individuals and/or families who cannot afford the minimum costs of buying goods which are included in a list of so-called essential items. Moreover, poverty leads to stigmatization, sometimes resulting in a family or individual feeling shame about their economic status. It can certainly be said that there is a very strong connection between poverty, deprivation and social exclusion, "societies with high levels of income inequality tend to have less social cohesion and more violent crime" (WHO, 2003, p. 22). Social isolation and social exclusion are issues that need to be analysed because older people identify them, among others, as key aspects of the quality of their lives, having relationships and a satisfactory life in addition to good health.

Paugam (2001) makes an important distinction, dividing poverty into three subcategories - the *"pauvreté intégrée",* the "marginal pauvreté" and the "pauvreté disqualifiante". Integrated poverty (*"pauvreté intégrée")* is poverty in the traditional sense of the term, meaning that there is a lack of material circumstances; marginal poverty ("marginal pauvreté") is closer to the concept of social exclusion but refers to subgroups of the

population, groups that are traditionally identified as poor and of which the society does load partially because of the fact that society considered them as individuals who have self-excluded themselves from society, an illustrative example are homeless, who are considered as people who have 'refused' society. Disqualifying poverty (pauvreté disqualifiante) is strongly linked to social exclusion, individuals within this group are those who come into the poverty group at a particular time of life and are often called the new poor. This group is spreading and growing on a daily basis. This implies, again in agreement with the thoughts of Paugam (2001), that society has an interest in this group because it becomes a social issue which does not happen for the first two groups. The elements that carry the so-called new poor to enter a world of poverty and exclusion that they very probably considered distant from themselves are of a personal nature (job loss, serious illness of a relative, or their own illness or retirement, for instance) and socio-historical such as the deep economic crisis that has hit Europe.

All those who are in the third group i.e. the new poor are included in it in such a way so to speak accidental, just like the older people that due to the retirement joined to the crisis are literally fallen in this contemporary form of poverty from which do not have the ability to come out, at least this is happening in Italy. Tsakloglou and Papadopolus (2002) point out that there are some elements which are able to protect individuals from social exclusion such as being integrated in the job marked, have good qualifications and a good and stable familiar relationship, this at personal level, furthermore the authors underline that the countries and the welfare are important facts in the development of social exclusion.

In the light of the above, although these concepts are crucial, they are difficult to define and categorize due to their complexity. This leads to consideration of how difficult it may be to tailor interventions to this section of the population and, as poor health and wellbeing and quality of life are made up of a plethora of elements, how difficult it is to succeed in terms of improvements in each of the above variables. Moreover, all these concepts are inter-related and one cannot be more important than the others. This can trigger a positive reaction because an intervention tailored to improve (or decrease) one aspect may have a domino effect. The strong relationship among and the multi-factorial nature of the above concepts is mirrored by that of the individual who is a complex machine made up of a wide range of aspects (biological, social, psychological, health and economic). In other words, each individual not only consists of social relationships but also job satisfaction, good health status or economic wellbeing. Therefore, well-designed health promotion tools should touch many aspects of an individual's life.

3.10. Chapter summary

The concepts reviewed in this chapter – health, wellbeing, quality of life, social capital, social exclusion, social isolation and poverty are seen by scientific and policy literature as central to coherent improvements of social welfare at national and international levels. These aspects can provide the foundation for a fairer society; for this reason, the analysis of the aforementioned concepts is useful primarily because it allows some key concepts of today's social framework to be sketched out. As seen the concepts are, for the main, multifactoral and change over time according to medical and/or social changes.

The concept of health stated by WHO in 1946 was an important starting point for developing health promotion strategies although a single definition to describe such an important concept is misleading. All other concepts mentioned in the chapter are important blocks in order to frame the status of individuals across age. Older individuals have their own nuance of health, wellbeing and quality of life as well as social exclusion, isolation, poverty have particular effects on them in comparison with other age groups. This should be kept in mind both in developing policies and health promotion intervention and in analysing their needs.
The next chapter will be focused on the contribution that arts make to wellbeing, health and the quality of life of individuals.

Chapter 4.

Arts, Music, Singing and Wellbeing

4.1. Introduction

This chapter reviews research on the effects of music and singing on individual health considering biomedical, psychological and social aspects. The quality of research is variable and concerns and issues have been raised within the scientific arena with respect to the design, sample and methodology. Accordingly, a critical analysis of research quality and its connection with the topic will be carried out. As a preliminary, there are two different ways of taking part in the arts - one could be defined as 'passive' when an individual or a group merely participates in the event as an audience or recipients; the second one is active participation in developing the arts activity (Barraket, 2005).

4.2. The problem of evidences

There is general agreement in literature that social participation and engagement, both in terms of being actively involved in groups and being part of a leisure activity, improves wellbeing and leads to a longer life (Konlaan, Theobald and Bygren 2002; Lutgendorf, et al. 2004; Sundquist, et al., 2004; Sirven and Debrand, 2008). An increasing body of evidence also points to the value of creative activity during leisure time in promoting health and wellbeing (Staricoff, 2004; Daykin, et al., 2008). Further, an extensive amount of epidemiological research suggests that there is a higher rate of mortality among people who rarely go to the cinema, theatre or arts exhibitions (Bygren, Konlaan and Johansson 1996; Konlaan, Bygren and Johansson 2000; Wilkinson, et al., 2007).

Arts have been recognized as having a role in helping to achieve wider public health objectives (Hamilton, Hinks and Petticrew 2003; Stuckey and Nobel, 2010; Clift, 2012) but there is a need for further high quality evidence on the value of creative arts for health. There is very great interest and growing concern about measurement and evaluation around arts and their impact on health (Belfiore and Bennett, 2007), therefore, one of the most central problems that affect arts projects focuses on their validity and evidence concerning the real improvement in the health (in the broader sense) of people. The concerns and issues raised by the scientific arena in assessing the impact of art in health and the problem of evidence can also be attributed to this.

A first aspect to be taken into account is that the combination of arts and health includes many facets and, in the scientific literature, as mentioned, the topic is acquiring increasing interest. According to Raw and colleagues (2012), the classification of the topic, while crucial, is difficult, due mainly to the fact that it is made up of a connection of different disciplines such as health, social science and arts. In recent years, there has been a growing discussion in literature about the real meaning and composition of the concept of arts and health, and a wide range of models have been developed with the common aim of having a clear taxonomy of the field.

Research has a solid hierarchy in the classification of its evidence. At the highest level, research begins with a theory/hypothesis which generates a prediction capable of being precisely tested through study designs that will determine whether the theory/hypothesis has a foundation. This is the experimental method, and is the basis of recent developments in systematic reviewing to support evidenced-based health care. Evidence to fit within the structure of Evidence Based Practice, known also as Evidence Based Medicine (EBM) (Bolton, 2001), must have three features showing that the practice is effective, safe and cost effective (Dileo and Bradt, 2009). Sackett et al. (1996) define EBM as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research" (p. 71). Some commentators stress the need for a biomedical model in evaluating research, as the dyad 'arts and health' contains the word health. Conversely, there are others who approach the connection between arts and health from a social science perspective and who regard qualitative approaches to research as more appropriate in order to understand the processes through which creative activity can lead to wellbeing.

According to Castora-Binckley et al. (2010), the limitations found in health promotion research focused on arts (lack of a control group, lack of randomization of the sample and sample size) are the same as those which may be found in research and validation initiatives to promote based on medical tools (mainly pharmacological). Broderick (2011), quoting O'Carrol (2009), claims that "seeking validated arts practices and impacts using the dominant evidence based model is futile" (p. 105). Petticrew and Roberts (2003) argue "the hierarchy of evidence is a difficult construction to apply in Evidence Based Medicine, and even more so in public health," (Petticrew and Roberts, 2003 p. 527). More specifically in arts and health, Raw et al. (2012), quoting Angus (2002) and White (2010), state that "using a medical measurement and assessment model is inappropriate" (p. 100). Therefore health promotion research based on arts should be developed bearing in mind a sort of intrinsic limitation. More precisely, the kind of research which should be developed should be

clarified from the start; if the aim is to carry out a general survey on beliefs, attitudes on arts and health or using physical measurement it may be feasible to follow Evidence Based Medicine rules. Conversely, if the research is focused on health promotion intervention using arts and health looking at general wellbeing, it may be much more difficult to generate research with a large sample size or which strictly follows Evidence Based Medicine rules.
In addition to the above Sackett et al., (1996) point out that Evidence Based Medicine should not exclusively involve meta-analysis or Randomized Controlled Trials, although these tools undoubtedly have strength in developing evidence. Looking for evidence is something broader, it is finding "the best external evidence with which to answer to clinical questions" (p. 72) (Sackett et al., 1996). In the light of this, therefore, it can be said that the right tool should be found to respond most appropriately to the question of whether art does or does not have an effect on the health and wellbeing of individuals, and this tool cannot be only RCTs or case controlled studies. Thus, to conduct a fair assessment of the research in this field, it might be better to consider the approach that uses the social paradigm of health, that is a broader view of the concept of health, starting from the fact that the dyad 'arts and health' can be considered as part of social sciences in the same way and, therefore, evaluating the research through a social rather than a biomedical paradigm.

4.3. Art therapy and art therapist

Castora-Binckley et al. (2010) accomplish an interesting division with respect to the use of arts. They believe there is a dichotomy between arts therapies and the therapeutic use of art. Arts therapies are used in clinical settings such as hospitals and nursing homes and are carried out by health care professionals. Their main objective is to improve the health of the individuals who participate/attend. The therapeutic use of art is rather different; those who lead sessions of art for therapeutic use are professional artists who essentially carry out substantially health promotion activities within the community. This dichotomy has great importance for a wide range of issues. First, the aim, environment, living conditions, health and activities are rather different. In other words, according to the division seen above between the active and passive use of music, it is easier for the passive use of music to be used in the first case while active use is made within the community. The above also involves another effect: it can be said that the use of arts in some specific settings are easier to evaluate through the use of validated measurement instruments, as it is probably easier to record improvements in a given clinical condition. On the other hand, it is more difficult to measure a feeling (such as social isolation, or loneliness) and its change (improvement/worsening) because feelings cannot be measured other than through individuals giving subjective reports on their feelings before and after the experience.

Therefore, it seems quite logical that a relatively high number of studies use self-rated questionnaires as a tool.

As far as specific disease is concerned, two studies on singing and Parkinson's disease are of particular interest. Di Benedetto et al. (2009) investigated 20 individuals suffering from Parkinson's disease, and report improvements in the quality of speech and breathing following engagement in group singing, Satoh and Kuzuhara (2008) examined the use of singing to improve the regularity of walking in people affected by Parkinson's disease. A small sample of patients with Parkinson's (7 individuals) was trained to sing a familiar Japanese song to themselves and they found that this simple procedure led to an improvement in both the length of step and the time of walking.

Returning to the discussion about arts therapies, Broderick (2011) makes another interesting point with respect to it. First, that there is great need to divide art therapy from arts practices. In agreement with the view taken by the Arts Council of Ireland, art therapies are "therapeutic intervention informed by the practice of psychology, psychotherapy, psychiatry" (p. 96), while arts practices are something carried out by an artist. And second, the first and most important result for an art therapist is an improvement in the client's health, the first and most important result for an artist is that the activity is enjoyable and he/she is interested in health results only as a second step.

4.4. Arts and health

A number of factors such as gender, social class, race and education influence the rate of engagement with the arts. Moreover, there are social and economic barriers, which block access for socially isolated people who have no friends or family interested in taking part in cultural events. "England is Taking Part", a national survey of cultural participation run by the Department for Culture, Media and Sport in partnership with the Arts Council, English Heritage, the Museums, Libraries and Archives Council and Sport England carried out in 2007/2008, revealed that large sections of the population do not have any access to the arts. Women and older people attend more arts activities than men and young people; in addition, more white people participate in arts events than do black and Asian groups. Further, the report shows that having a low level of education and being part of a lower social class group are the most "powerful factors in predicting levels of arts attendance" (Bunting et al., 2010 p. 26). Thus inequalities in attending arts events and having access to cultural experience seem to be parallel to those in other aspects of social and economic life (Bunting et al., 2010). Therefore, socio-economic features influence health status, socio-economic barriers influence arts consumption and, in turn, arts consumption influences health. This, once more,

means that socio-economic status has a very significant role in the lives and on the health of individuals.

Attending events "may be stimulating and relieve stress, hence leading to improved happiness-life satisfaction" (Guetzkow, 2002 p.10) while active participation in the arts leads to a sense of self-worth and self-esteem With respect to active participation in cultural programmes, there are good patterns in terms of overall health but there is also an interesting aspect in both terms of access to health care (i.e. GPs) and prescription medication. Research involving two groups, one taking part in an arts programme and the comparison control group involved in usual activities, showed that there was an increase in doctors' visits and the consumption of medicines in the comparison group (Cohen, et al., 2007).

Guetzkow (2002) has argued that there is a problem of identifying the causal mechanisms through which the arts have an impact (Jermyn, 2001; White, 2003). Moreover, as Cameron et al. (2013) note, quoting Pawson and Tilley (1997), understanding three main aspects in "what it is about a programme which works for whom in what circumstances" (p. 56), beyond the mechanisms involved, is crucial. Actually a clear understanding of those three elements would not only help to clarify the causal mechanisms but would provide the basis for transforming the arts into effective forms of health and social care for people. Besides this, another important challenge to assessment focuses on the micro or macro level of the impact on arts - the literature generally agrees on the fact that arts improve individual health. Despite this, some authors underline that arts are able to create "bridging" social capital (Milyo and Oh, 2004), while others believe that arts are able to generate "bonding" social capital because they create interaction among similar individuals with similar interests (White, 2003). In their review, De Silva and colleagues (2005) quoted by Livesey et al. (2012) show that social capital has a crucial importance in preventing mental health diseases; they found that there is strong evidence that "high social capital is associated with fewer common mental health problems" (p. 11).

Staricoff (2004) reviews a substantial body of medical research which indicates that the arts have a role in improving the care of cancer and heart patients. Furthermore, the arts make a contribution in the context of medical procedures, for example in promoting relaxation before anaesthesia or in pain management. Staricoff's (2004) review looked at both passive and active involvement in the arts and indicated that the arts could have benefits when considered from a medical point of view. Likewise, Stuckey and Nobel (2010) consider the role of the arts in a wider public health context and argue that a variety of art forms – music, visual arts, dance and expressive writing - can have a positive effect on individual health.

The most interesting aspect of the review, beyond the fact that the authors underline issues related to the research topic analysed (sample, control group and so on), is the idea that different kinds of art engage the body and the human mind at different levels and, in their different ways, can have positive effects on health and wellbeing. Furthermore, because art has such a number of different facets and can be used in such a number of different ways, this may lead to thinking that the most varied combinations can be tested and there would always be positive results.

4.5. Music and health

Among the arts which might be used for improving the health and wellbeing of individuals in accordance with the definition given by WHO, music certainly plays a predominant role. An increased interest in music and its benefits in terms of social and individual wellbeing and quality of life over the lifespan has flourished in the last 30 years; further, there is considerable interest in using music as a resource for the community. Stuckey and Nobel (2010) in their literature review states that "music can calm neural activity in the brain" (p. 255). Dileo and Bradt (2009), referring to their meta-analysis carried out in 2005, show that all the studies carried out on medical specialities reported that both music and music therapy have significant effects on patients. The fact that music has an effect in all medical specialities except dentistry shows its great strength and real effectiveness.

The use of music and singing in the older population is of particular interest because listening or singing are activities which can even be done during late life. The study developed by Cohen, Bailey and Nilsson (2002) interviewing groups (in a rural area and a more urban one) of older people twice within about two and a half years showed that participants love music, with most of them listening to music every day and recognising that music as an important aspect of their lives.

An even more important feature, in agreement with the study, is that regardless of the level of cognitive ability (measured in research with MMSE), music plays an important role in the lives of older people with mental decline and memory loss problems.

Music is often perceived by older people with objective economic difficulties as a way of passing the time in a non-expensive way, and even though older people claim to have more important hobbies, music "seemed to be part of their everyday lives" (Flowers and Murphy, 2001 p. 31).

As mentioned above, listening to music is an activity open to all and has a function of companionship while still being passive and, therefore, the involvement is primarily mental.

Conversely, singing is an activity which gives individuals the opportunity to be involved in live music and goes beyond the technical skills of using a musical instrument.

4.6. Singing and health

There is a considerable body of research focused specifically on singing and its effects on individual life. Singing is certainly an active way of taking part in music and is open to all since, with a few exceptions, most people are able to sing. It can be said that there is general recognition in the literature that singing, especially in singing groups/choirs, may have positive effects at different levels (Stacy, Brittain and Kerr, 2002). Research carried out on the subject has focused on different indicators of wellbeing and health (e.g. on physiological or psychological aspects or general wellbeing), with the majority of studies identifying some positive effects of singing on the individual.

Hulme (et al., 2009) reviews evidence to show that music can have a wide range of beneficial effects for patients with mental decline and memory loss problems. With respect to singing actively, there are some studies which display the positive effects of singing (Svansdottir and Snaedal, 2006; Myskja and Nord, 2008, for instance) but it should be borne in mind that there is often effective inability to sing in more severe stages of mental decline and memory loss problems. Conversely, it is interesting to look at the results of research in which care givers sing to people with such difficulties, where it has been found that this calms individuals and improves the patient's ability to express positive emotions and moods (Gottel, Brown and Ekman, 2008).

As Coffman (2002) states, older adults report psychological and social benefits in making music; in the light of the fact that the older often suffer from low levels of wellbeing and poor physical health, and research showed that their status can be improved though the opportunity of being with other people and having relationships, it can be said that the activity of singing in groups can be a valuable tool in achieving better health and wellbeing in the older population.

Singing as an activity involves both mental and physical elements, and it is this mixture of body and mind and its ability to enable individuals to connect with one another, that is its strength. In agreement with the arguments made by Beck et al. (2000), singing is an activity which is considered very positive per se, and this is demonstrated by the very high number of choirs and singing groups scattered all over the world (Bayle and Davidson, 2002). Already in 1996, Bygren, Konlaan and Johansson indicated singing in a choir as one of the factors that were positively correlated with the reduction in mortality. As Brown, Gottel and

Ekman (2001) state, “singing is thought to have multiple benefits for the individual at the physiological, emotional and social levels” (p. 128). Clift and Hancox (2001) found that singing has beneficial effects in six main areas: wellbeing and relaxation, benefits for breathing and posture, social benefits, spiritual benefits, emotional benefits and benefits for the heart and immune system, in other words singing has beneficial effects on health.

Bearing in mind that the research on the subject encompasses a wide range of studies yet, despite this, the field is still at an embryonic level (Clift et al., 2008). In addition to this, research on singing and health has two major limitations - that of the design (both as methodology and measures) and the purpose, in other words what the research is trying to clarify/demonstrate. As Clark and Harding (2012) argue, the problem of research on this topic is not so much focused on the amount of research done and the number of studies carried out, considering the new area is quite large, but on the fact that there is an inherent difficulty, as said for arts in general, in gathering quantitative data showing when, how and why singing is good for the health of individuals; in other words, evidence which explains the hidden mechanism in singing.

With respect to the second aspect – what the research is trying to demonstrate - this is complicated and has no easy solution. Using a mixed approach with qualitative and quantitative methods leads to having a large number of results which are also difficult to categorize and classify, and that seldom answer a specific question. Furthermore, the above is certainly linked to the fact that substantial results of policies to promote health and correspondingly research into health promotion are often seen in the long term and not the immediacy, and therefore studies which look at small samples for a short period of time do not have the strength needed to confirm the validity of the intervention itself and the area of research as a whole. It is essential that there are some studies which look at the effect that singing has on the individual, and then demonstrate the repeatability of these effects, to make singing a tool of health promotion. That being said, the fact remains that singing improves health in people in a very large number of levels and facets ahead of the issues already mentioned.

4.6.1. Physiological effects of singing

A significant amount of research has looked at the effects of singing, including its effects on physiological variables and physical functioning. Measuring biological and objective health variables helps to give greater scientific credibility to research as opposed to self-reports of wellbeing and health. This section will give critical consideration to this and, more specifically, research has mainly been focused on breathing problems (COPD and asthma),

the immune system, Parkinson's disease, blood pressure and hormone levels (e.g. cortisol and oxytocin).

As regards the improvement in lung function/breathing, some studies such as that conducted by Wade (2002) have shown that singing improves lung function in the specific case of the group of asthmatic children. The quantitative study gave children hours of singing and listening; the sample was very small (9 children) but there was clearly an improvement in lung function and this was also maintained after the singing sessions. This study is interesting for two main aspects, first the improvement in health was measured in terms of lung function which is a solid and reliable measurement; secondly the improvement is maintained after the intervention which is one of the main aims from a health promotion point of view. In this case results are important in the short and long term.

Studies have also been carried out on COPD patients; in both studies (Engen, 2005; Bonilha et al., 2009) the sample was small, nevertheless the latter was a RCT, with the sample of 30 individuals split into two groups of 15 each, one doing singing and the other being a control group and having a handicraft session. Interestingly, both groups showed a higher level of quality of life, probably connected to the fact that they were involved in two interesting activities; however, as far as breathing was concerned, only the 'singing group' improved its level of cardio-respiratory function. Pai and collegues (2008) focused their research on snoring problems to discover if singing could prevent invasive surgical solutions. They compared two groups of individuals, one of semi-professional singers and the other of non-singers. Snoring was measured in participants and sleeping partners and the results displayed that the singers had lower snoring scores. Gale (et al., 2012) conducted research on cancer survivors and their careers, focused on the quality of life, mood, depression and lung function. The study reports no changes in lung volumes but they did find an improvement in maximal expiratory pressure.

A number of studies have focused on the impact of singing on salivary immunoglobulin A (SlgA) and/or cortisol. Most of these studies show an increase in levels of SlgA in response to singing (Beck et al., 2000, Khun, 2002, Kreutz et al., 2004, Beck et al., 2006). With respect to the cortisol level, two studies have shown the absence of any change. The first study focused its attention on rehearsals and the saliva sample was taken at the end of 60 minutes of rehearsal (Kreutz, et al., 2004), while the other study focused attention at different times – after individual singing, rehearsals or performances (Beck et al., 2006). In contrast to these two studies, there are others (Beck et al., 2000; Grape et al., 2003) which found changes in cortisol associated with singing, although the patterns are complex and affected by other factors. Grape et al. (2003) found an increase of the level of cortisol for men but a decrease for woman following singing, while Beck et al. (2000) found that the

level of cortisol decreased after rehearsals (two and a half hours) and increased after a performance (one and a half hours).

4.6.2. Singing groups

There is a body of literature that focuses its interest on the use of choral singing as a tool for health promotion; the literature is considerable and looks at a number of issues, both biomedical and more psychosocial aspects. Several pieces of research underline that being part of a singing group gives the opportunity to make new friends and have more social contacts with people who share similar interests (Hillman, 2002; Livesey et al., 2012); in this way, participation in choirs produces social capital, as the group of individuals share the same interest. As a consequence, social capital could give a contribution to society as claimed by Putnam (2000) and at the same time improve health status through individuals' interactions.

Mood

There is general agreement in literature that singing in groups improves mood (Clift and Hancox, 2001; Tonneijck, Kinebanian and Josephsson 2008; Livesey et al., 2012) and calmness and alleviates depression, perhaps connected with the feeling of relaxation. Lally (2009) found that the change in mood, seen as good spirits and happiness but also in relaxation, calmness and self-esteem, was the main result of her research. An even more important aspect is that an increase in social interaction beyond being part of a singing group "has spin-off effects for people in other areas of their lives" (Lally, 2009 p. 34). Taking this into consideration, there is substantial literature that focuses on the fact that singing groups have the effect of defocusing people from negative and daily thoughts, in other words "having a break from life's troubles" (Von Lob, Camic and Clift, 2010 p.50). As one participant said to Beck and colleagues (2000) in their research, "It gives me something to focus my energy on that takes me away from the worries of the daily job" (Beck et al., 2000 p. 105). Singing gave the possibility to escape from problems, and to have more positive thoughts, for instance "people are less focused on symptoms of illnesses when they are in the company of others than when they are alone" (Bayley and Davidson, 2002, p. 239). Singing has also reflected on highly emotional aspects such elevation of mood and the stimulation of positive emotions (Clift and Hancox, 2001).

A quantitative study carried out by Sun and Buys (2012) shows the results of a study carried out on 18 Australian Aborigines who took part in sessions of a singing group. The participants had a history of poor mental and physical health and a high level of depression. Different questionnaires were used to assess primarily resilience and depression, and there

was also a singing questionnaire. The results show a statistically significant improvement in the ability of the participants of recover from stress, quality of life (physical and mental) and a reduction in the level of depression.

Giaquinto et al. (2006) developed an intervention aimed at avoiding the use of drugs as post-operatory treatment for anxiety and depression after surgery. A sample of 12 people, all in the older section of the population, was split into two groups. One group was given singing and conversation while the other had conversation and singing for a period of two weeks. The result showed a decrease in both anxiety and depression; further, after singing, depression was lower when measured on its own. Moreover, the sample preferred singing in comparison with the time spent on conversation.

The improvement in the general level of mood and decrease in the level of depression, therefore, is quite a relevant result; according to the WHO (2010), 151 million people are currently suffering from depression and, in the projections, it is considered as a major cause of disability in the future, more than heart disease, stroke, road traffic accidents and HIV/AIDS. In the light of this, the reduction in depression should be among the most important issues which health promotion addressed, considering the improvement in the quality of life of individuals as one of the best uses and savings of public money.

Social isolation

People living in social isolation need relationships and connection with others; in other words, they need more all-round social interaction, isolation "is an important risk factor for future mental health conditions" (WHO, 2010 p. XXVI). Interestingly, Lally (2009) underlines that the people who are socially isolated and have little contact with other people or do not speak on a regular basis are those who have greatly benefited from being part of a choir. Of even more interest, those feelings of companionship and social interaction were not only perceived by those who are socially isolated but also by those who are not so isolated. In the light of this, the experience of singing appears really powerful - on one hand, it is a relief to have the chance to share a passion and spare time with other people for those who live the experience of social isolation and loneliness, while on the other, the fact that people who did not have to deal with these problems also felt the same emotions shows that singing has a really strong impact on an individual's life.

Camaraderie

In addition to addressing problems of social isolation, singing groups can also promote a sense of camaraderie and fellowship (Bailey and Davidson, 2005; Lally, 2009), as well as group cohesion (Silbert, 2005) and a sense of cooperation. According to Faulkner and Davidson (2006), "Group singing in general and harmony in particular, requires highly developed levels of mutual, cooperative and coordinated behaviour control" (p. 230). As far as the concept of coordination is concerned, and the effect it has on a singing group, Müller and Lindberger (2011) argue that "singing in a choir is a highly synchronized form of social interaction" (p. 1). These authors carried out a study focused on the ability and degree of synchronicity among people looking at the autonomic nervous system during an individual activity taking place in the group (singing groups/choirs). Their results showed a high level of synchronicity both at breathing and heart rate level during singing which, compared to rest and synchronization, is higher when the individual sings alone compared to multiple voice parts. Wiltermuth and Heat (2009) argue that "synchronous movement improves group cohesion" (p. 1), therefore, group cohesion is directly connected to singing through the synchronisation of breathing and heart rates.

Cohen (et al., 2006) underlined that "being part of a singing group gave people the possibility of being more socially active in other areas of their lives" (p. 72). On this, the study conducted by Silber (2005) in a very specific context - a prison - appears very interesting; the study documents the development of cohesion within the group, and the development of relationships among the female inmates, all of whom had significant relationship and personal problems. Tonneijck, Kinebanian and Josephsson (2008) also argue that a choir could be seen as "a platform where participants felt safe, connected with others, and experienced a sense of wholeness" (p. 175).

Self-esteem and confidence

With respect to the concept of self-esteem and self-confidence, the literature reports that there is a growth of both of these among people who become part of a choir (Hillman, 2002; Lally, 2009). Self-esteem has many facets and the experience of singing groups may produce it in many different ways. In particular, increased self-esteem can arise as a result of learning a new skill and having the opportunity to demonstrate this skill in performance. Bauer, McAdams and Pals (2008) argue that personal growth, in this case in terms of new knowledge and skills acquired, is certainly one of the main components of individual wellbeing. Along with these aspects, satisfaction cannot be forgotten. Satisfaction is derived from the fact that the individual produces, along with others, a good performance. This is

summed up by Zanini and Leao (2006): “singing is a means for both self expression and fulfilment” (p. 1).

It should also be borne in mind that there is no exposure in a singing group, i.e. a person is not alone in facing the world but is in a group that protects and supports; indeed Chong (2010) underlines that there are a number of obstacles to singing. Social conventions, the fear of exposing themselves and the feeling of being vulnerable prevent many people from facing new experiences or relationships. Bailey and Davidson (2005) note that: "group singing and performance can produce satisfying therapeutic sensation even when the sound produced by the vocal instrument is of mediocre quality” (p. 299). This is one of the most important points, and certainly one of the aspects that most strongly lead to increased self-esteem, in those who experience choirs, especially when the sample consists of marginalized people such as homeless men, prisoners or ethnic minorities, as in the research carried out by Bailey and Davidson (2002), Silber (2005) and Sun and Buys (2012). However, in the subsequent qualitative study carried out by Bailey and Davidson (2005) where two singing groups were compared, one of disadvantaged and the other of more privileged people, the authors underlined that both groups emphasized the beneficial aspect of singing, but then there were substantial differences with regard to the fact that the singing group of homeless stressed that this activity allowed them to channel their thoughts better, while the group of more advantaged emphasized the difficulty and stress of learning musical passages to arrive at a sense of achievement. As Faulkner and Davidson (2006) argue, singing in a mixed, formal or informal context leads to an “ideal order to social relationships” (p. 235).

An aspect that should be underlined that is apparent already in the study by Bailey (and Davidson, 2005), but more marked in Sandgren’s (2002), is that when members of a choir experience stress and performance anxiety, singing has less positive effects and, instead, participants focus more on the quality of the performance. Interestingly for people who sing as work, or who are part of a choir and come from a situation of social advantage, the activity of singing produces stress, but also achievement, and therefore wellbeing in the light of what Diener (2000) identified as a part of the subjective wellbeing of a person i.e. “satisfaction with important domains (e.g. work satisfaction)” (p. 34). Singing gives those who have nothing to do (older people, for example) or those who have lost everything (the homeless, prisoners) a feeling of life, something to look forward to routinely during their daily life, a sense of purpose, which is an element that Ryff (1989) includes among those making up wellbeing. This is also supported by Skingley and Bungay (2010). Indeed, their sample, although quite small, showed that it had an attachment to singing that goes beyond the time of the activity itself but expanded into the days before and after.

4.6.3. Older people and singing

As mentioned above, the number of older people has increased exponentially and the related costs of care have increased in direct proportion. The literature review carried out by Teater and Baldwin (2012) focuses attention on older people and illustrates how the older population show positive improvements in health and wellbeing through the use of art and creativity. Studies reported indicate that a number of interventions with different methods show similar results, i.e. that this section of the population likes to use their creativity and learn new skills and express themselves. According to Akbaraly et al. (2009) older people involved in stimulating activities where the authors included "practising an artistic activity" (p. 858) reduced the risk of mental decline and memory loss problems in older age. According to the above, arts also have an important role in improving health condition not only of the older person who enjoys life within the community but also those who are experiencing mental decline and memory loss problems.

Findings from studies on singing and wellbeing have relevance for everyone, across the whole lifespan, but they are of particular importance in thinking about the needs of older people who often live in a state of social isolation, with challenges to their sense of wellbeing and poor health. An important starting point is, ideally, to separate older people into two main groups. The first group is made up of people who live in the community, and the second of people in sheltered accommodation, nursing homes and so on. The second group can be further divided into a subset of people who have developed serious degenerative diseases and those who live in protected structures but maintain their physical-cognitive abilities intact. It is important to underline that the whole group needs health promotion but certainly health and programmes should be tailored for the different groups. These differences are also reflected in literature which shows several studies on the older and the use of music and singing groups in different contexts, spaces and with different objectives. The existing literature on the value of singing for older people and the oldest old has limitations methodologically speaking, but it certainly provides interesting insights on the use of singing as a tool for health promotion. In addition, considering the above-mentioned division, it is also important to note that, paradoxically, the most isolated among older people may well be those who still live in the community rather than those living in a nursing home. This is because it is not uncommon for those in a protected house to have opportunities for recreation and entertainment that those living alone do not have. In addition, those living in the community may find it difficult to go out, perhaps because they cannot move easily, or do not have easy access to public transport and so on.

Reference is made above to the role of music and singing for people with mental decline and memory loss problems. However it is important to emphasize that the focus must not be put exclusively on those who have developed a disease (such as Parkinson's or Alzheimer's) but also on older people who still live in the community but may be vulnerable to health problems leading to a need for health and social care. According to the Department of Health (2010), programmes for older people are aimed at maximizing their functioning alongside the promotion of wellbeing and independence; in other words, the Department of Health is trying to tailor interventions for older people to enable them to age as well as possible through activities which enhance their wellbeing and lead them to age successfully. In this sense, there is a lot of research focused on singing with older people, and even more specifically on singing groups and older people.

Most of the research carried out is mainly focused on two points - on the one hand, there are studies that have formed singing groups specifically for research to assess the benefits of choral singing at health promotion level and, on the other, studies that analyse existing groups. Social isolation among older people is one of the main issues that they suffer in later life. Therefore, providing older people and, even more specifically, older, socially isolated people, with a way of connecting with peers seems important and crucial. However, as Teater and Baldwin (2012) point out, older people do not always have easy access to these kinds of activities - financial resources, limitation of space and auditions are some of the causes which prevent older people from taking part in choirs. As also mentioned in the previous chapters, the older of today live and perceive their life in a very different way which cannot be compared with that of those of yesterday. Cohen (2009) makes an interesting analysis of the different stages of people's lives, saying that "older adults are more in touch with their inner psychological life than at any point in the life cycle" (p. 52); furthermore they are more likely to be involved in new experience, due to the idea of now or never.

It is important to underline that almost all studies on the subject have found similar results, i.e. that singing is good for the health of the older person. Common illustrative themes are the general improvement in wellbeing, increased psychological wellbeing, relaxation and change of mood. This centrality and commonality of results beyond the methodology of the research carried out raises the consideration that it can only mean that being part of a singing group has beneficial effects for older people and that what has been analysed methodologically in the study as less stringent can no longer be evaluated as anecdotal. As noted above, the studies often have a limitation. However, an interesting study was conducted by Cohen et al. (2006); the sample of 160 individuals over 60 was divided into a control group and a singing group. More specifically, the control group continued with

normal activities while the other one had 30 weekly singing sessions. After one year, the results showed that those taking part in singing groups had statistically significant decreases in levels of depression and loneliness.

The above study is of particular interest as there was a control group, however studies carried out with less strong methods also underlined the effectiveness of singing with older people. They reported enjoyment, social interaction, memory, recall and an overall improvement in the quality of life and social wellbeing (Hillman, 2002; Skingley and Bungay, 2010). Further, Hillman (2002) reported statistically significant improvements in emotional wellbeing. Similar results are reported in a recent study (Teater and Baldwin, 2012) which looked at benefits perceived by older people taking part in singing groups. A mixed approach (questionnaire and semi-structured interviews) was used to evaluate three main areas - perception of health, personal development and social connection. Beyond to the limitations already reported by the authors, it is interesting to evaluate how the study is consistent with the results of previous studies. Participants perceived an improvement in their life in general and more specifically aspects such as emotional wellbeing and social connections. The words used by the older people in the interviews showed that as social isolation is a key factor, older people looked with desire at participating to the experience. Further, they considered that participation in group singing was a good way of avoiding social isolation.

Finally, the most important recent contribution to research on singing and older people is a randomised controlled trial which compared two groups of older people of 60 and above (Coulton et al., in press), and inspired the study presented in this thesis. The control group carried out their normal activities while the intervention group had 12 weekly singing sessions. The main purpose of the research was to consolidate previous research on singing and health, and provide robust evidence on the value of singing for wellbeing. Questionnaires comprising three validated self-report quality of life measures were administered at baseline, immediately after a three-month singing programme and finally after another three months. The measures were the York SF-12 (Iglesias, Birks and Torgerson, 2001), the Hospital Anxiety and Depression Scale (HADS) (Snaith and Zigmond, 1994) and the EuroQoL five-dimensional questionnaire (EQ-5D-3L) (Euroqol Group, 1990). Findings showed a significant difference between the singing and non-singing groups at three and six months for mental health, and also for specific anxiety and depression measures after three months.

4.7. Chapter summary

Some conclusions can be drawn from the literature and the evidence considered in this chapter, which has reviewed research on the effects of music and singing on individual health considering biomedical, psychological and social aspects. The problem of evidence of research into arts (music and singing) and health has been analysed, the literature recognizes that there has probably been an incorrect approach in evaluating research on this field and that it would probably be more appropriate to evaluate it beyond the strict rules of evidence. Furthermore, it should be borne in mind that the difference between art therapy and an arts therapist is also important in evaluating results of arts and health promotion activities.
In addition to the above, a wide range of research has been reported in the chapter showing that social participation and engagement in both terms of being actively involved in groups or being part of a leisure activity improves wellbeing and leads to longer life among all ages. Further, epidemiological research suggests that there is a higher rate of mortality among people who rarely go to the cinema, theatre or arts exhibition. Singing, especially singing in groups/choir may have positive effects on different levels i.e. physiological, mental and social. An extensive body of research displays that singing across age and especially for older people has a number of benefits, among others on mood, self esteem, sense of fulfilment, social interaction and relaxation.

Taking into account the above on the problems connected to the transferability of health promotion models and some significant differences between Italy and England, the following chapters will be focused on the evaluation of the validity and exportability of the Silver Song Clubs model to a different context, that of Italy, the author's native country.

Chapter 5.

Aims, Objectives and Methods

5.1. Introduction

This research is a study which explores the effectiveness and transferability to Italy of an English model of health promotion intervention (Silver Song Clubs), to promote the wellbeing and quality of life of older people through participation in singing groups. In Italy, the project was named *Canzoni d'Argento*. As has already been indicated above, the literature supports the idea that involvement in activities of many different kinds can have a significant impact on the health and quality of life of older people. One of the main problems facing the older population in Europe and worldwide are social isolation and loneliness, poor quality of life and poor relationships. The study presented here will compare its results with both literature on the topic and a Randomised Controlled Trial (RCT) which was undertaken to assess the effectiveness and cost-effectiveness of participative singing groups for older people (Coulton, et al., in press) more rigorously.

In the Silver Song Clubs study mentioned above, a sample of volunteers aged 60+ (n=265) was randomised into one of five new weekly singing groups in East Kent or control (usual activities) groups. Questionnaires comprising three validated self-report quality of life measures were administered at baseline, immediately after a three-month singing programme and finally after another three months. The measures were the York SF-12 (Iglesias, Birks and Torgerson, 2001), the Hospital Anxiety and Depression Scale (HADS) (Snaith and Zigmond, 1994) and the EuroQoL five-dimensional questionnaire (EQ-5D-3L) (Euroqol Group, 1990). The Hospital Anxiety and Depression Scale (HADS) (Snaith and Zigmond, 1994) was not used by the Italian study, mainly for practical reasons.

5.2. Aim and objectives of the research

The aim of this research was to explore the effectiveness and transferability of the Silver Song Clubs model a project which is running very successfully in the south of England, on older people in a different social and cultural context, i.e. in the capital city of Italy, Rome. The specific objectives were to:

a) To gather information on and assess the situation of the older population in Italy, and particularly Rome, both from the point of view of the older population and the professionals involved in the care of older people,

b) To explore the meaning and role of music across the lifespan and currently of older Italian people,
c) To assess participants' reactions and their perceived wellbeing before and after the experience of regular group singing and after a 3 months follow-up period,
d) To assess issues of organization, repertoire and delivery in terms of effectiveness and transferability and their differences with the English experience.

5.3. Methodology

A mixed method approach was adopted by the author as the best way of addressing the specific research questions because it "offers the best chance of obtaining useful answers" (Burke Johnson and Onwuegbuzie, 2004 p. 18). Quantitative methods provide quantitative/numerical data, which are less subject to bias while the qualitative approach provides insights into people's perceptions of an experience or phenomena, and more information on motivations and beliefs and attitudes. According to Burke Johnson and Onwuegbuzie (2004), mixed method research is "an attempt to legitimise the use of multiple approaches in answering the research question rather than restricting or constraining researchers' choices" (p. 17). Given the aim and objectives of the current project, both numerical data and qualitative data is needed to answer the research questions posed.

The research was divided into two parts, Part A and Part B, and the data was collected in the following ways: semi-structured interviews, observation of the groups, questionnaires and focus group discussion. Part A was focused on exploring the status of older people living in Rome and their interest in music and singing nowadays and in the past. Further, their interest in participating in the experience of singing was also examined as well as exploring the position of older people as seen by local politicians and social workers. Part A was carried out by one-to-one semi-structured interviews. Pilot sessions were held followed by a questionnaire devised for the purpose. Part B of the research process was focused on setting up and evaluating singing groups and gathering information from participants on their experiences of singing. Three groups were organized in three different Municipi of Rome, and weekly sessions of about two hours of singing were held for 12 weeks. Observations were carried out in an alternative way for 6 sessions with a pre-coded schedule to assess participants' involvement. The older people completed a questionnaire at the start of the group, then at the end of 12 sessions and again after three months as a follow up. The first and 'follow up' questionnaires had the same content while the questionnaire completed at the end of the experience also included six more items and two open questions requesting comments about the experience of singing and health, mirroring those already raised during

the pilot sessions. Further, a focus group was carried out at the end of the experience in order to gather comments on the experience.

With reference to objectives a) and b), semi-structured interviews were carried out with both professionals involved in the care of older people and older people themselves. With reference to objective c), questionnaires standardized and devised for the study were completed by participants and direct observations were carried out by the author. In addition to this a focus group was set up. With reference to objective d), the last part of the questionnaire proposed at the end of the experience and focus group were administered.

The questionnaire presented at the beginning of the experience consisted of 22 items (four on demographic information, six included in EQ-5D-3L and 12 included in York SF-12). Items on demographic information concerned age, gender, level of education, and living conditions to clarify whether the person lived alone, with a partner, their children and so on; EQ-5D-3L is a standardized and widely-used health utility questionnaire which consists of five items and a rating scale for assessing health; the York SF-12 is made up of 12 items to assess mental and physical wellbeing. As also noted above, the questionnaires used at the baseline and follow up were exactly the same, whilst the questionnaire at the end of the experience had some additional questions where the sample could express their views about the experience itself and their perceived health status (six more items with two open questions).

5.3.1. EQ-5D-3L

The two questionnaires mentioned above are generic tools that assess quality of life in general without close relationship to a specific disease. The Italian version of the EQ-5D-3L was used, supplied directly by the owner of the questionnaire, therefore the author did not intervene in any way on the questionnaire. This questionnaire consists of five three-level items making it very straightforward for all kinds of populations, older people included. The questionnaire has two main parts, the first part consisting of five question in relation to the physical and mental health status of participants (mobility, self-care, daily activities, pain or discomfort and anxiety or depression) while the other part is a graduated scale called the Visual Analogue Scale (VAS) that was called the “thermometer” during the study to make it more understandable for the sample. Participants can answer each item by reporting whether they feel no difficulty, some difficulties or extreme difficulty with specific items. With respect to the VAS, it runs from 0 (worst possible health status) to 100 (best possible health status).

The algorithms used to create the scores are based on the Anglo-Saxon population but were validated for the Italian population by Savoia (et al., 2006) and, subsequently, also by Balestroni and Bertolotti (2012) so it can be properly used. All the answers of the 5 items are used to calculate the EQ-5D-3L tariff or index that indicate the self-perceived health status. The highest value that can be obtained is 1.000 (perfect health) while lower values indicate worse health through to the worst value that can be obtained with all the answers indicating "extreme difficulty" (-0.594) (EuroQol, 1990).

For each item where the answer is not "no difficulty", there are some negative values that are detracted from the starting value (1.000) depending on the answer to the questionnaire (Table 5.1). Another two constants are detracted in the following cases:

- if there is at least one item where the answer is not 'no difficulty' (-0.081),
- if there is at least one item where the answer is 'extreme difficulty' (-0.269).

Table 5.1 Weight of each items for EQ-5D-3L index calculation (EuroQol, 1990)

Item	No Problem	Moderate Problem	Extreme Problem
Mobility	0	-0.069	-0.314
Self-Care	0	-0.104	-0.214
Usual Activities	0	-0.036	-0.094
Pain or Discomfort	0	-0.123	-0.386
Anxiety or Depression	0	-0.071	-0.236
Constants	0	-0.081	-0.269

5.3.2. York SF-12

As for the York SF-12 (Iglesias, Birks and Torgerson, 2001), the process was slightly more complicated and the author played a role, although very limited, in the construction of the questionnaire. The text of the official Italian translation and validation of the original SF-12 (Apolone et al., 2005) was employed but laid out according to the format of the York SF-12. With regard to the York SF-12 questionnaire (Iglesias, Birks and Torgerson, 2001), this is an evolution of the SF-12; the evolution of the tool has been driven by the fact that older people have difficulties in correctly completing the original version. In agreement with the developments by the above-mentioned authors, the transformation of the instrument did not affect the validity of the original SF-12 questionnaire but simply makes easier to use as there is also an improvement in response rates using this version "the modified SF-12 had a statistically significant lower item non-response rate of 8.5%, compared with the 26.6% of the SF-12" (Iglesias, Birks and Torgerson, 2001 p.695). In the light of this and the need to use the same tools as those of the English RCT, already described, the author decided 'to create' the Italian version of the York SF-12, also due to the fact that the SF-12 has been validated in Italy (Gandek et al., 1998; Apolone et al., 2001) and the York SF-12 is equally

reliable in detecting quality of life of a sample, further, it is strongly recommended with older populations.

The questionnaire is made up of 12 items, some of which focus on physical health, others on mental health and one item on general health rating. All items except items 2 and 3 have a Likert scale of 5 levels while these two questions have a Likert scale of only 3 levels. All York SF-12 items can be reconnected within 8 health domain scales which contribute, with different weights, to building physical and mental component scores (PCS and MCS) (Table 5.2).

Table 5.2 Weight of each items for York SF-12 PCS and MCS calculation

Health Domain	Related York SF-12 Item	PCS weight	MCS weight
Physical Functioning (PF)	2-3	**0.42402**	-0.22999
Role-Physical (RP)	4-5	**0.35119**	-0.12329
Bodily Pain (BP)	8	**0.31574**	-0.09731
General Health (GH)	1	**0.24954**	-0.01571
Vitality (VT)	10	0.02877	**0.23534**
Social Functioning (SF)	12	-0.00753	**0.26876**
Role Emotional (RE)	6-7	-0.19206	**0.43407**
Mental Health (MH)	9-11	-0.022069	**0.48581**

As Table 5.2 shows, some health domains (Physical Functioning, Role-Physical, Bodily Pain and General Health) mainly contribute to the PCS score while the remaining ones (Vitality, Social Functioning, Role Emotional and Mental Health) mainly contribute to the MCS score (Ware, Kosinski and Keller, 1995).

5.4. Ethical considerations

The research received ethical approval from Canterbury Christ Church University (Appendix 1). No formal procedure was needed for ethical approval in Italy (Appendix 2). The researcher's principal responsibilities in this research were to respect the participants during the study and protect their rights and welfare. Two main aspects should be borne in mind. The first concerns informed consent. Each person interviewed in Part A was asked to sign an informed consent form (Appendix 3) with respect to the interview, while agreement to complete the questionnaire was also considered as consent. As for the interviews with the professionals, there were no particular problems because of their age and professional position. In working with older people, while "age in itself is not a determinant of an individual's ability to give consent" (Harris and Dyson, 2001 p. 644), special care was taken in both explaining what the meaning and purpose of the research was and asking for the signature on the informed consent form. The majority of the older people, however, were

reassured by the fact that the researcher had been in touch with the Municipio and the President of the Centri Anziani, with further reassurances being given when the interview actually took place. In any case, as far as the interviews are concerned, complete anonymity was guaranteed.

The situation is different for the questionnaires. Just agreeing to completion was deemed to be acceptance of participation in the research. There was space on the first page of the questionnaire to create an identification code as the questionnaires needed to be traceable. Participants were well informed about the purpose of the study. The whole research was explained before they filled in the questionnaire so that the sample could understand what the research involved. The content of the research and the meaning and objectives were repeated in every session by the author during the research.

5.5. Timetable of the research

Part A of the research began in December 2010 and ended in June 2011 with the three taster singing sessions. Part B began in July 2011 and the two first groups both started in October 2011 and ended in December 2011. Two performance events were then organized to which the Presidents of the Centri Anziani and local politicians were invited. The third group started in January 2012 and finished in April 2012 followed by a performance event, to which the President of the centre and local politicians were invited. The three-month follow up completion of questionnaires took place in March 2012 for groups one and two and July/September 2012 for group three. Focus groups were held between July and September 2012.

5.6. Part A methods

5.6.1. Interview

With respect to objectives a) and b), mentioned above, the researcher considered semi-structured one-to-one interviews as the best method of gathering data. Two different kinds of people were interviewed during the research - professionals of various types involved in the care of older people and older people recruited in a number of Centri Anziani across the city of Rome (Appendix 4 and 5). In methodological discussions, interviews are generally divided into three categories: structured, semi-structured and unstructured and, in this research, semi-structured interviews were used "to allow the person interviewed much more flexibility of response" (Robson, 2002 p. 270) with a list of questions and prompts to encourage participants to elaborate on their answers. Informed consent was given for all the

interviews. Figure 5.1 gives the sequence followed in organizing and conducting interviews with both the professionals and older people.

5.6.2. Interview of professionals

In order to investigate the condition of the older population as perceived and judged by politicians and social workers, semi-structured interviews were carried out to gather information on the following four issues (Figure 5.1):

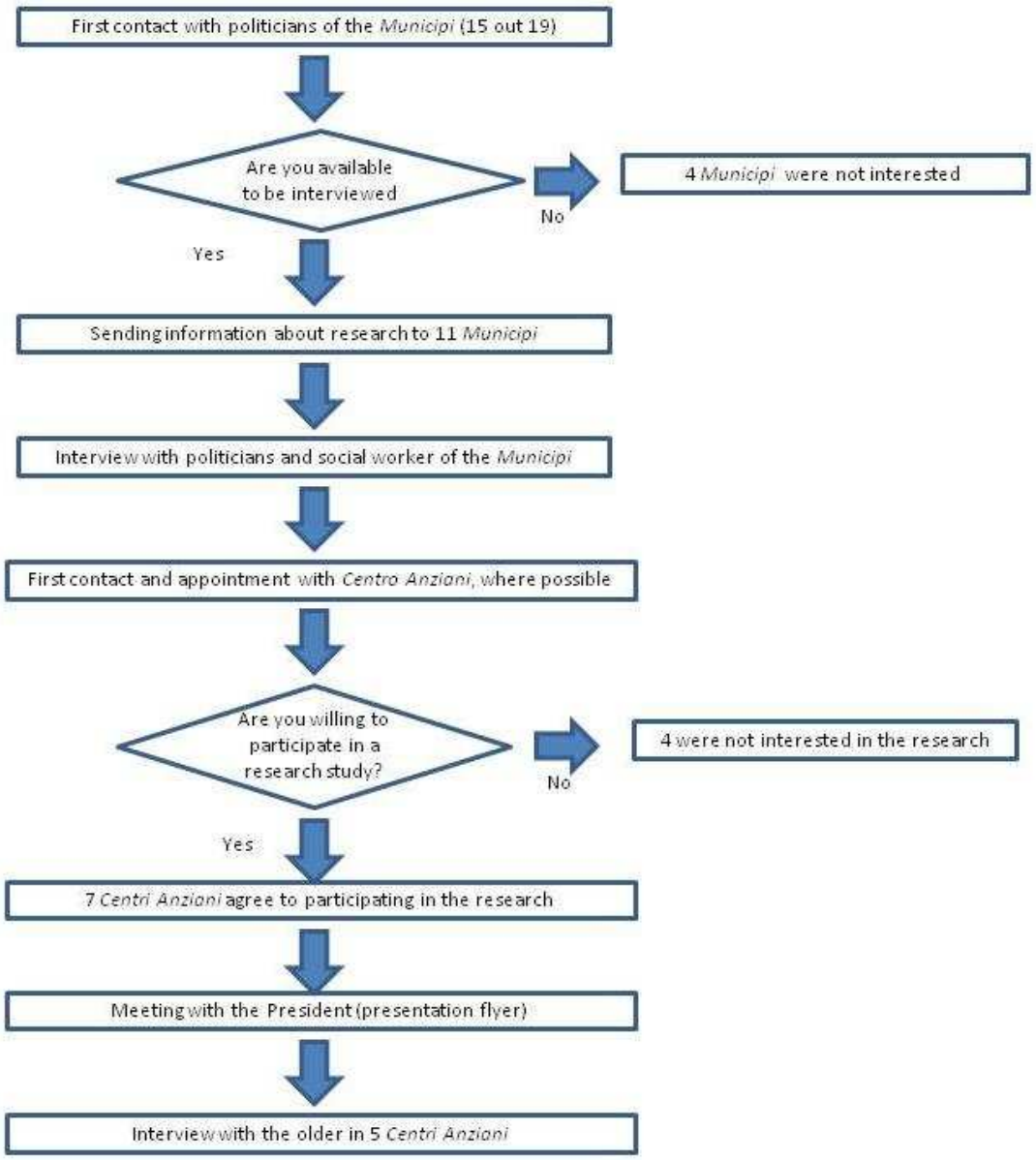


Figure 5.1 Flow chart of interviews

- Social-demographic information about the area;

- Conditions of the older population in Rome;
- Quality of life of the older population;
- Assumed interest among older people in taking part in singing groups.

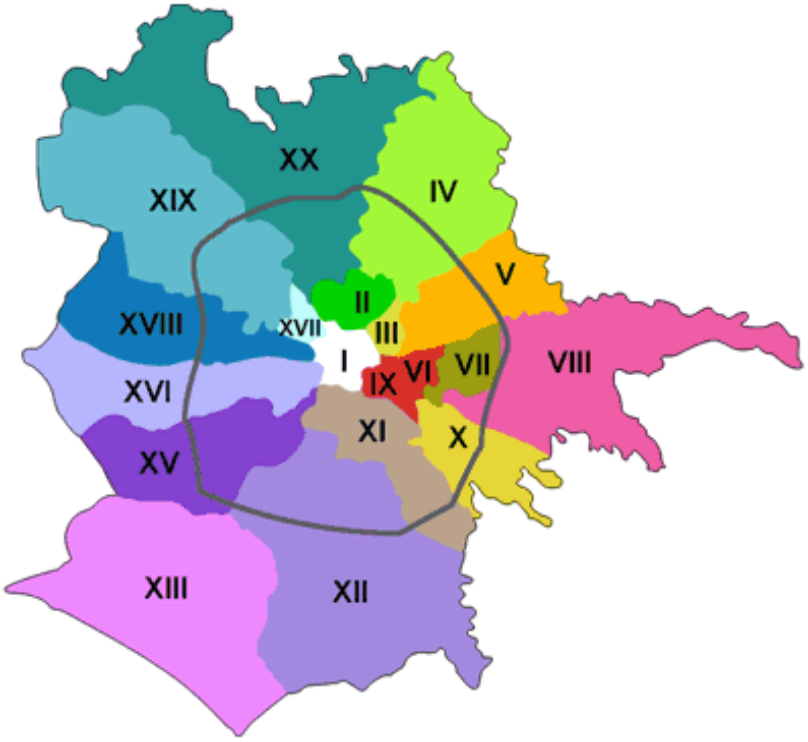


Figure 5.2 Map of Municipi of Rome

Rome was divided at the time of the research into 19 districts (the so-called Municipi) that have areas of different sizes, each with a population of around 100-150,000 individuals on average. Each of these municipalities has a local government that deals with the problems and issues concerning the area. The districts have considerable economic and social differences with some areas heavily affected by immigration while others are predominantly Italian. The socio-economic situation of all districts was analysed through official data, i.e. the ageing index, dependency ratio, single person households and socio-economic index, and starting by identifying those districts with the highest proportion of older people (60+). Interviews were subsequently carried out with representatives of local authorities/professionals (i.e. with some members of the district governments and social workers), and older residents in the Municipi through Centri Anziani for older people. The city of Rome has grown towards the suburbs and, as a result, can be divided into three different parts:

- The central part where there is a large number of older people with good economic status;

- The middle part (the popular part of the 1960s) where there are quite a few older people with bad economic status;
- The suburbs where the economic conditions are similar to those of the middle part but there is a smaller proportion of older people.

The final choice of the three Municipi where the singing sessions were set up was determined by considering three main aspects:

- The demographic features of the area;
- The interest of older people in participating in the research;
- The willingness of Centri Anziani to be involved as a venue for singing groups.

Rome at the time of the research was divided into 19 Municipi but, since then, a Municipio (number 14) has become a separate town from Rome (Figure 5.2). Each Municipio has a geographical area of interest and elected politicians who work in that area. Each Municipio has its own President and a number of 'Ministers' (in this case, the name is Assessori in Italian) with responsibility for specific areas such as health, transport, environment, education and so on (Table 5.3).

Table 5.3 Population of the City of Rome and its Municipi (Comune di Roma, 2012)

Municipio	Population	Municipio	Population
1	133.590	11	134.351
2	122.477	12	179.248
3	51.790	13	230.996
4	205.719		
5	177.737	15	153.817
6	123.268	16	143.504
7	125.029	17	68.132
8	256.416	18	137.566
9	125.546	19	189.512
10	185.032	20	160.423
City of Rome		2.904.153	

The researcher contacted "ministers-assessori" responsible for health, social care or social policies in order to interview them. Generally speaking, the procedure was as follows - politicians were firstly contacted by phone and this was followed by a letter of introduction (Appendix 6), a brief summary of the research and a presentation of the researcher. A specially designed flyer outlining the research was also sent to interested professionals (Appendix 7). Once politicians agreed to the interview, an appointment was made; the researcher subsequently contacted the social workers in order to interview them. A total of

20 professionals, 11 politicians and 9 social workers, agreed to be interviewed. Ten politicians allowed recording but one preferred being interviewed by email. For the social workers, 3 out of 9 did not allow recording.

The author tried to see the two points of view (politicians and social workers) as far as possible for each Municipio. This procedure was chosen to have two distinct points of view in this first phase of the research so that a comparison could be made. Unfortunately, this was not always possible and was done in only five Municipi. The researcher contacted 15 out of the 19 Municipi, a choice made on demographic features, to set up interviews with professionals. Not all the Municipi contacted were interested in participating in the research; specifically 11 of the 15 contacted were interested but four were not.

5.6.3. Interviews with older people

The main aim of the interview was to gather information about five main issues:

1. Social-demographic data;
2. The role of music in their life;
3. The role of music in their life at the moment;
4. Information about everyday activities;
5. Interest in participation in singing groups.

5.6.4. Procedures

As far as the interview of older people is concerned, the procedure followed is given below. During the interview with the politicians and/or social workers, the whole research was explained. Further, the researcher made social workers and politicians aware that she would visit the Centri Anziani to interview older people. Each Municipio has a number of Centri Anziani scattered throughout its area where older people can pass time, even all day, except for meals. Although coordinated by the Municipio, the Centri Anziani are completely independent and the President of each one is an older individual elected by the users of the Centro Anziani. The professionals generally advised the President of Centri Anziani that the researcher would phone to interview some of the people using the centre and propose a singing experience.

Setting up Part A was long and, with reference to the flow chart above, made up of a number of different steps.

An appointment was first made with the President, then the entire research was presented to him/her in a conversation; subsequently, a second meeting was arranged, announced by a flyer on the bulletin board of the centre, where those interested could be interviewed by the researcher. A very small number of older people were willing to be interviewed. A total of 40 older people were interviewed through a semi-structured interview in Centri Anziani in

those Municipi which were interested in taking part in the research; only 5 out of 11 Municipi were involved. The researcher tried to interview older people from many different social-cultural and economic contexts. The interview was recorded, transcribed and analyzed for the main themes. Each interview lasted between 6-7 minutes and 35-40 minutes. The language during interview was appropriate for the target sample.

5.6.5. Inclusion and exclusion criteria

Only older people of 60 years old and above without cognitive problems were involved in this research.

5.6.6. Piloting work in preparation for the main study

There were two main pilots, the first focused on the interviews of the older people, the second on the music sessions. The design of the interview was different in the early stage of the research and was modified on the basis of the pilot. The original intention was to lead focus groups with the older population to make them more comfortable and simplify the conversation, seeing that the questions were very general and referred almost exclusively to the role music had had in their lives and the role it has in their life today, as older people. Therefore, a pilot focus session with a first group of older people was carried out, but this created friction and disputes within the group since some of the participants had some experiences in life and others had had different ones, even though they were contemporaries. These differences in experience were largely determined by socio-economic and environmental features. As a result of the above problems, the approach to interviews with participants was changed and the researcher continued by carrying out one-to-one interviews. This allowed the demographic data to be gathered more precisely and the discussion to be calmer and more serene.

With respect to the singing sessions, three pilot sessions were held in June 2011 to check not only the interest of older people in taking part in the research, already assessed through interviews, but also to understand any practical issues that would need to be addressed in the organization of the singing sessions in the main research phase. The three Municipi where the pilot sessions were held were chosen in the light of socio-demographic information of the entire Municipio, as well as the interest shown by the older people during the interviews and the support of the presidents of the Centri Anziani involved.

A first draft of a song book was created with a number of songs chosen by the researcher in the light of the semi-structured interviews with the help of the two musicians. A specially devised questionnaire (Appendix 8) was given at the conclusion of each pilot session and

answered anonymously, and a precompiled observation was used. It had 13 items (4 about gender, age, living conditions and level of education) and 9 about the experience, with some space to allow the participants to make personal comments, especially with reference to the repertoire used and suggestions for other songs the participants would have liked to sing. The aim was to assess interest in participating in a programme of 12 sessions on which the entire research would be based.

5.7. Part B methods

5.7.1. Observation schedule

The pre-coded schedule used for this study is based on an observation schedule used in an earlier evaluation of the Silver Song Clubs project in England (Corvo, 2005). According to Bowling (2007) "Observation is a research method in which the investigator systematically watches, listens to and records the phenomenon of interest," (Bowling, 1997 p. 316). It has been suggested that observation is "a valuable and underused technique for collecting data," (Taylor-Powell and Steele, 1996 p. 21) but it clearly offers the opportunity and advantage of obtaining information as soon as it happens and in context. The main objective of observation in this research was to understand the positive and negative emotions and reactions of participants during the sessions and about songs. The most interesting aspect of using observation as a research method is that it is a very incisive and direct process and can also be used in different ways, e.g. in the form of a free-form diary/notes or with pre-coded sheets. It seems obvious that observation has a major limitation - it is likely that the researcher may not be objective in his/her observations; as noted by Grimes and Shulz (2002), "selection bias, information bias, and confounding are present to some degree in all observational research" (p. 248). In order to avoid the problem, the researcher chose to use a sheet in which pre-compiled specific items of interest to the research were specified, but supplemented this with a diary record of each session (Appendix 9).

An observation pre-coded schedule was devised before the start of the project to assess the engagement of the participants. It was divided into 2 sections - the first section recorded the venue where the groups were held, the start time, the end of the session and the duration of the break. In the second section, there was a record of the songs sung and the reactions of participants. With reference to the impact, there were variables such as level of participation, attention, smiles, comments/chatting, the pre-coded schedule included the most prominent aspects of the session. There was also some space for the author to add comments beyond those codified in the pre-coded schedule.

In addition the research kept a diary throughout the project. This was completed following each session to comment on what could not be recorded through the pre-coded schedule. In particular, the comments of participants during breaks and assessments or requests for specific songs were taken into account. It should be borne in mind that the researcher could not register every aspect of the session therefore some aspects may have escaped.

5.7.2. Questionnaires

Three questionnaires were used - the EQ-5D-3L, a widely used standardized measure of health utility, the York SF-12, a widely used standardized measure of health-related quality of life and wellbeing, and a questionnaire devised for the study (Appendix 10, 11 and 12).

5.7.3. Focus group

A focus group interview was used to interview the participants in the research. The focus group was created in two venues involving about 15 participants from venue S and venue T. Participants from venue F were not involved for practical reasons. They were held in July and September 2012. The main aim of the focus group was to gather information about 2 main aspects:

1. Impact of the experience on the wellbeing and quality of life of the participants;
2. Opinions about the experience as a whole (timing, repertoire and so on).

The focus group was conducted in an interactive circle to allow each participant to express views and feelings about the experience for around 35 minutes. The researcher took notes during the discussion.

The researcher first asked a question:

a) What do you think about the experience?

This question was followed by further prompts:

b) What about your feelings during the experience? And after?
c) Which kind of impact did it have on your life?
d) What is your opinion about the structure of the experience?

The focus group was considered as the most effective way of allowing participants to give their own perception of the whole project. Further, the focus group "facilitated communication and promoted an exchange of ideas and experiences" (Robson, 2002 p. 286), and a focus group is a "useful strategy either as stand-alone data gathering strategy or as a line of action in a triangulation project" (Berg and Lune, 2011 p.158)

5.7.1. Procedures

The researcher explained the purpose of the research in each session and, the issues covered by the questionnaires. The explanation was repeated at the start of every session for two main reasons, firstly because other older people not in the study joined in and needed to understand the research and, secondly, because members of the sample asked questions about the research, which led to the researcher deciding to clarify the project and the purpose in each session.

5.8. Singing group for the research

All three presidents of the Centri Anziani involved agreed to the experience (Appendix 13). The group set up in Municipio 17 (Group S) performed on Monday afternoons from 4:45 to 6:45 pm, with a short break in the middle of the session, while the group set up in Municipio 6 (Group F) performed on Tuesday mornings from 9:45 to 11:45 am, with a short break in the middle of the session. The group set up in Municipio 9 (Group T) performed on Wednesday afternoons from 4:30 to 6:30 pm, with a short break in the middle of the session (Table 5.4). Two musicians assisted in the sessions.

Table 5.4 Timetable of the sessions

Venue/Session	Municipio 17 Group S	Municipio 6 Group F	Municipio 9 Group T
1	10 Oct	11 Oct	25 Jan
2	21 Oct	19 Oct	01 Feb
3	24 Oct	25 Oct	08 Feb
4	31 Oct	2 Nov	15 Feb
5	7 Nov	8 Nov	22 Feb
6	14 Nov	15 Nov	29 Feb
7	21 Nov	22 Nov	07 Mar
8	28 Nov	29 Nov	14 Mar
9	30 Nov	6 Dec	28 Mar
10	5 Dec	9 Dec	4 Apr
11	12 Dec	13 Dec	11 Apr
12	22 Dec	20 Dec	18 Apr

5.8.1. Participants of the singing group

The choice of the Municipi for the singing group was influenced by four main issues:
The demographic features of the area (Table 5.5 and Figure 5.3).

1) Groups were established in three different Municipi of Rome, Municipio 17, Municipio 6 and Municipio 9. As shown by the Table below, the average ageing

index (percentage between the old age population [over 65] and the young population [under 15]) in the city of Rome is 144.8. As far as the socio-economic index is concerned, 19.2% of the population is in the group with a high socio-economic index while 21% is in the group with a low socio-economic index (census variables were chosen to represent different dimensions of social disadvantage: education, employment, housing conditions, family composition and immigration);

2) According to Table 5.5, the three areas selected for the sessions have a high ageing index while a low (Municipio 6) or high (Municipio 17) or medium (Municipio 9) socio economic index (Table 5.6);
3) The interest of older people in participating in the research;
4) The support of the presidents of the Centri Anziani involved;

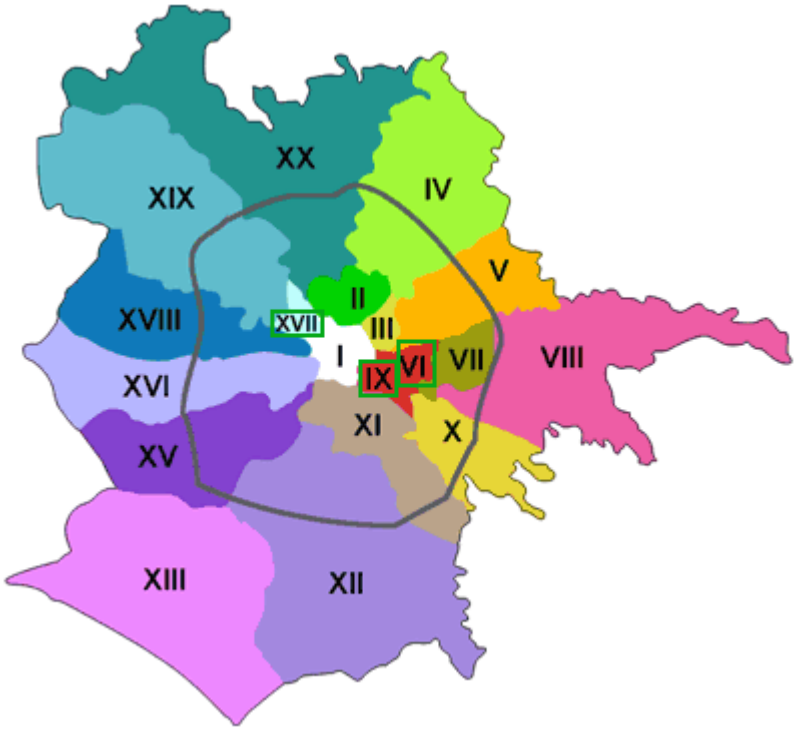


Figure 5.3 Map of Municipi of Rome with the three Municipi chosen

As far as point (2) is concerned, the researcher took into account the results of the interview and the anonymous questionnaires completed during the pilots. As for point (3), an appointment with the president of the Centro Anziani was made to investigate their attitude with respect to the possible development of the 12 weekly sessions. With respect to point (1), the author, as for the pilot sessions, took into consideration some demographic information, in particular the ageing and socio-economic index, looking for areas which have a high ageing index (the ratio of older people to the number of younger people and low or high income level) in order to assess the impact of the experience and its effectiveness and transferability in areas with different economic levels (ASP Lazio, no date). With respect to

point (4), after the pilot sessions the author had a meeting with the President of the Centro Anziani to evaluate their willingness to take part in the study.

According to Table 5.5 and Table 5.6, the three areas selected for the sessions have a high ageing index but vary socio-economically; a low index for Municipio 6 (Torpignattara) a medium for Municipio 9 (Tuscolano Nord) and a high for Municipio 17 (Prati) socio economic index (ASP Lazio, no date).

Table 5.5 Ageing index of selected areas of Rome (ASP Lazio, no date)

Ageing index/Areas	All	Women	Men
Rome	144,8	176	115,4
Appio	230,6	300,3	162,1
Appio – Claudio	203,8	252,4	158,7
Aurelio Nord	265,8	328,4	207,9
Aurelio Sud	228	287,5	172,1
Borghesiana	59,6	64,4	55,1
Bufalotta	89,5	98,4	81,2
Centocelle	161,5	192,6	130,6
Hystorical Centre	163,2	190,2	136
Don Bosco	243	293,3	196,7
Eroi	275,4	372,8	189,7
Garbatella	232,1	290,1	175,1
Giardinetti	85,8	98,5	74,3
Pietralata	212	258,1	169,2
Prati	227,8	269,4	182,1
Quadraro	157,3	193,4	123,3
Testaccio	239,3	318,9	165,8
Torpignattara	205,2	257,7	156,7
Tuscolano Nord	230,6	299,2	164,1

Table 5.6 Socio-Economic index of selected areas of Rome (ASP Lazio, no date)

Socio economic index/Areas	High	Medium-High	Medium	Low-Medium	Low
Rome	19,2	19,6	19,8	20,5	21
Appio	34,6	45,9	18	1,5	0
Aurelio Nord	38,5	29,4	13,4	10,9	7,8
Aurelio Sud	40	21,9	26,9	10,7	0,4
Borghesiana	0	0	1,6	28,5	70
Bufalotta	1,7	2,7	18,2	54,3	23,1
Centocelle	0	1,3	23,4	40,4	34,8
Hystorical Centre	11,8	30,1	30,5	15,8	11,8
Don Bosco	0,4	10,9	30	41,1	17,6
Eroi	29,9	37,8	22,5	9,3	0,5
Garbatella	18,9	37,1	17,9	9,9	16,2
Giardinetti	2,2	1,4	1,6	48,7	46,2
Pietralata	0	23,5	41,4	16	19,1
Prati	40,6	31,7	20	7,3	0,3
Quadraro	2,7	3,5	5,9	31,6	56,4
Testaccio	12,4	13,1	19,4	43,6	11,5
Torpignattara	1,4	16,4	26,3	35,4	20,6
Tuscolano Nord	33,2	38,4	15,8	12,6	0

5.8.2. Inclusion and exclusion criteria

Only older people of 60 years old and above without cognitive problems were involved in this research.

5.8.3. Observation

Continuing observation resulted in an alternative way of running sessions each month (Table 5.7), i.e. Session 1 observation was performed, Session 2 no observation was performed, Session 3 observation was performed and so on; this was applied for the two first groups while for the third observation started from the second session.

Table 5.7 Observation Timetable

Venue	1st	2nd	3rd	4th	5th	6th
S	10 Oct	24 Oct	7 Nov	21 Nov	5 Dec	19 Dec
	Session 1	Session 3	Session 5	Session 7	Session 9	Session 11
F	11 Oct	25 Oct	8 Nov	22 Nov	6 Dec	20 Dec
	Session 1	Session 3	Session 5	Session 7	Session 9	Session 11
T	1 Feb	8 Feb	29 Feb	14 Mar	4 Apr	18 Apr
	Session 2	Session 4	Session 6	Session 8	Session 10	Session 12

5.8.4. Questionnaires

There were 62 people in the sample at the start of the research who completed the questionnaire properly. The questionnaires at baseline were completed in October and at the end of the experience for the first two groups in December, the follow up in March while in January, April and July for the third (Table 5.8,Table 5.9,Table 5.10)

Table 5.8 Timetable of questionnaires

Venue	1st	2nd	3rd
S	10 Oct	20 Dec	12 Mar
F	11 Oct	22 Oct	13 Mar
T	25 Jan	18 Apr	11 Jul/24 Sep

Table 5.9 Total sample at baseline

Venue	Men	Women	Total
S	6	27	33
F	0	13	13
T	0	16	16
Total Sample	6	56	62

Table 5.10 Total sample at the end of the experience

Venue	Men	Women	Total
S	4	19	23
F	0	8	8
T	0	14	14
Total Sample	4	41	45

Seventeen people who had completed the first questionnaire left the group after a few sessions. Some (5) of them reluctantly, due to health issues of partners or relatives, while 12 simply never attended the subsequent sessions without giving any reasons. All those who completed the second questionnaire participated regularly in the experience, with great punctuality and enthusiasm. Four people who had completed the two first questionnaires did not complete the third questionnaire mainly due to personal issues (Table 5.11).

Table 5.11 Total sample after the follow up

Venue	Men	Women	Total
S	3	18	21
F	0	8	8
T	0	12	12
Total Sample	3	38	41

5.9. Translation process

This health promotion model was ‘translated’ to fit better into Italian culture in order to be transferred to Italy from England. Carrying out this kind of work was particularly challenging - all processes started with a thorough analysis of all the aspects which make up the model in England. The analysis was twofold; on one side all the practical issues were analysed and resolved and, on the other, a clear analysis of the model itself was carried out by the author.

At this point, it is important to mention a significant fact. The British model was developed, as mentioned, in the south-east of England in a series of small towns close to Canterbury, a small city (pop. 145,000). The Italian model was developed in Rome (pop. c. 2,750,000).

The socio-cultural differences between a big city and small one are actually an element which should be considered as, beyond the differences between nations, there are even greater ones between large and small cities.

The first part of the study involved contacts with local authorities and Centri Anziani in the search for a suitable venue, and then there was the transfer of the model itself. This first part was very important in the setting of the whole experience and was crucial preparatory work for the exploration of the transferability.

The preparatory work was hard because the author had to present the model of health promotion, the aims of the study, her role, the role of universities (English and Italian) and the scientific interest in that to both professionals (politicians and social workers) and managers in the Centri Anziani. Further, it was not far from easy to have appointments with all these people. Besides the presentation of the project, it was important to underline that the research had to follow a strict methodology both in terms of time (12 weeks) and respect for the standardized questionnaires which had to be filled in at specific times.

Before and during the collection of data, the author decided that this had to be broken down into a number of different elements, forming the skeleton of the intervention, to transfer the model in Italy. The skeleton of the study was then analysed to identify a number of elements eminently distinctive of the country where Silver Song Clubs were developed. The main aim of this was to try and "copy" the model as much as possible so that the effectiveness and transferability could be established

In the light of the data collected during Part A, the author identified the elements that could be copied and those which could not be included in the Italian cultural context. The elements reported in full were: the number of sessions (12), the length of the sessions (approximately two hours), the pattern of sessions (singing/break/singing). The aspects changed were mainly the times of the sessions, the break (shorter) and repertoire.

Focusing our attention on the changes, the sessions were held during the late afternoon (after 4 p.m.), the only attempt at sessions in the morning led to a low number of participants; this was because the venue available in that area was only free in the morning. At that time in Italy, the average retired family is concerned with housework, shopping and preparing meals, while the afternoon is reserved for leisure activities, as discovered during the preparatory work (PART A). As far as the break is concerned, it was shorter and of course there were no tea and biscuits, absolutely foreign to the Italian culture, but fruit juices and cakes. The break was shorter because there were often comments on the songs, both anecdotal (past experiences of the participants) or techniques of musicians, during the sessions. As far as recruitment is concerned, this was strongly influenced by two elements. First, the connection that the project in Italy had with Centri Anziani and the innate distrust of older Italians, as

most older people are afraid of strangers. In the light of these two elements, participants were recruited through the Centri Anziani where numerous adverts were placed.

The most substantial and important change certainly concerned the repertoire proposed during the sessions. The search and choice of the songs was made taking into account two main aspects – data collected during interviews with older people across Rome before starting the testing of the model, and the advice of the two musicians about the most traditional and well known songs that would have had a good impact on the older people, linked, for instance, to the time of their youth.

5.10. Data analysis

The research was divided in two parts, Part A informative of Part B. A qualitative approach was used in Part A and a mixed method approach was used for Part B. In particular, the research was carried out using "multiple and different sources (e.g. informants)" (Robson, 2002 p. 371), particularly with regard to research question (c) (assess participants' reactions and their perceived wellbeing before the experience, after the experience and at 3 months from the end of the experience).

5.10.1. Analysis of interview data

Analysis of the interviews was made through listening to the recorded interviews, transcribing them, then looking for common themes and issues, as well as key phrases and statements. The same method was used for the analysis of the interviews which had not been recorded; in this case, the data already transcribed was analysed directly. As regards the interviews with the professionals, the author made an analysis similar to that described above but this only concerned the first step, namely the classification and aggregation into themes. As far as the interview of older people are concerned a descriptive analysis of data, according to the classification derived from the interviews, was made with the basic variables of the level of education, age, income area (Municipi more or less economically advantaged). The author assessed the classification through these variables.

It should be noted that, during the interviews, not all older people answered all the questions because in some cases they did not remember and, in others, they were confused or reticent.

5.10.2. Analysis of observation data

Initially, the author analysed each pre-coded schedule and then compared it with the others in the same group; this was repeated for the three groups. The three groups of pre-coded schedule were then compared to find similarities or differences among them; comparison

was made choosing songs in common in order to assess the impact of the same songs in different groups.

Each item of the pre-coded schedule was given a value between 5 and -1, 5 being the highest value and -1 the lowest (Table 5.12). As can be seen from the diagram shown here, the highest values were given to 100% participation (5) and attention (4), while other data values were given to a lower percentage or gradation. A negative score was given to 'less than 50% participation', 'no attention' and the absence of positive reactions to the song and general mood of the participants (e.g. no smiles or laughter). Each song was labelled with a number (Table 5.13).

Table 5.12 Values given to the checklist

Reactions	Values
100% Participation	5
75% Participation	3
50% Participation	1
Less than 50% Participation	-1
Attention	4
No Attention	-1
Smiles	3
Comments-Chatting	3
No Smiles or Laughter	-1

Table 5.13 List of songs sung during the session observed

Number	Songs	Type of song
1	Arrivederci Roma	Popular Italian song
2	Chitarra Romana	Traditional song of Rome
3	Funicolì Funicolà	Traditional song of Naples
4	*Ma l'amore no*	Popular Italian song
5	Nel blu dipinto di blu	Popular Italian song
6	*Parlami d'amore Mariù*	Popular Italian song
7	*Roma nun fa' la stupida stasera*	Traditional song of Rome
8	Sora Menica	Traditional song of Rome
9	*Tanto pe' cantà*	Traditional song of Rome
10	Vecchia Roma	Traditional song of Rome
11	*Va' Pensiero*	From the Chorus of Nabucco by G. Verdi
12	Vecchio Frac	Popular Italian song
13	Venticello de Roma	Traditional song of Rome
14	Voglio vivere così	Popular Italian song
15	*Vola vola l'aritornello*	Traditional song of Abruzzo
16	Azzurro	Popular Italian song
17	Ave Maria	Classical song by F. Schubert
18	Abete di Natale	Christmas song
19	Astro del Cielo	Christmas song
20	Tu scendi dalle Stelle	Christmas song

NB In the delivering overall additional songs where sung which are not listed here as they were not sung during the session observed (Appendix 14).

5.10.3. Analysis of the questionnaire

With reference to the three pilot sessions, analysis was performed by making a statistical examination of the anonymous questionnaires delivered at the end of two hours of group singing. For the questionnaires (baseline, end of the experience and follow up), analysis was carried out using SPSS software, with standard algorithms used to arrive at total scores and sub-scores exactly the same as those used for the English research, as already highlighted above (Coulton et al., in press).

At baseline, 62 participants completed questionnaires. Of those 62, only 45 completed questionnaires at the end of the experience and 41 participants compiled the follow up questionnaires. Therefore, during the research, 21 people were lost and, of those 21, 17 were lost between the first and second questionnaires with a further 4 being lost between the end of singing and the follow up. On all occasions, the author carefully explained the structure of the questionnaire and the meaning of each single item in order to clarify the sample, which mainly consisted of people with low-middle educational level.

5.10.4. Analysis of the focus group

Examination of the focus group discussions were made through analysing notes taken during the focus group in order to identify trends and patterns that reappear, as well as identifying key phrases and statements. In analysing this data, the researcher took into account the context and circumstances in which the interview of the focus group was carried out (Robson, 2002).

5.11. Data triangulation

Lastly, the results emerging from questionnaires, observations, and focus groups were compared to find out whether similar results were being found. According to Thurmond (2001), triangulation is "the combination of two or more data, sources, investigators, methodological approaches, theoretical perspectives [...] or analytical methods" (p. 253). If the conclusions from each analysis of the different sources of data are the same, similar or very close, validity of the research is established (Thurmond, 2001). Moreover, triangulation is important to avoid bias. The triangulation method was chosen to raise the credibility and validity of the results, starting from the fact that the standardized questionnaires, observations and focus group had, as said, objective c) in common.

5.12. Chapter Summary

The chapter describes the methodology followed during the study.

The research was divided into two main Parts, A and B; a mixed method approach was adopted. Part A focused on exploring the status of older people living in Rome, their interest in music and singing today and in the past, and in taking part in a singing experience. Semi-structured interviews were carried out with older people recruited by Centri Anziani scattered throughout Rome. In addition, the first part of the research explored how local politicians and social workers see the status of older people. The city of Rome is described.

Part B was focused on setting up and evaluating singing groups and gathering information from participants on their experiences of singing. In this part, a mixed approach was used with observation schedules developed for the purpose and two widely-used questionnaires were used to assess wellbeing and quality of life of the participants. The primary outcome measure was an Italian version of the York SF-12 which provides scores for physical and mental wellbeing. The Italian version of the EQ-5D-3L questionnaire was also adopted. The questionnaires were completed by participants at baseline, end of singing and follow up.

The start of the research with the analysis of the health promotion model and its transfer in the Italian context was also described. The analysis of the data was also clarified in the chapter for both Parts A and B and particular emphasis was given to the triangulation of data.

Chapter 6.

Result Part A: Interviews with Professionals and Older People and Result from Pilot Session

6.1. Introduction

The results from Part A of the research undertaken will be reported in the following sections. For Part A, the interviews with both professionals (politicians and social workers) and older people and the questionnaires of the three pilot sessions will be analysed. This section aims, firstly, to report on the status of older people in the areas, secondly to highlight the role and place which music and singing have had and have in the lives of the older people interviewed, and, thirdly, to present the findings from the evaluation of the pilot sessions.

6.2. Interviews with politicians and social workers

Part A of the research was focused on interviews with politicians and social workers and members of the older population in Rome. Table 6.1 and Table 6.2 report details of the samples interviewed.

Table 6.1 Interviews of social workers and politicians

Municipi	Politicians	Social Workers
Municipio 2	1	1
Municipio 3	1	-
Municipio 4	1	-
Municipio 5	-	1
Municipio 6	1	-
Municipio 7	1	-
Municipio 9	1	3
Municipio 11	1	-
Municipio 13	1	-
Municipio 15	1	1
Municipio 16	1	1
Municipio 17	1	2
Total	**11**	**9**

Table 6.2 Interviews of the older population

Municipio	Older people interviewed
Municipio 5	5
Municipio 6	9
Municipio 9	12
Municipio 11	6
Municipio 17	8
Total	**40**

The final sample of interviews consisted of 20 politicians and social workers and 40 members of the older population.

6.2.1. Data analysis of interviews of professionals (politicians and social workers)

The results of the interviews carried out during Part A are given below. Analysis of the interviews was made through listening to the recorded interviews, transcribing them, then looking for common themes and issues, as well as key phrases and statements. The same method was used for the analysis of the interviews which were not recorded; in this case, notes were taken directly during the interview.

The tables below show the main results with respect to the interviews of social workers and politicians. They raised three main issues concerning the health and social status of the older population - poverty and its consequences, social isolation and its connections (loneliness/loss of the feeling of community and peer support) and the growing number of older people and the effects of this on society and family structure. Once identified, the three issues were used in the analysis of the interviews by looking at how frequently certain comments were made, and which facet of the issue was particularly highlighted by the interviewees. The aforementioned themes could be found in almost all the interviews carried out, with marked differences in the perceived severity of effects experienced by older people of Rome where the professionals worked. Poverty, social isolation and increasing age are all factors that could lead to increased health problems.

6.2.2. Poverty

Figure 6.1 below shows the theme of poverty as seen by social workers and politicians. From their point of view, one of the main causes of poor health and poor quality of life is poverty.

Respondents identified the low level of pensions and the loss in the value of money as one of the main causes of poverty among the older population:

"Pensions do not have any practical value" (social worker 1),

"An old person in their 70s with a pension barely manages to survive now" (social worker 2).

"They [the older people] have money just for the bare necessities and sometimes not even for that" (social worker 1).

"There are older people who renounce lunch or just have lunch with a cappuccino and croissant" (politician 1).

"The increased demand for subsidies in recent years is a clear sign of poverty" (politician 2).

This means that older people are faced with a series of problems like evictions or having to make choices such as health care or food, or even food or paying the rent:

"Even if you're an octogenarian, you can be evicted" (social worker 3).

"There is such a huge number of evictions that older people are forced to leave their neighbourhood and go farther and farther away, not only to the suburbs but also to small towns around Rome, losing their reference points" (social worker 1).

"The high number of evictions has become a cause of growing concern" (politician 2).

"Losing your home brings great discomfort, fear of the future and disease" (politician 1).

The problem of poverty affects all Municipi, both poorer and wealthier areas, because even in the wealthiest areas, there are large pockets of poverty. This is mainly due to the fact that women, especially widows who have been housewives all their life, may find themselves in a very poor economic situation after the death of their partner, women may lose their economic wellbeing, but refuse to change the area where they live although they cannot deal with payment of the rent.

"At the moment, when one of the two older people dies,
the survivor automatically becomes needy, because the couple
could face the situation with two pensions while it is nearly
impossible with one" (politician 1).

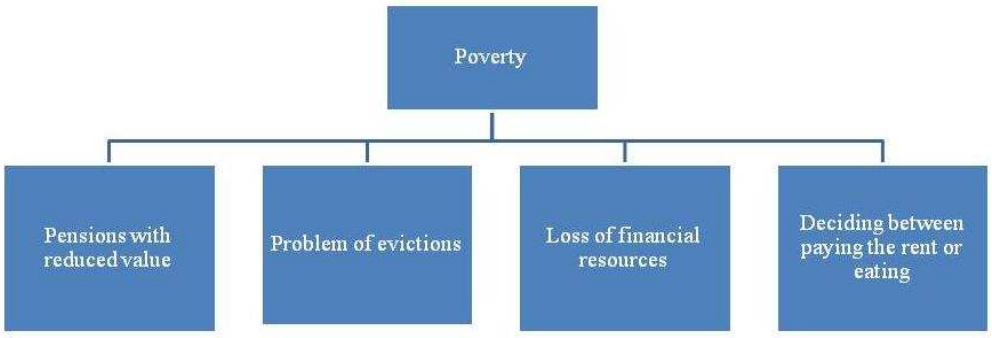


Figure 6.1 Poverty

6.2.3. Social isolation

Figure 6.2 below shows the theme of social isolation as seen from the social workers and politicians' point of view. Social isolation and loneliness are further problems highlighted by those interviewed - both recognized that the problem exists, but social workers emphasized the seriousness more. The above situation is expressed by the growing phenomenon of 'homeless at home' people of people living like down-and-outs in their own homes, and the related problem of reaching a large number of older people, living in total isolation, who have no contacts with the outside world. This is connected with the loss of the concept of community, because nobody (the neighbours, for instance) reports problems or issues:

"Social isolation and loneliness are the main elements of
frailty in the elderly" (social worker 3).

As an important factor associated with social isolation, both types of professionals highlighted the fragmentation of the family:

"There is a complete breakdown of the family" (social worker 4).

"The family as conceived in the past, with older people cared for by
their children and who, in turn, took care of grandchildren,
no longer exists. Nowadays old people are alone and
cannot count on their children" (social worker 1).

> "There are older people who have a family, but family members
> don't want to care for them because they are, in turn,
> crushed by a huge number of problems" (social worker 3).

> "When it exists, family's essential"
> [as an informal social network that holds and has held, against
> almost every social problem in Italy] (politician 3).

The loss of the reference points, such as siblings, peers and friends, leading to a general absence of meaningful relationships which go beyond the simple everyday greeting is also associated with social isolation:

> "They not only don't have meaningful relationships,
> they don't have any kind of relationship" (social worker 5).

> "There are older people that tell me very clearly that they
> don't even talk to anyone for weeks and weeks" (social worker 1).

Social isolation is a cause and consequence of poor health:

> "As long as an older person has a good level of health,
> he-she is able to go out and have some contact, but when
> he-she becomes ill, or worse, loses his-her independence
> and stays at home, he-she no longer has contact" (social worker 6).

A further aspect underlined by both politicians and social workers was the loss of the feeling of community, especially in less wealthy areas where, in the past, this feeling and the resulting support has been very important:

> "In the past, if there was an older person in a building,
> the whole building took care of him-her. Now, when the neighbours
> see a problem, they simply call the police" (politician 4)

> "If the old person is lucky enough to live in the same area
> for 20/30/40 years, they feel safe and can count on some help,
> but if they move to another area they are completely alone" (politician 5).

"The so-called social solidarity that there was in the past no longer exists. There is selfishness in society, even among the elderly, who are afraid of getting in contact with an ill peer, for fear of being dragged down" (social worker 6).

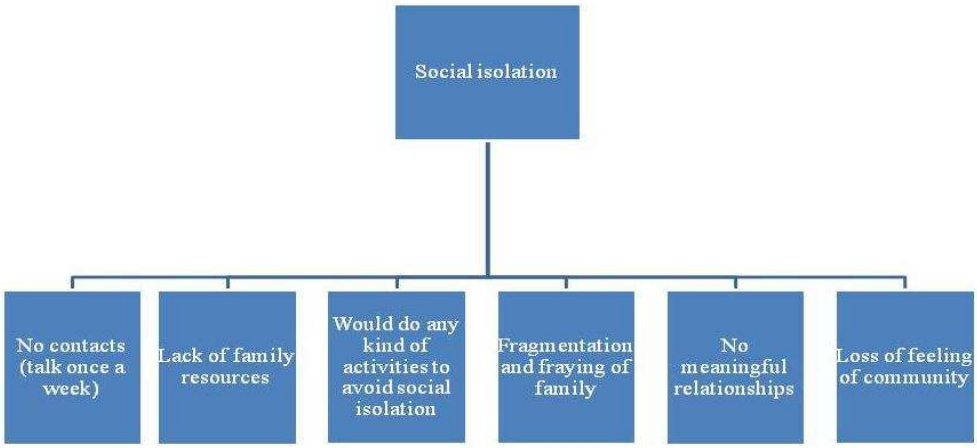


Figure 6.2 Social Isolation

6.2.4. Growing number of older people and the lengthening of life

Figure 6.3 below shows aspects connected with the issue of the growing numbers of older people and the general issue of the lengthening of life. One aspect underlined by both types of professionals - but especially by politicians - was the growing numbers of older people and the consequences that this entails for both the Municipi - administratively - and the older population itself. The lengthening of life involves a corresponding extension of requests for help, which are much more expensive, since they focus mainly on people who need treatment for long-term illness and degenerative diseases:

"The lengthening of life expectancy reveals growing health and social needs" (politician 6).

"In recent years, for instance, the Municipio has had to set up a number of new services, such as, for instance, The Alzheimer's Helpdesk, because the number of people asking for help is growing and growing" (politician 4).

"One of the services which is required more and more is in-home care of older people who are clients with long-term illness and degenerative diseases" (social worker 3).

The social workers and politicians from both wealthy and less wealthy Municipi indicated very clearly that almost all the economic resources of the Municipi are committed to meeting basic needs (social and medical assistance):

> "The resources are designed to meet medical and social needs fully" (Politician1).

> "Requests for financial support, and support for health care are so many that whereas before the Municipio managed to organize projects for socialising and to improve the quality of life of older people in the area, the Municipio nowadays have to help older in the bare necessities, which means that if the Municipio doesn't give them financial support, the person ends up on the street" (social worker 1).

The increased need of support for medical and social care is compounded by the fact that the increase in the length of life implies a growing number of old parents with older children:

> "Older children no longer have either the physical or economic strength to help old parents" (social worker 1).

> 'There are 95 year olds, who have children of 70-75, who, in turn, have children of 50; in this framework it is unlikely that the child will assist parents" (politician 7).

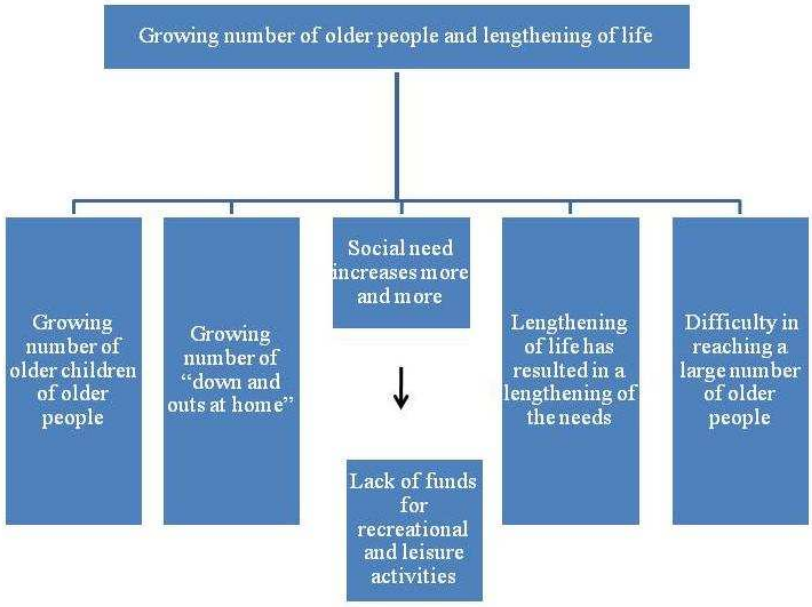


Figure 6.3 Growing numbers of older people and the lengthening of life

Beside these three main themes, there are others which were raised by some of the interviewees, such as the growth of social tensions, and the clear demand of older people for leisure activities. Social workers working in the poorest areas underlined the growing incidence of social tensions, determined by living in tiny apartments in buildings in a poor sanitary condition. The situation is further exacerbated by high levels of immigration, the associated unfamiliarity with the smells and sounds in the buildings, and all the problems connected with close and uncomfortable coexistence.

> "Italy is experiencing problems with the integration of immigrants that other countries faced 30-40 years ago" (politician 5).

> "There is a real war between the poor, between people who are harbingers of social distress, be they immigrants or the elderly. They are forced to live in slums, close together with social tensions growing every day" (social worker 7).

Social workers and politicians who work in the areas of greatest need underlined the growing demand for recreational activities; this is probably due to the lack of personal money to pay for participation in leisure.

> "Older people have so much free time therefore the Municipi should pay attention to their free time and offer more activities" (politician 1).

> "Often the older people say they are tired of health promotion programmes because they would prefer to hike, sing or dance rather than think about their blood pressure, heart disease or diabetes all the time" (politician 5).

> "The better educated the older person is, the easier it is for them to socialize and build new friendships" (social worker 8).

The entire sample interviewed recognized that older people are open and available to any kind of proposed activity in order to avoid isolation and build new friendships.

6.3. Interviews of the sample of older people

First of all, two main aspects should be noted:

a) although 40 people were interviewed, the sample size varies in the tables due to several factors:
   - in some cases, the interviewee's answers were unclear or no answer was given,
   - in some cases, the questions were not asked as they were not appropriate with respect to the interviewees,
   - some interviewees showed signs of impatience and irritability, and so the interview was shortened,

b) carrying out the interviews was very challenging because the sample;
   - often did not fully grasp the purpose of the research,
   - did not fully understand the individual questions and then responded with phrases out of context,
   - wanted to talk about themselves, their life and their problems, rather than answer questions about music.

Analysis of the interviews of older people was made through listening to the recorded interviews, transcribing them, then looking for common answers. The tables below summarize the results of the questions raised through the interview, both those focused on everyday life and those trying to obtain an aspect of the character, beliefs, and attitudes about the role of music and singing throughout their life. A separate section has been structured with the results on the role and place of music and singing in the life of the interviewees currently. Figure 6.4 reports the age composition of the sample.

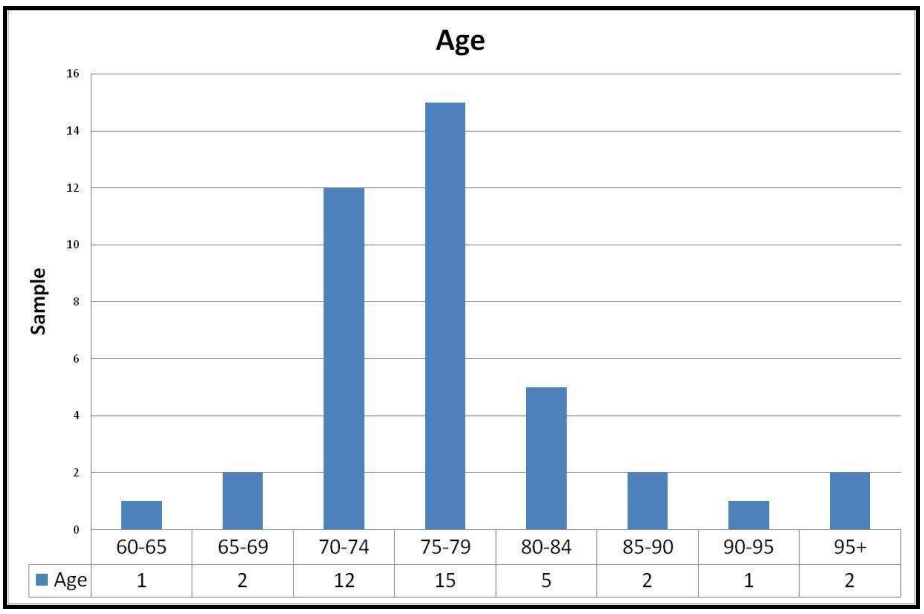


Figure 6.4 Age of the sample of the older people (N=40)

It can be said that the largest age group is from 75 to 79, followed by the group from 70 to 74. Groups between 60 and 65 and 90 years old and over are the least numerous.
The sample is predominantly female (73%).

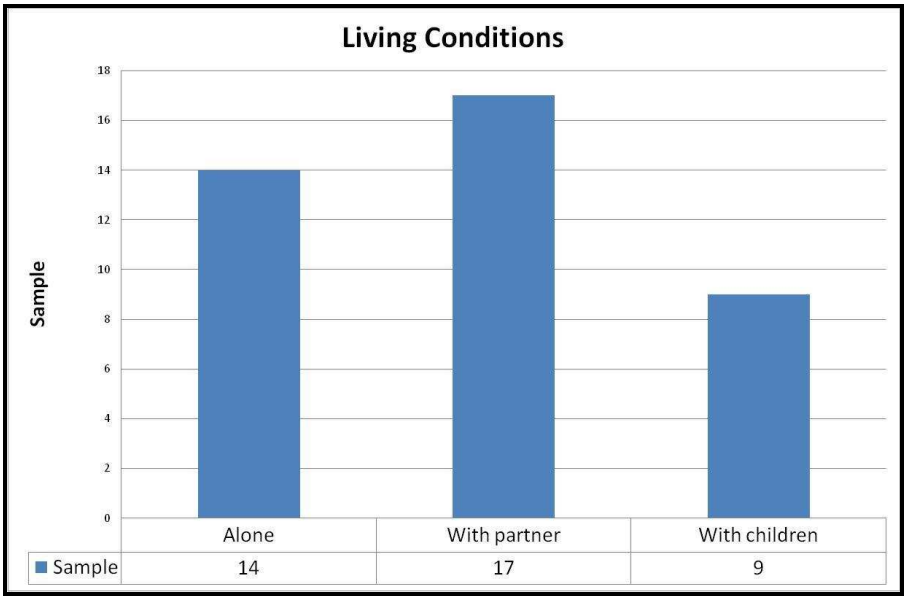


Figure 6.5 Living conditions of the sample of the older people

Figure 6.5 shows that the sample is split into two main groups, where one group of people lives with their partners (17 out of 40) and another group lives alone (14 out of 40); 9 people live with their children. In some cases, this is because children have never left their parents' home or they have lost their jobs; alternatively, parents have moved to their children's home because of their age and serious economic difficulties.

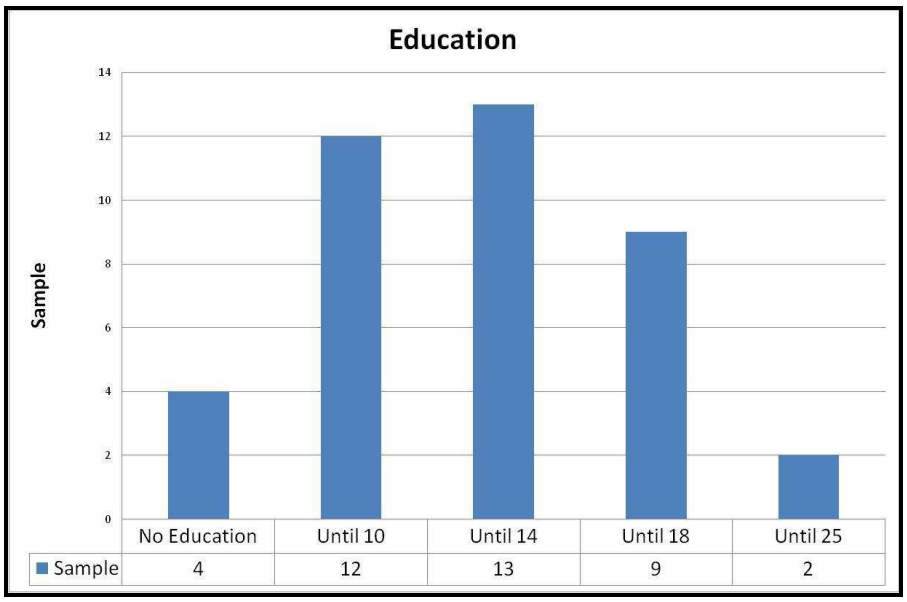


Figure 6.6 Level of education of the sample of the older people

As far as the level of education is concerned, Figure 6.6 clearly displays that, generally speaking, the sample has a low, at times very low, level of education. A small proportion of the sample, 4 out of 40 respondents, said they did not finish the primary school. This group pertains mainly to the age group 75-79 and this lack of education is probably due to the Second World War; furthermore, it reflects where they lived as children in Italy. Some of those interviewed (12) claim they completed primary school. A similar number (13 respondents) said they received secondary school education and a group (9 people) claims to have obtained a high school diploma. Therefore, the highest level of education attained by 29 out of 40 people was the Middle School (up to the age of 14). Finally, two people claim to be graduates.

6.3.1. The older person's everyday life

How do you spend your days?

Table 6.3 summarizes the results of the question "How do you spend your days?" The same variable was then analysed with respect to education level, age group and income of the Municipio. The activities carried out by the older population are principally two and these can be summarized as housework and attendance of the Centri Anziani.

The majority of the sample (n=16) divides its day between housework (during the morning) and staying at the Centri Anziani in the afternoon; one large portion of the sample (n=9) said that housework prevails. Similar patterns were found for staying in the Centre (n=5) and other activities (n=7) such as watching television, staying with grandchildren, staying with friends, and going to cinemas or theatre. Two people (n=2) declared that they stayed alone at home doing nothing.

Where the level of education is higher, more of the participants declared that they do 'various activities'. None of the more educated (both Middle and High Schools) said that they spend their time alone. With respect to age, it can be said that the greater the age, the less this group is involved with other activities while increase going to the Centro Anziani in comparison with the other two groups; similar patterns can be observed for the more advantaged areas.

Table 6.3 How do you spend your days?

How do you spend your days?	**All Sample**		
Housework	9		
Housework + Centre	16		
Centre	5		
Alone	2		
Various Activities	7		
Education	**<10**	**10-14**	**>14**
Housework	4	4	1
Housework + Centre	7	7	2
Centre	1	1	3
Alone	2	0	0
Various Activities	1	1	5
Age	**<75**	**75-80**	**>80**
Housework	4	3	2
Housework + Centre	6	4	6
Centre	1	3	1
Alone	0	2	0
Various Activities	4	2	1
Income District	**Low**	**Medium**	**High**
Housework	1	5	3
Housework + Centre	9	5	2
Centre	2	3	0
Alone	0	2	0
Various Activities	1	3	3

Do you have any hobbies?

Table 6.4 reports the results of the question "Do you have any hobbies?" In general, most of the sample has no hobby (n=18), across all the variables considered. It should be noted, however, that more than half (5 out of 8) of the group with a higher level of education claims to have hobbies (cinema and theatre) while only 2 of the less educated said they have a hobby. Five out of 11 of the younger part of the sample claims to have hobbies. The sample belonging to the wealthier areas was not able to give a response, while the sample from middle-income Municipi was split exactly into two parts. As far as the lower income Municipi are concerned, it can be said that they reflect the patterns of the entire sample.

Table 6.4 Do you have any hobbies?

Do you have any hobbies?	**All Sample**		
Yes	13		
No	18		
Education	**<10**	**10-14**	**>14**
Yes	2	6	5
No	10	5	3
Age	**<75**	**75-80**	**>80**
Yes	5	5	3
No	6	9	3
Income District	**Low**	**Medium**	**High**
Yes	4	9	0
No	9	9	0

6.3.2. Question about music during life

In this section, the results for the question in the interview focusing on listening to music and singing through life are displayed; the times of life analysed are childhood, adolescence, adulthood and older age. In general, interviewees gave brief answers to these questions. The results are given in the Tables below. A selection of comments are reported in Table 6.5, Table 6.6, Table 6.7 and Table 6.8.

Did you listen to music?

Table 6.9 summarizes the results of the question "Looking back at your childhood/adolescence/adulthood/older age, did you listen to music?" The same question was then analysed with respect to education level, age group and income of the districts. The majority of the sample answered that they had listened to music during their childhood, adolescence and older age. The childhood section for the sample is divided into two parts, two thirds of the sample said they listened to music while a third said they did not have this habit. Moreover, in the younger part of the group the participants who said they listen to music during childhood are the majority (11 vs 4) while older participants are more equally divided (6 vs 4). Regarding adolescence, almost all the sample (36 out of 40) answered that they listened to music during that part of their life and only 4 out of 40 said they did not. On adulthood, the sample is split into two very similar groups numerically. In this case, however, the majority said that they did not listen to music during this period of life as they were focused on their family or work, while 17 of 40 claimed to have listened to music also during adulthood. There are similar patterns (childhood and adolescence) for older age with 38 out of 40 interviewees declaring that they listened to music.

Table 6.5 Comments on questions about music during Childhood

CHILDHOOD	
I used to hear my father singing snatches of operas. And my mother used to sing quite often, too.	Municipio 9, 70-74, F, with children, up to 14
Mainly sacred music because I was an altar boy and so the music was that. My parents had a restaurant and so they didn't have time or the chance to listen to music or sing for us.	Municipio 9, +95, M, alone, up to 18
First of all, I was really tone deaf and every time I started to sing they stopped me. In addition, I was one of 8 and my parents had nothing for us and didn't have time either. The first time I saw a radio I was 9 and my brother brought one home and it seemed something incredible to me.	Municipio 9, 90-95, F, alone, up to 14
The war had just ended then, there was desperation, misery and hunger. I was one of 9 and we had nothing.	Municipio 5, 75-79, F, alone, up to 10
When I was a child I worked night and day, to eat. When I was 6 years old, I already went to harvest the grain to eat and then I was a bricklayer carrying sacks.	Municipio 11, 75/79, M, alone, up to 10
I don't have particular memories connected with listening or playing, when I was a child, because of the war, there wasn't time, desire or the chance to listen and sing.	Municipio 5, 75-79, M, with partner, up to 18
I mainly used to hear my father sing; he sang very well and my uncle played the guitar	Municipio 5, 80-84, F, alone, up to 14

Table 6.6 Comments on questions about music during Adolescence

ADOLESCENCE	
During the American occupation, I heard a lot of music, including American music. There were also lots of patriotic songs.	Municipio 9, 70-75, M, partner, up to 14
Occasionally because my father bought a radio when I was about 15 years old.	Municipio 6, 75-79, F, alone, up to 10
Mainly with the radio and then the television but you couldn't keep the television on all day because the electricity cost too much.	Municipio 11, 60-65, with children, up to 18

Table 6.7 Comments on questions about music during Adulthood

ADULTHOOD	
While I was on my way to work and then at work.	Municipio 17, 70-74, M, partner, up to 14
At that time, I didn't have much time for music; I was too busy just getting on with life.	Municipio 17, 70-74, M, partner, up to 10

Table 6.8 Comments on questions about music during Old Age

OLD AGE	
I turn the radio on in the morning and I keep it on almost all day.	Municipio 5, 80-84, M, with partner, up to 14
On my own, it's like company.	Municipio 9, 85-90, M, with partner, up to 14
There's no fixed rule, I'd say almost every day. I turn the radio on when I go to bed and fall asleep like that then, when I wake up, I switch it off.	Municipio 9, +95, M, alone, up to 18
It was an important part of my life, so always.	Municipio 9, 75-79, M, with partner, up to 14

The patterns are similar within each age stage with respect to education, age and income district. As far as adulthood is concerned, there are some differences; in the group with an average level of education and the economically wealthier district, the values are reversed (the majority says they had the habit of listening). Only two of participants from the wealthier area claimed they did not listen to music in the older section.

Table 6.9 Did you listen to music?

Did you listen to music?	Childhood			Adolescence			Adulthood			Old Age		
Yes	N=26			N=36			N=17			N=38		
No	N=14			N=4			N=23			N=2		
Education	**<10**	**10-14**	**>14**	**<10**	**10-14**	**>14**	**<10**	**10-14**	**>14**	**<10**	**10-14**	**>14**
Yes	N=11	N=9	N=8	N=14	N=12	N=10	N=7	N=7	N=3	N=15	N=12	N=11
No	N=4	N=4	N=3	N=2	N=1	N=1	N=9	N=6	N=8	N=1	N=1	N=0
Age	**<75**	**75-80**	**>80**	**<75**	**75-80**	**>80**	**<75**	**75-80**	**>80**	**<75**	**75-80**	**>80**
Yes	N=11	N=9	N=6	N=14	N=13	N=9	N=5	N=7	N=5	N=14	N=13	N=10
No	N=4	N=6	N=4	N=1	N=2	N=1	N=10	N=8	N=5	N=1	N=1	N=0
Income District	**Low**	**Medium**	**High**	**Low**	**Medium**	**High**	**Low**	**Medium**	**High**	**Low**	**Medium**	**High**
Yes	N=7	N=13	N=6	N=12	N=18	N=6	N=3	N=8	N=6	N=16	N=16	N=9
No	N=7	N=5	N=2	N=2	N=0	N=2	N=11	N=10	N=2	N=0	N=0	N=2

When did you listen to music?

Table 6.10 displays the results of the question, "Looking back at your childhood/adolescence/adulthood/ old age, when did you listen to music?" The sample is different across the four times of life due to different response rates. The childhood section is made up of 19 respondents, the adolescence section of 34, the adulthood section of 12 and the old age section of 37. With respect to childhood, the majority (11 out of 19) listened to music every day, the other respondents are spread over the other 3 headings - often, occasionally or on church (during the service). Education, age and income districts do not seem to be a moderating factor, as the sample answers in a very similar way. People reported that they listened to music a lot as a teenager compared to childhood and adulthood, 21 out of 34 people answered 'everyday' and 8 out of 34 'occasionally'; only one person says 'often' and 4 on church. The value in the subgroups reflects those of the whole sample. As far as adulthood is concerned, the table shows that the sample is made up of 12 people divided into two main groups, one which claims it always listens to music and the other claiming it listens to music occasionally. The sample created two new headings - 'working' and 'dancing', which are connected to the time of life of the sample. On this it can be said that none of the more educated and participant from the wealthier areas answer that they listen to music while they were 'working'. In old age, the majority of the sample declared that they listened to music 'everyday' (24 out 37) or (7 out 37) 'occasionally' and 6 interviewees reported 'often' or 'when I can'. According to the education/age/income area table, these variables do not seem to be a modulating factor with the majority listening 'everyday' while other interviewees are spanned over the other headings.

Where did you listen to music?

Table 6.11 summarizes the results of the question "Looking back at your childhood/adolescence/adulthood/old age, where did you listen to music?" The sample is different across the four times of life, the first (childhood) is made up of 24 respondents, the second (adolescence) 33 while there are 10 for adulthood and 35 for old age. As far as childhood is concerned, the majority (18 out of 24) listened to music at home, some at church and in school. As far as education is concerned, all participants with a low level of education answered that they listened to music at home. The sample with average and higher levels of education is more divided into the different headings with a prevalence of 'home'. The younger respondents claimed that they listened to music at home or in church and similar patterns can be found for the older people in the sample. As far as adolescence is concerned, the sample is divided into two main groups - 13 who claimed that they listened to music at home and the other subgroup (13 people) while they danced or during parties.

Table 6.10 When did you listen to music?

When did you listen to music?																
Childhood				**Adolescence**				**Adulthood**				**Old Age**				
Everyday	N=11			Everyday	N=21			Always	N=5			Everyday	N=24			
Often	N=2			Often	N=1			Working	N=2			Often	N=2			
Occasionally	N=3			Occasionally	N=8			Dancing	N=1			When I can	N=4			
In church	N=3			In church	N=4			Occasionally	N=4			Occasionally	N=7			
Education	**<10**	**10-14**	**>14**	**Education**	**<10**	**10-14**	**>14**	**Education**	**<10**	**10-14**	**>14**	**Education**	**<10**	**10-14**	**>14**	
Everyday	N=5	N=3	N=3	Everyday	N=10	N=6	N=5	Always	N=2	N=2	N=1	Everyday	N=8	N=9	N=7	
Often	N=0	N=1	N=1	Often	N=0	N=0	N=1	Working	N=1	N=1	N=0	Often	N=0	N=1	N=1	
Occasionally	N=1	N=1	N=1	Occasionally	N=2	N=4	N=2	Dancing	N=0	N=1	N=0	When I can	N=3	N=0	N=1	
In church	N=0	N=1	N=2	In church	N=1	N=2	N=1	Occasionally	N=2	N=1	N=1	Occasionally	N=4	N=2	N=1	
Age	**<75**	**75-80**	**>80**	**Age**	**<75**	**75-80**	**>80**	**Age**	**<75**	**75-80**	**>80**	**Age**	**<75**	**75-80**	**>80**	
Everyday	N=4	N=4	N=3	Everyday	N=7	N=9	N=5	Always	N=1	N=3	N=1	Everyday	N=9	N=9	N=6	
Often	N=2	N=0	N=0	Often	N=0	N=1	N=0	Working	N=0	N=2	N=0	Often	N=2	N=0	N=0	
Occasionally	N=1	N=1	N=1	Occasionally	N=5	N=2	N=1	Dancing	N=1	N=0	N=0	When I can	N=2	N=0	N=2	
In church	N=0	N=1	N=2	In church	N=2	N=0	N=2	Occasionally	N=2	N=0	N=2	Occasionally	N=2	N=3	N=2	
Income District	**Low**	**Medium**	**High**	**Income District**	**Low**	**Medium**	**High**	**Income District**	**Low**	**Medium**	**High**	**Income District**	**Low**	**Medium**	**High**	
Everyday	N=3	N=6	N=2	Everyday	N=8	N=9	N=4	Always	N=1	N=4	N=0	Everyday	N=9	N=9	N=6	
Often	N=0	N=1	N=1	Often	N=0	N=1	N=0	Working	N=1	N=1	N=0	Often	N=2	N=0	N=0	
Occasionally	N=0	N=1	N=2	Occasionally	N=2	N=5	N=1	Dancing	N=0	N=0	N=1	When I can	N=2	N=1	N=1	
In church	N=0	N=2	N=1	In church	N=2	N=1	N=1	Occasionally	N=0	N=0	N=4	Occasionally	N=0	N=6	N=1	

Table 6.11 Where did you listen to music?

Where did you listen to music?																
Childhood				**Adolescence**				**Adulthood**				**Old Age**				
Home	N=18			Home	N=13			Home	N=5			Home	N=25			
Church	N=2			Party/Dancing	N=13			Concerts	N=1			Car	N=2			
School	N=3			Everywhere	N=7			Dancing	N=2			Home-Center	N=6			
Other	N=1			Church	N=0			Teather	N=2			Other	N=2			
Education	**<10**	**10-14**	**>14**	**Education**	**<10**	**10-14**	**>14**	**Education**	**<10**	**10-14**	**>14**	**Education**	**<10**	**10-14**	**>14**	
Home	N=7	N=7	N=4	Home	N=4	N=7	N=2	Home	N=3	N=1	N=1	Home	N=12	N=8	N=5	
Church	N=0	N=0	N=2	Party/Dancing	N=6	N=2	N=5	Concerts	N=1	N=0	N=0	Car	N=0	N=0	N=2	
School	N=0	N=2	N=1	Everywhere	N=2	N=3	N=2	Dancing	N=1	N=1	N=0	Home-Center	N=3	N=2	N=1	
Other	N=0	N=0	N=1	Church	N=0	N=0	N=0	Teather	N=0	N=1	N=1	Other	N=0	N=1	N=1	
Age	**<75**	**75-80**	**>80**	**Age**	**<75**	**75-80**	**>80**	**Age**	**<75**	**75-80**	**>80**	**Age**	**<75**	**75-80**	**>80**	
Home	N=9	N=5	N=4	Home	N=7	N=3	N=3	Home	N=1	N=2	N=2	Home	N=7	N=9	N=9	
Church	N=0	N=0	N=2	Party/Dancing	N=3	N=5	N=5	Concerts	N=1	N=0	N=0	Car	N=1	N=1	N=0	
School	N=2	N=1	N=0	Everywhere	N=4	N=3	N=0	Dancing	N=0	N=2	N=0	Home-Center	N=5	N=1	N=0	
Other	N=0	N=1	N=0	Church	N=0	N=0	N=0	Teather	N=2	N=0	N=0	Other	N=1	N=1	N=0	
Income District	**Low**	**Medium**	**High**	**Income District**	**Low**	**Medium**	**High**	**Income District**	**Low**	**Medium**	**High**	**Income District**	**Low**	**Medium**	**High**	
Home	N=6	N=7	N=5	Home	N=5	N=6	N=2	Home	N=1	N=1	N=3	Home	N=6	N=14	N=5	
Church	N=0	N=1	N=1	Party/Dancing	N=6	N=3	N=4	Concerts	N=0	N=1	N=0	Car	N=2	N=0	N=0	
School	N=1	N=2	N=0	Everywhere	N=1	N=6	N=0	Dancing	N=1	N=1	N=0	Home-Center	N=5	N=0	N=1	
Other	N=0	N=1	N=0	Church	N=0	N=0	N=0	Teather	N=0	N=0	N=2	Other	N=0	N=1	N=1	

Values with respect to the subgroups are similar to those of the entire sample, only the youngest group shows a set of values that differ from the other two groups (based on age) because the majority claims that they listened to music at home while the other two groups listened outside (dancing/everywhere).

Only 10 people responded to this question in relation to their adult years and most said they listened to music at home, when others went dancing or to concerts. Group variables do not give any special indications as the number of participants answering is small.

As far as the old age section is concerned, the majority said they listened to music at home, followed by the Home-Centre heading. Similar patterns can be found for the education variable; with respect to age, the younger section of the group enjoyed music both at home and in the Centro Anziani while the older group just at home. As far as the income area is concerned, it can be said that participants from the less wealthy areas is split into two main headings (home and home/Centre) while the majority listen to music at home in the middle income and wealthier areas.

Who did you listen to music with?

Table 6.12 summarizes the results of the question "Looking back at your childhood/adolescence/adulthood/old age, who did you listen to music with?" The sample is different across the four times of life, the first (childhood) is made up of 23 respondents, the second (adolescence) 32, adulthood 10 and 36 for old age. With respect to childhood, the majority (17 out of 23) listened to music with the family, some (2 out of 23) with friends and 3 interviewees claim that they listened to music alone and one with classmates. These patterns are similar for each variable considered. The sample from middle-income Municipi was where the answers were spread wider with a majority who said they listened to music in the family, with friends, class mates or alone; participants belonging to low income areas answered in the family and the higher income group is split between family and alone.

The sample says that, during adolescence, they mostly used to listen to music with friends and/or the family; this applies to all the variables considered. As far as adulthood is concerned, only 10 people responded to this question. Most said they listened to music in the family or with their husband (the sample is predominantly female). Group variables do not give any special indications as the number of participants was small.
With respect to older age, the majority of the sample claimed that they listen to music alone (27 out of 36) while 6 with the family. The variables reflect the results of the main sample where 'alone' is the heading with the highest number of answers.

Table 6.12 Who did you listen to music with?

Who did you listen to music with?																
Childhood				**Adolescence**				**Adulthood**				**Old Age**			
Family	N=17			Family	N=11			Family	N=3			Alone	N=27		
Friend	N=2			Friend	N=10			Husband	N=4			With Other	N=1		
School	N=1			Family-Friend	N=9			Friend	N=1			With Family	N=6		
Alone	N=3			Alone	N=2			Alone	N=2			With Everyone	N=2		
Education	**<10**	**10-14**	**>14**	**Education**	**<10**	**10-14**	**>14**	**Education**	**<10**	**10-14**	**>14**	**Education**	**<10**	**10-14**	**>14**
Family	N=6	N=6	N=5	Family	N=4	N=5	N=2	Family	N=2	N=0	N=1	Alone	N=11	N=9	N=7
Friend	N=2	N=0	N=0	Friend	N=3	N=4	N=3	Husband	N=2	N=1	N=1	With Other	N=1	N=0	N=0
School	N=0	N=0	N=1	Family-Friend	N=3	N=3	N=3	Friend	N=0	N=1	N=0	With Family	N=2	N=2	N=2
Alone	N=0	N=2	N=1	Alone	N=1	N=0	N=1	Alone	N=1	N=1	N=0	With Everyone	N=1	N=1	N=0
Age	**<75**	**75-80**	**>80**	**Age**	**<75**	**75-80**	**>80**	**Age**	**<75**	**75-80**	**>80**	**Age**	**<75**	**75-80**	**>80**
Family	N=6	N=7	N=4	Family	N=6	N=3	N=2	Family	N=0	N=2	N=1	Alone	N=11	N=8	N=8
Friend	N=1	N=1	N=0	Friend	N=2	N=5	N=3	Husband	N=3	N=1	N=0	With Other	N=1	N=0	N=0
School	N=1	N=0	N=0	Family-Friend	N=5	N=2	N=2	Friend	N=0	N=1	N=0	With Family	N=2	N=3	N=1
Alone	N=2	N=0	N=1	Alone	N=1	N=0	N=1	Alone	N=1	N=0	N=1	With Everyone	N=3	N=1	N=0
Income District	**Low**	**Medium**	**High**	**Income District**	**Low**	**Medium**	**High**	**Income District**	**Low**	**Medium**	**High**	**Income District**	**Low**	**Medium**	**High**
Family	N=6	N=7	N=4	Family	N=6	N=5	N=0	Family	N=1	N=1	N=1	Alone	N=6	N=15	N=6
Friend	N=0	N=2	N=0	Friend	N=4	N=4	N=2	Husband	N=0	N=2	N=2	With Other	N=0	N=0	N=1
School	N=0	N=1	N=0	Family-Friend	N=2	N=5	N=2	Friend	N=1	N=0	N=0	With Family	N=6	N=0	N=0
Alone	N=0	N=1	N=2	Alone	N=0	N=0	N=2	Alone	N=0	N=0	N=2	With Everyone	N=1	N=1	N=0

How did you listen to music?

Table 6.13 shows the results of the question "Looking back at your childhood/adolescence/adulthood/old age, how did you listen to music?" The sample is different across the four times of life. The first (childhood) is made up of 23 respondents, the second (adolescence) 30, adulthood is 13 and there is a sample of 34 participants in the old age section. The majority (16 out of 23) listened to music on the radio and television, and the other 7 respondents are divided between the use of the record player, listening through attendance at theatres and churches and, finally, some of them play instruments.

The patterns of education, age and income area follow those of the main results; with regard to individuals from the less wealthy areas, none of them claimed to have benefited from the theatre while one person from each of the other two groups (medium and high income) said yes. Two people in the less wealthy area said they play music (they play an instrument) as did one in the medium group while none in the wealthiest group did.

Half the sample responded that they used the radio as a means of listening to music during their adolescence while the other half of the sample said they used the record player, radio/TV and other media. The media most used to listen to music, across age, income area and education, was the radio.

As far as adulthood is concerned, the media most used to enjoy music was radio and TV while some say they went to the theatre. There were no significant differences for the variables (education, age and income districts).
The sample says that the TV and CD player were also used although the majority said that the radio was the most normal media in older age.

Table 6.13 How did you listen to music?

How did you listen to music?																
Childhood				**Adolescence**				**Adulthood**				**Old Age**			
Radio-Television	N=16			Radio	N=16			TV	N=1			Radio	N=16		
Record player	N=2			Record player	N=5			Radio	N=5			TV	N=5		
Church- Theatre	N=2			Radio-TV	N=5			TV-Radio	N=4			Radio-TV	N=6		
Sung and played by ourselves	N=3			Other	N=4			Theatre	N=3			CD	N=7		
Education	**<10**	**10-14**	**>14**	**Education**	**<10**	**10-14**	**>14**	**Education**	**<10**	**10-14**	**>14**	**Education**	**<10**	**10-14**	**>14**
Radio-Television	N=9	N=4	N=3	Radio	N=6	N=7	N=3	TV	N=1	N=0	N=0	Radio	N=7	N=5	N=4
Record player	N=1	N=1	N=0	Record player	N=2	N=1	N=2	Radio	N=2	N=3	N=0	TV	N=1	N=4	N=0
Church- Theatre	N=0	N=1	N=1	Radio-TV	N=1	N=2	N=2	TV-Radio	N=3	N=0	N=1	Radio-TV	N=3	N=2	N=1
Sung and played by ourselves	N=1	N=1	N=1	Other	N=4	N=0	N=0	Theatre	N=1	N=1	N=1	CD	N=4	N=1	N=2
Age	**<75**	**75-80**	**>80**	**Age**	**<75**	**75-80**	**>80**	**Age**	**<75**	**75-80**	**>80**	**Age**	**<75**	**75-80**	**>80**
Radio-Television	N=9	N=4	N=3	Radio	N=6	N=8	N=2	TV	N=1	N=0	N=0	Radio	N=6	N=5	N=5
Record player	N=1	N=1	N=0	Record player	N=2	N=3	N=0	Radio	N=1	N=3	N=1	TV	N=2	N=0	N=3
Church- Theatre	N=0	N=1	N=1	Radio-TV	N=4	N=0	N=1	TV-Radio	N=0	N=3	N=1	Radio-TV	N=3	N=2	N=1
Sung and played by ourselves	N=1	N=1	N=1	Other	N=1	N=1	N=2	Theatre	N=2	N=1	N=0	CD	N=2	N=4	N=0
Income District	**Low**	**Medium**	**High**	**Income District**	**Low**	**Medium**	**High**	**Income District**	**Low**	**Medium**	**High**	**Income District**	**Low**	**Medium**	**High**
Radio-Television	N=5	N=7	N=4	Radio	N=6	N=8	N=2	TV	N=0	N=1	N=0	Radio	N=7	N=6	N=3
Record player	N=0	N=1	N=1	Record player	N=0	N=3	N=2	Radio	N=1	N=2	N=2	TV	N=1	N=3	N=1
Church- Theatre	N=0	N=1	N=1	Radio-TV	N=3	N=2	N=0	TV-Radio	N=1	N=2	N=1	Radio-TV	N=3	N=1	N=2
Sung and played by ourselves	N=2	N=1	N=0	Other	N=0	N=2	N=2	Theatre	N=0	N=1	N=2	CD	N=2	N=4	N=1

Did you sing?

Table 6.14 describes the results of the question "Looking back at your childhood/adolescence/adulthood/old age, did you sing?" With respect to childhood, the sample is split into two numerically equal parts. The majority (21 out of 40) answers positively to the question, and the others, 19 out of 40, answer negatively. As regards the level of education, in the less educated group there is a preponderance of people who claim to have sung as a child (10 out of 16) while, in the group of more educated people, there is a division into two (of 11, 6 answer positively and 5 answer negatively). In the group with an average level of education, most people (8 of 13) did not sing during childhood. With regard to age, the older group is divided into two equal numbers - 5 said they sang and 5 did not sing. In the younger group, the sample is again split into two but, in this case, the negative heading prevails (8 state that they did not sing and 7 say they did), then the middle group patterns are similar to those for the whole sample. Finally, the group from low income areas overturns what has been said so far and the negative answer prevails - 9 out of 14 people said they did not have the habit of singing while the values mirror those of the general sample for the areas with middle and high income.

As far as adolescence is concerned, the values show a sample split into two parts with similar values. In spite of this, the majority of the sample (24 of 40) said they had not sung during adolescence. In particular, those who have the lowest level of education said that they did not sing in their adolescence (13 of 16), and these are similar values to those with a medium level of education, while values are reversed in the group of the more educated. With respect to the age of interviewees, the two older age groups were more likely to say that they did not sing, while the pattern is reversed for the younger group. As regards the income area, the values follow those of education for the economically less advantaged group while the samples of the other two groups are equally divided.

For adulthood, 35 out of 40 people said they did not sing during adulthood, while only five said they did. The values broken down by education, age and income reflect those of the entire sample, showing that singing was not part of adult life. In the old age section, a negative answer prevails with 29 out 40 not singing while 11 claim that they sing. The negative value is predominant across age/education and income area.

When did you sing?

With respect to the question "Looking back at your childhood/adolescence/adulthood/old age, when did you sing", the sample is different across the two times of life, the first (childhood) is made up of 19 respondents and the second (adolescence)

Table 6.14 Did you sing?

Did you sing the music?	Childhood			Adolescence			Adulthood			Old Age		
Yes	N=21			N=16			N=5			N=11		
No	N=19			N=24			N=35			N=29		
Education	**<10**	**10-14**	**>14**	**<10**	**10-14**	**>14**	**<10**	**10-14**	**>14**	**<10**	**10-14**	**>14**
Yes	N=10	N=5	N=6	N=3	N=5	N=8	N=1	N=2	N=2	N=4	N=3	N=4
No	N=6	N=8	N=5	N=13	N=8	N=3	N=15	N=11	N=9	N=12	N=10	N=7
Age	**<75**	**75-80**	**>80**	**<75**	**75-80**	**>80**	**<75**	**75-80**	**>80**	**<75**	**75-80**	**>80**
Yes	N=7	N=9	N=5	N=9	N=5	N=2	N=2	N=2	N=1	N=6	N=4	N=0
No	N=8	N=6	N=5	N=6	N=10	N=8	N=13	N=13	N=9	N=9	N=10	N=10
Income District	**Low**	**Medium**	**High**	**Low**	**Medium**	**High**	**Low**	**Medium**	**High**	**Low**	**Medium**	**High**
Yes	N=5	N=11	N=5	N=3	N=9	N=4	N=1	N=3	N=1	N=2	N=7	N=2
No	N=9	N=7	N=3	N=11	N=9	N=4	N=13	N=15	N=7	N=12	N=11	N=6

Table 6.15 When did you sing?

When did you sing?							
Childhood				**Adolescence**			
Everyday	N=7			*Family*	N=3		
School	N=1			*Friend*	N=3		
Fascist Saturday	N=3			*School*	N=9		
Occasionally	N=8			*Alone*	N=1		
Education	**<10**	**10-14**	**>14**	**Education**	**<10**	**10-14**	**>14**
Everyday	N=4	N=3	N=0	*Family*	N=0	N=2	N=1
School	N=1	N=0	N=0	*Friend*	N=0	N=2	N=1
Fascist Saturday	N=0	N=1	N=2	*School*	N=3	N=1	N=5
Occasionally	N=4	N=1	N=3	*Alone*	N=0	N=0	N=1
Age	**<75**	**75-80**	**>80**	**Age**	**<75**	**75-80**	**>80**
Everyday	N=2	N=5	N=0	*Family*	N=1	N=1	N=1
School	N=1	N=0	N=0	*Friend*	N=2	N=1	N=0
Fascist Saturday	N=0	N=2	N=1	*School*	N=5	N=3	N=1
Occasionally	N=4	N=1	N=3	*Alone*	N=1	N=0	N=0
Income District	**Low**	**Medium**	**High**	**Income District**	**Low**	**Medium**	**High**
Everyday	N=1	N=6	N=0	*Family*	N=0	N=2	N=1
School	N=0	N=1	N=0	*Friend*	N=0	N=3	N=0
Fascist Saturday	N=2	N=1	N=0	*School*	N=3	N=4	N=2
Occasionally	N=2	N=1	N=5	*Alone*	N=0	N=0	N=1

(Table 6.15). The sample for childhood consists of 19 people and is divided into two main groups, one (7 people) which said they sang everyday and one which claimed they sang occasionally; other people are divided between the 'Fascist Saturday' and school.

Fascist Saturday was instituted by Benito Mussolini through Italian Royal Decree Law No. 1010 of 20 June 1935. A year later the Theatrical Saturday was instituted which had the aim of allowing the population to improve their culture. The Fascist Saturday began around one o'clock on Saturday and continued for most of the afternoon, the population was invited to engage in recreational activities of all kinds, from gymnastics to singing or military parades. Groups were structured following age criteria and involved the younger population between 6 and 21.

Education patterns show that those with a lower level of education are the ones who sang more, dividing their time between a group which claims to have sung every day and another that says it sang only occasionally; these are similar results to those in the group of middle-level education, none of the more educated people claiming to have sung 'everyday', and all claiming to have sung only occasionally. The people in the group ranging from 75 to 80 are among those respondents who stated they sang the most while older ones only occasionally; younger people are divided more or less homogeneously for all labels. The interviewees from the wealthier areas claimed they sang occasionally while those with an average economic level are those who claimed to have sung 'everyday'. Those from the less advantaged areas are spread across all headings.

During adolescence, the majority of respondents, 9 out of 16, claimed they mainly sang at school and only one person claimed to have sung alone while the other interviewees are divided equally between family and friends. The more educated said they sang particularly in school while those with an average level of education are distributed equally among the various categories; the less educated people said they sang within the family. It can be said that there are no differences among the various categories as the values are distributed similarly to those of the entire sample.

Where did you sing?

In the question "Looking back at your childhood/adolescence/adulthood/old age, where did you sing?', the sample is different in the two times in life that have been analysed (Table 6.16). The first (childhood) is made up of 20 respondents and the second (adolescence) 14 (Table 6.16). The majority (12) said they sang at home, others (4) in church while yet others claimed they took part in the Fascist Saturday. Half the less educated sang at home, then at church, at school and the Fascist Saturday while the most educated are divided more or less

homogeneously in all the categories created. Most younger people sang mainly at home and one member of the middle age group (75/80) also sang during the Fascist Saturday. The older people mentioned ‘home’ and ‘church’ and the Fascist Saturday. As far as the income area is concerned, the values mirror those of the whole sample. In relation to adolescence, the majority (9) said they sang at school and the other values are spread among other labels. Education, age and income area seem not to be modulating factors, with results for the three groups reflecting the total sample.

Who did you sing with?

With respect to the question “Looking back at your childhood/adolescence/ adulthood/old age who did you sing with?”, the sample is different across the three times of life, the first (childhood) is made up of 19 respondents and the second (adolescence) 15 (Table 6.17). The majority of the sample claimed they sang in the family (11 out of 19), with similar mention of friends, school or alone. The less educated sang mainly in the family or at school while groups with a higher level of education reported a wider range of context for singing.

Looking at the age variable, the values are similar in all categories while both the younger and middle age category answered ‘family’. With regard to the income district, the middle income districts said that they had sung more in the family; for the other two categories, the values are spread mainly in all headings.

As far as adolescence is concerned, respondents are divided into two main groups. Some said they sang alone, and the other group said with friends. The less educated claimed they sang with colleagues and the family while the most educated sang alone or with friends. Age is not a moderating factor, as there is only one representative of the older category. With regard to the differences in income, it can be said interviewees from the less wealthy areas said they sang more in the family than those from the wealthier.

Table 6.16 Where did you sing?

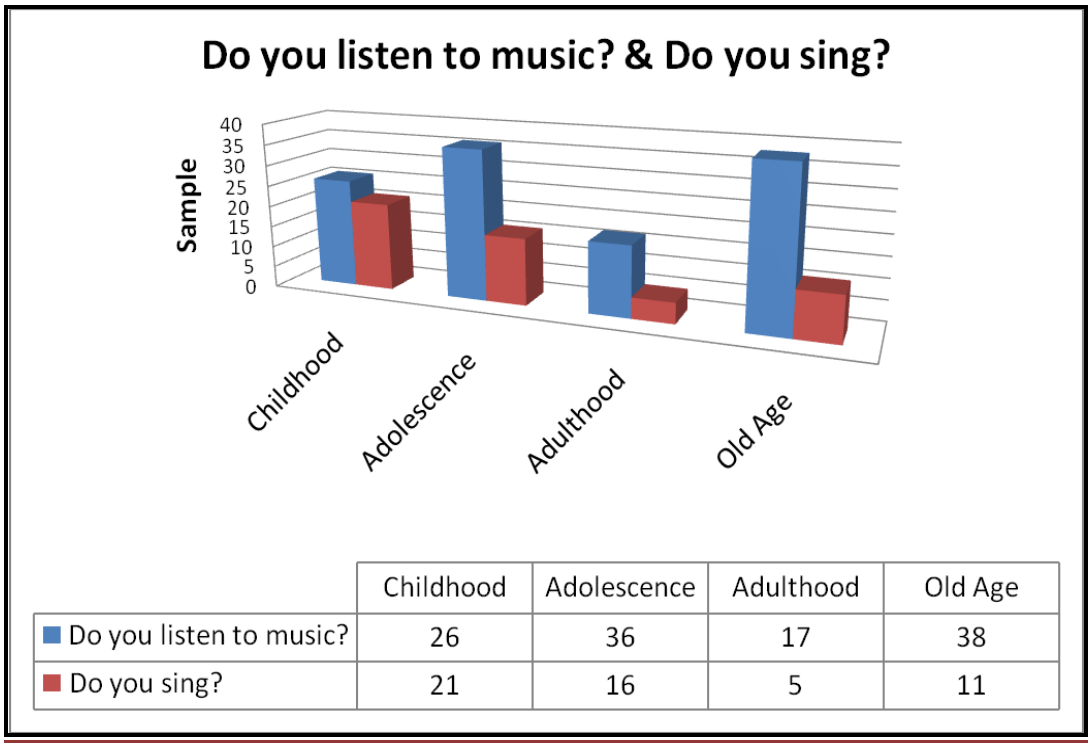
Where did you sing?							
Childhood				**Adolescence**			
Home	N=12			*Family*	N=2		
Fascist Saturday	N=2			*Friend*	N=2		
Church	N=4			*School*	N=9		
School	N=2			*Alone*	N=1		
Education	**<10**	**10-14**	**>14**	**Education**	**<10**	**10-14**	**>14**
Home	N=5	N=5	N=2	*Family*	N=0	N=2	N=0
Fascist Saturday	N=1	N=0	N=1	*Friend*	N=0	N=0	N=2
Church	N=2	N=0	N=2	*School*	N=2	N=2	N=5
School	N=1	N=0	N=1	*Alone*	N=1	N=0	N=0
Age	**<75**	**75-80**	**>80**	**Age**	**<75**	**75-80**	**>80**
Home	N=5	N=5	N=2	*Family*	N=2	N=0	N=0
Fascist Saturday	N=0	N=1	N=1	*Friend*	N=1	N=1	N=0
Church	N=1	N=1	N=2	*School*	N=6	N=2	N=1
School	N=1	N=1	N=0	*Alone*	N=0	N=1	N=0
Income District	**Low**	**Medium**	**High**	**Income District**	**Low**	**Medium**	**High**
Home	N=3	N=5	N=4	*Family*	N=0	N=2	N=0
Fascist Saturday	N=1	N=1	N=0	*Friend*	N=0	N=1	N=1
Church	N=1	N=2	N=1	*School*	N=3	N=3	N=3
School	N=0	N=2	N=0	*Alone*	N=0	N=1	N=0

Table 6.17 Who did you sing with?

Who did you sing with?							
Childhood				**Adolescence**			
Family	N=11			*Alone*	N=5		
Friend	N=3			*Friend*	N=6		
School	N=2			*Working*	N=1		
Alone	N=3			*Family*	N=3		
Education	**<10**	**10-14**	**>14**	**Education**	**<10**	**10-14**	**>14**
Family	N=6	N=3	N=2	*Alone*	N=0	N=1	N=4
Friend	N=0	N=1	N=2	*Friend*	N=0	N=3	N=3
School	N=2	N=0	N=0	*Working*	N=1	N=0	N=0
Alone	N=1	N=1	N=1	*Family*	N=2	N=0	N=1
Age	**<75**	**75-80**	**>80**	**Age**	**<75**	**75-80**	**>80**
Family	N=4	N=6	N=1	*Alone*	N=4	N=1	N=0
Friend	N=0	N=1	N=2	*Friend*	N=3	N=2	N=1
School	N=1	N=1	N=0	*Working*	N=0	N=1	N=0
Alone	N=2	N=0	N=1	*Family*	N=2	N=1	N=0
Income District	**Low**	**Medium**	**High**	**Income District**	**Low**	**Medium**	**High**
Family	N=3	N=7	N=1	*Alone*	N=1	N=1	N=3
Friend	N=1	N=1	N=1	*Friend*	N=0	N=5	N=1
School	N=1	N=1	N=0	*Working*	N=0	N=1	N=0
Alone	N=0	N=0	N=3	*Family*	N=2	N=1	N=0

Listening to music and singing across the lifespan: a summary

The bar chart below (Figure 6.7) describes graphically the trend of listening to music or singing during the four times of life analysed. The blue bars display the habit of listening to music which was very common across all times of life although there was a decrease in this habit with the highest incidence found during adolescence and older life. As far as singing is concerned, about half the sample claimed that they sang during childhood. This dropped for adolescence and adulthood but shows a rise in older age.



	Childhood	Adolescence	Adulthood	Old Age
Do you listen to music?	26	36	17	38
Do you sing?	21	16	5	11

Figure 6.7 Do you listen to music and do you sing?

6.3.3. Question about music at present

It should be noted that even participants in the 60-70 age group were asked the questions about the present although they are in the group of young older. The author accepted a repetition of the answers previously given.

Do you listen to music occasionally or every day?

Table 6.18 below summarizes the result of the question "Do you listen to music occasionally or every day?" Listening to music is clearly an important aspect in the everyday life of the sample interviewed with the most frequent response being 'I listen to music every day';

more specifically, more than half the entire sample listened to music every day. The two headings ‘seldom’ and ‘occasionally’ have the lowest values across all groups.

Table 6.18 Do you listen to music occasionally or every day?

Do you listen to music occasionally or every day?	**All Sample**		
Every day	20		
Seldom	2		
Occasionally	2		
Often	5		
Nearly every day	5		
Education	**<10**	**10-14**	**>14**
Every day	8	8	4
Seldom	1	1	0
Occasionally	1	0	1
Often	1	1	3
Nearly every day	2	2	1
Age	**<75**	**75-80**	**>80**
Every day	8	8	4
Seldom	0	1	1
Occasionally	2	0	0
Often	2	1	2
Nearly every day	1	2	2
Income District	**Low**	**Medium**	**High**
Every day	4	11	5
Seldom	0	2	0
Occasionally	0	2	0
Often	3	1	1
Nearly every day	5	0	0

As far as the level of education is concerned, 4 out of 9 of the more educated said that they listened to music ‘every day’ compared with 8 out of 13, and 8 out of 12 of the other two groups (low and middle levels of education). As far as income area is concerned, the table shows that income seems to be a moderating factor as listening ‘every day’ increases from the low to the medium income areas. As far as age is concerned, 4 out of 9 said that they listened to music ‘every day’ compared to a high proportion of the younger group (8 out of 13) and the middle age range groups (8 out of 12).

When do you listen to music during the day?

Table 6.19 below summarizes the result of the question "When do you listen to music during the day?" Music is shown to be the favourite pastime for the people interviewed, across all the variables analysed. The majority of the sample (n=14) listens to music 'when I have time' meaning that when the sample has some spare time, they listen to music. The other two highest values are 'When I get the chance' (n=6) or 'always' (n=5). With respect to the latter, the table shows that none of the group with a higher level of education claims that they 'always' listen to music.

Table 6.19 When do you listen to music during the day?

When do you listen to music during the day?	**All Sample**		
When I get the chance	6		
When I have time	14		
When I feel like	1		
Always	5		
Various	2		
Education	**<10**	**10-14**	**>14**
When I get the chance	4	1	1
When I have time	6	4	4
When I feel like	0	1	0
Always	2	3	0
Various	1	0	1
Age	**<75**	**75-80**	**>80**
When I get the chance	3	2	1
When I have time	6	7	1
When I feel like	1	0	0
Always	2	2	1
Various	0	0	2
Income District	**Low**	**Medium**	**High**
When I get the chance	2	3	1
When I have time	2	10	2
When I feel like	1	0	0
Always	2	1	2
Various	0	1	1

As far as age is concerned, the results above show that the older part of the sample is divided nearly equally in all headings. The income factor shows that participants from the wealthier areas of the sample seem to have more time to listen to music in the light of the highest percentage (2 out of 6) of the heading 'always', whereas the lower income have a higher level of the percentage 'When I get the chance' or 'When I have time'.

How do you choose the kind of music to listen to?

Table 6.20 below summarizes the results of the question 'How do you choose the kind of music to listen to?' As a preliminary, the table shows that music is not chosen. The majority of the respondents (n=17) said that 'I switch on the radio and I accept what the radio plays', while 3 out of 24 said that 'I choose the music' and 'It depends on my mood'.

Table 6.20 How do you choose the kind of music to listen to?

How do you chose the kind of music to listen to?	**All Sample**		
I switch on the radio	17		
I choose the music	3		
Depends on my mood	3		
Other people choose for me	1		
Education	**<10**	**10-14**	**>14**
I switch on the radio	8	6	3
I choose the music	0	2	1
Depends on my mood	0	0	3
Other people choose for me	1	0	0
Age	**<75**	**75-80**	**>80**
I switch on the radio	5	8	4
I choose the music	2	0	1
Depends on my mood	1	2	0
Other people choose for me	1	0	0
Income District	**Low**	**Medium**	**High**
I switch on the radio	5	7	5
I choose the music	1	2	0
Depends on my mood	1	1	1
Other people choose for me	1	0	0

Mood does not particularly affect choice except for the most highly educated group (3 out of 7), while the less educated one (8 out of 9) accepts what the radio plays; for this group and for the middle educated, there is no value for the heading 'it depends on my mood'. Furthermore, none of the less educated group said that they 'choose the music' while the section of the sample with a middle level of education and those with a higher level of education said they choose the music that they listen to, although with a different value (2 out of 8) for the former and (1 out of 7) for the latter.

With respect to the age variable, the younger part of the sample uses the radio less compared to the middle age section of the sample. As far as the income variable is concerned, the figures do not show marked differences among the three levels of income.

Compared with the past, is music more or less important in your personal life now?

Table 6.21 below summarizes the result of the question 'Compared with the past, is music more or less important in your personal life now?' In the main, the majority of the sample (19 out 35) said that music is more important in their life now compared with the past; only 5 out of 35, of the entire sample said that music has 'Never been important' while a section of the sample said that music had always had an important place in their life (always very important 6 out of 35).

Table 6.21 Compared with the past, is music more or less important in your personal life now?

Compared with the past, is music more or less important in your personal life now?	**All Sample**		
More important	19		
Never being important	5		
Like in the past	2		
Always very important	6		
Other	3		
Education	**<10**	**10-14**	**>14**
More important	9	5	5
Never being important	1	2	2
Like in the past	1	1	0
Always very important	0	4	2
Other	2	0	1
Age	**<75**	**75-80**	**>80**
More important	8	8	3
Never being important	1	1	3
Like in the past	1	0	1
Always very important	3	2	1
Other	1	2	0
Income District	**Low**	**Medium**	**High**
More important	5	9	5
Never being important	1	3	1
Like in the past	1	1	0
Always very important	3	2	1
Other	2	1	0

By analysing the table in the light of the education, age and income area, the majority of the less educated (9 out of 13) said that music is now more important. As far as the other two groups are concerned, similar patterns can be found with respect to the heading 'more important'; conversely, the middle educated (4 out of 12) said that music has 'always been very important' as did 2 out of 10 of the higher educated group.

With respect to age groups, music is more important now compared with the past for the 75-80 age group, there are similar values for the younger age group. In the older group an equal number of those interviewed said that music has never been important in their lives (n=3) and it is more important now. With reference to the income area, music is more important for the majority from the wealthier areas analysed, followed by the middle whereas participants from the less advantaged areas have the lowest number of people in this heading.

Do you prefer singing or listening or do you like both?

Table 6.22 below summarizes the results of the question 'Do you prefer singing or listening or do you like both?' The majority of the sample said that they preferred listening to music rather than singing, and a large part of the sample (10 out of 34) said they did not have any preference between the two activities; 9 out of 34 said that they preferred singing to listening.

Table 6.22 Do you prefer singing or listening or do you like both?

Do you prefer singing or listening or do you like both?	**All Sample**		
Singing	9		
Listening	13		
Both	10		
I don't know	2		
Education	**<10**	**10-14**	**>14**
Singing	3	4	2
Listening	4	4	5
Both	4	4	2
I don't know	0	1	1
Age	**<75**	**75-80**	**>80**
Singing	5	4	0
Listening	3	6	4
Both	6	1	3
I don't know	1	0	1
Income District	**Low**	**Medium**	**High**
Singing	0	8	1
Listening	8	3	2
Both	4	2	4
I don't know	0	2	0

The level of education shows that the sample with a middle level of education is broken into three groups with the same values concerning preference. However, the patterns are similar to entire sample for the less educated and more highly educated groups.

As far as the age groups are concerned, the older group showed a clear preference for listening, or has no preference and so liked both activities. None of this group indicated that singing is a favourite activity. However, there is a marked difference with the group of younger people - while the 75-80 group expressed a preference for listening to music, compared with singing, the youngest group said they preferred singing to listening.
As far as area is concerned, none of the participants from the less wealthy areas said they preferred singing and more than half of this sample preferred listening. The section of the sample from the wealthier areas appreciated both singing and listening, but also said they preferred listening to singing, while the middle preferred singing.

Looking at the present, do you sing?

Table 6.23 below summarizes the results of the question 'Looking at the present, do you sing?' The sample was asked if they sing at present; 24 out of 35 said they do not sing. The better educated are more likely to say that they sing whilst the less educated are more likely to say that they do not sing. The older section of the sample categorically excluded singing; in general, this section of the sample is not in the habit of singing, while the younger ones, like those of the 75-80 group, are fairly equally divided. In addition, individuals from the less wealthy areas almost totally excluded singing (11 out of 13), followed by the wealthier areas (6 out of 8); whereas the middle income area of the sample is perfectly divided.

Table 6.23 Looking at the present, do you sing?

Looking at present, do you sing?	**All Sample**		
Yes	11		
No	24		
Education	**<10**	**10-14**	**>14**
Yes	4	3	4
No	9	9	6
Age	**<75**	**75-80**	**>80**
Yes	6	5	0
No	9	7	8
Income District	**Low**	**Medium**	**High**
Yes	2	7	2
No	11	7	6

Are you interested in participating in singing groups?

The last question of the interview was aimed at understanding the interest of interviewees in taking part in singing groups (Table 6.24). According to the table below, there are three main answers - Yes, No and I'd like to try. Just over half (21 out of 40) answered that they would definitely like to take part and 16 said that they liked the idea overall and were well prepared to try even though they felt unable to sing (e.g. because they were tone deaf) or they were probably not able to reach the venue, and 3 said that they were definitely not interested in the experience.

Table 6.24 Are you interested in participating in singing groups?

Are you interested in participating in singing groups?	
Yes	21
No	3
I' d like to try	16

6.4. Pilot sessions

The pilot sessions had three main aims - firstly to discover whether the experience of singing was welcomed by older Italians, secondly to clarify whether the repertoire proposed could match older people's taste and, lastly, what kind of adjustments the sessions needed from the UK Silver Song Clubs model to be acceptable to Italians.

6.4.1. Pilot study results

Three pilot sessions were held in June 2011 in three different Municipi of Rome - Municipio 6 (low income), Municipio 9 (middle income) and Municipio 17 (high income). Most of the people interviewed took part in the pilot sessions but additional people joined the session due to advertisement in the Centri Anziani used and word of mouth. The sample originally consisted of 51 people (Table 6.25) but only 46 correctly completed the anonymous questionnaire used to gather feedback. Therefore the sample of the pilot sessions consists of 46 older people.

Table 6.25 Total sample pilot sessions

Venue	Men	Women	Total
T	1	7	8
S	2	19	21
F	4	18	22
Total Sample	7	44	51

Almost half the entire sample consisted of people who belong to the 70-74 age group, whereas 11 out of 46 are in the 75-79 group. This follows the pattern seen in the sample of interviews. In the sample of pilot sessions, no-one belonged to the 60-64 group and the 65-69 and 80-84 age groups are almost equal. Finally, only one person in the whole group of 46 people was over 90 (Figure 6.8). The sample was predominantly female (85% female and 15% male).The bar graph shows the living conditions of the sample (Figure 6.9). There is a prevalence of people living alone, almost half the sample, while 15 out of 46 live with a partner. Lastly, 11 people live with their children.

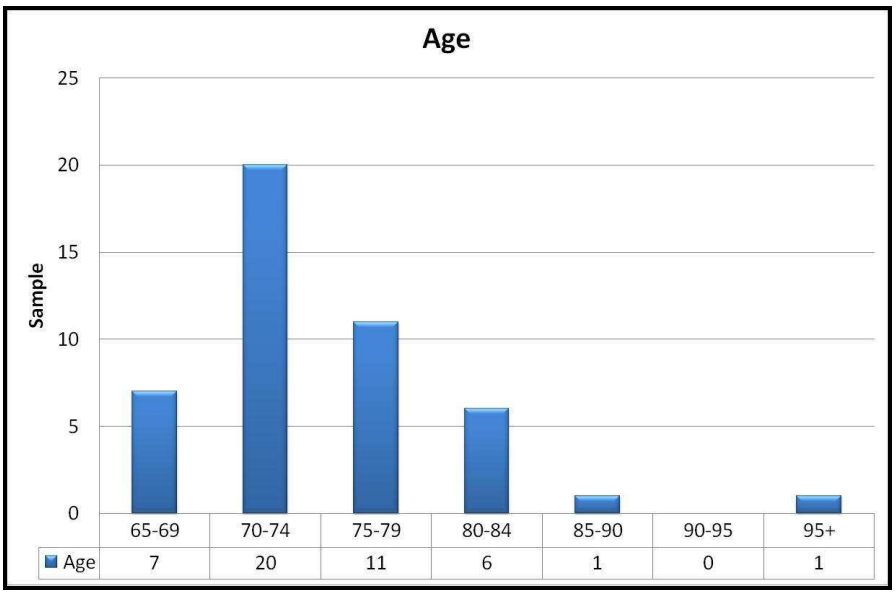


Figure 6.8 Age of the sample

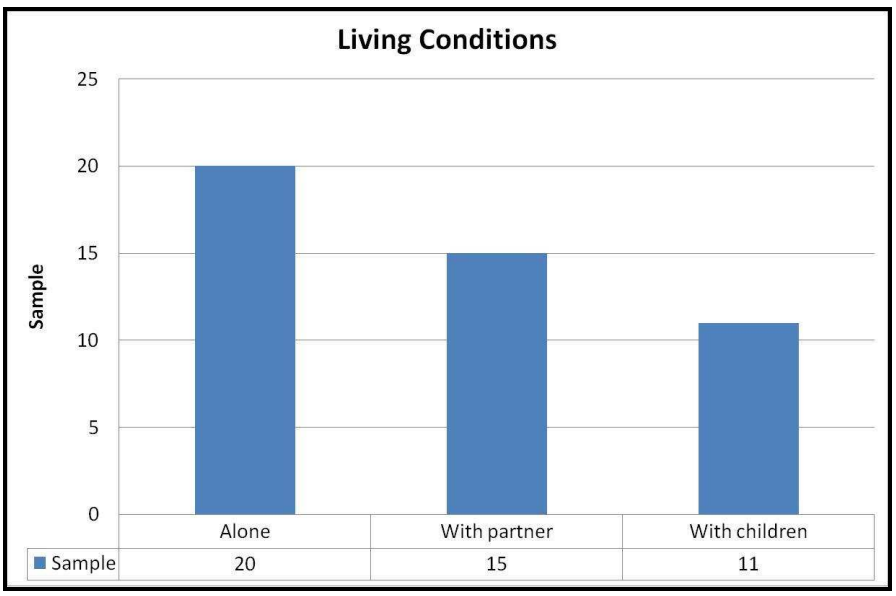


Figure 6.9 Living conditions

The bar chart refers to the level of education of the sample (Figure 6.10). First, the distribution of the level of education is nearly equal because the sample is divided into 3 groups with similar values; the fourth group has the lowest value and consists of people who studied until they were 25. No-one belonged to the group of people who did not receive any type of education. The majority of the sample has a low level of education - 13 out of 46 people studied up to the end of the elementary school whereas 12 out of 46 hold a High School diploma.

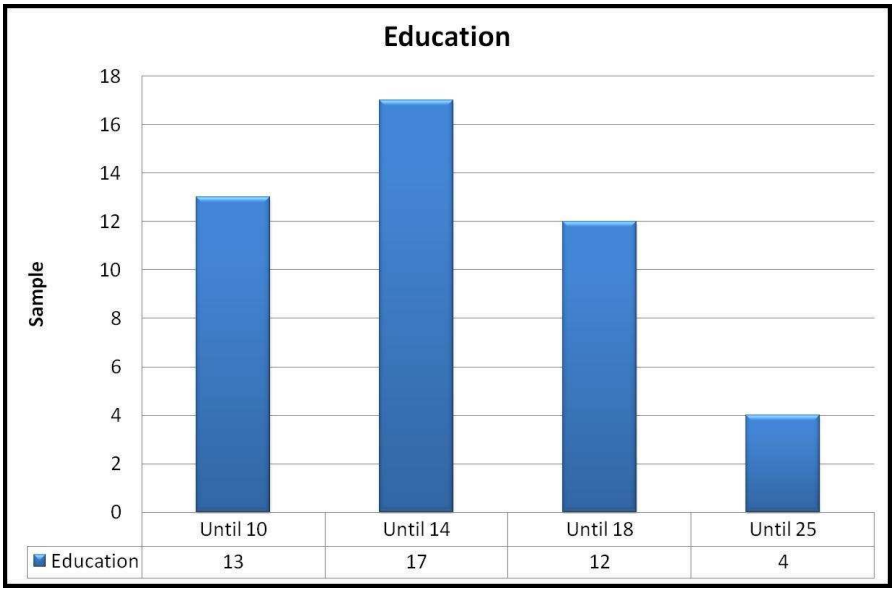


Figure 6.10 Level of education

Have you enjoyed the session?

Figure 6.11 displays the results of the first question of the questionnaire 'Have you enjoyed the session?' Firstly, all the sample enjoyed the session. The sample answered grading the level of enjoyment from 1 (not much) to 2, 3, 4 and 5 (very much). Almost all the sample (41 out of 46 people) gave a score of '5'. No-one gave the lowest scores i.e. 1 or 2 while, with respect to the remaining components of the sample, one person gave a score of 3 and 4 people gave a score of 4.

Which aspect of the session do you find most enjoyable?

Figure 6.12 displays the result of the second question of the questionnaire 'Which aspect of the session do you find most enjoyable?' The sample chose more than one aspect or 'all the above'; furthermore, there was also the opportunity to add other aspects that were not listed in the questionnaire. The variables were 'singing', 'listening to music', 'sharing moments with other people', 'all the above' and 'others'. The favourite variable of the sample was 'singing', the sample then highlighted that the most enjoyable aspect was being able to share

moments with other people. There was also an appreciation of 'all the above'. Only 2 people out of 46 added other dimensions - more specifically, one person wrote 'learning new things' and another 'spending my time in a pleasant way'.

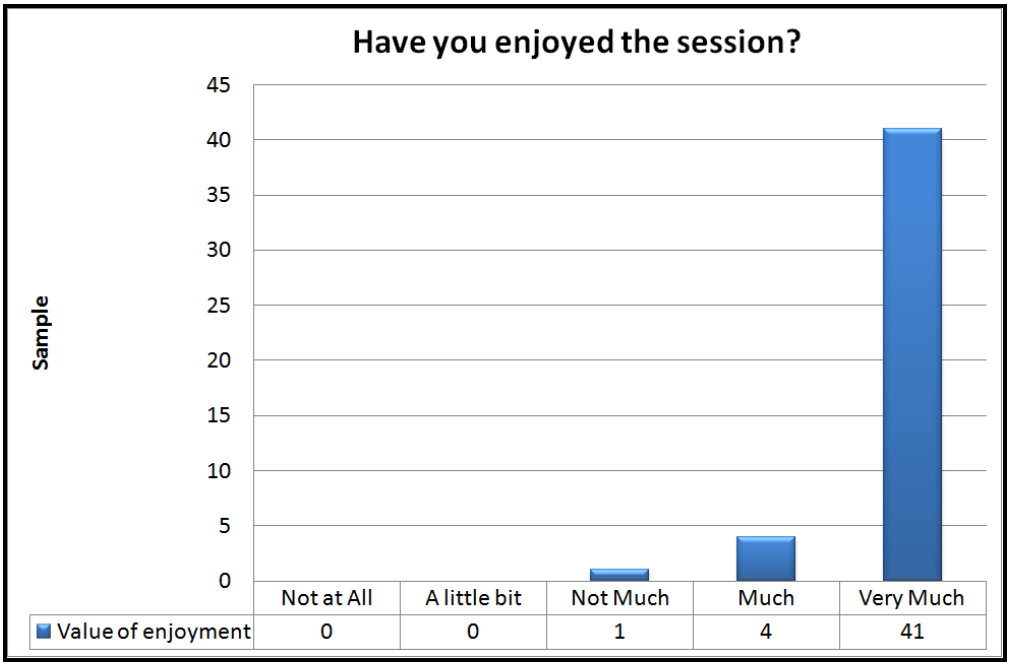


Figure 6.11 Level of enjoyment of the session

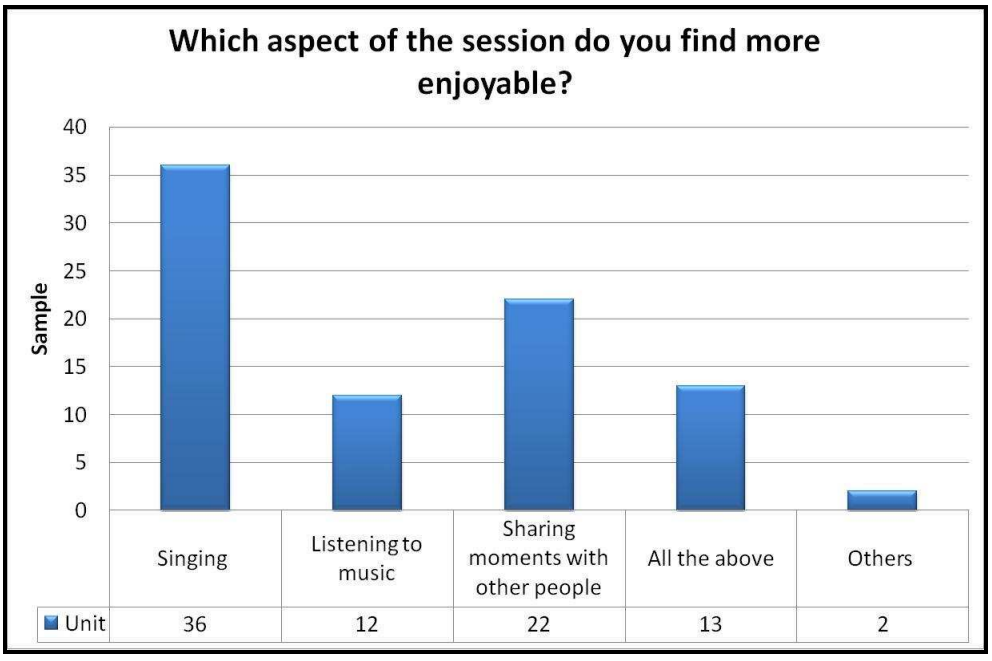


Figure 6.12 Which aspect of the session do you find most enjoyable?

How did you feel during the session?

This bar chart (Figure 6.13) displays what the sample felt during the session. The sample had the opportunity to choose more than one response category, and also in this case could add

comments. No-one chose the option ‘boredom’ and only one person said they felt stressed while a part, albeit small, of the sample felt sadness. The other variables show a broad consensus. More specifically, the variables receiving the greatest consensus are ‘joy’, and also ‘happiness’ and ‘serenity’ during the session; furthermore, another option that received a lot of agreement, though slightly below the above, was ‘a sense of being involved in something’.

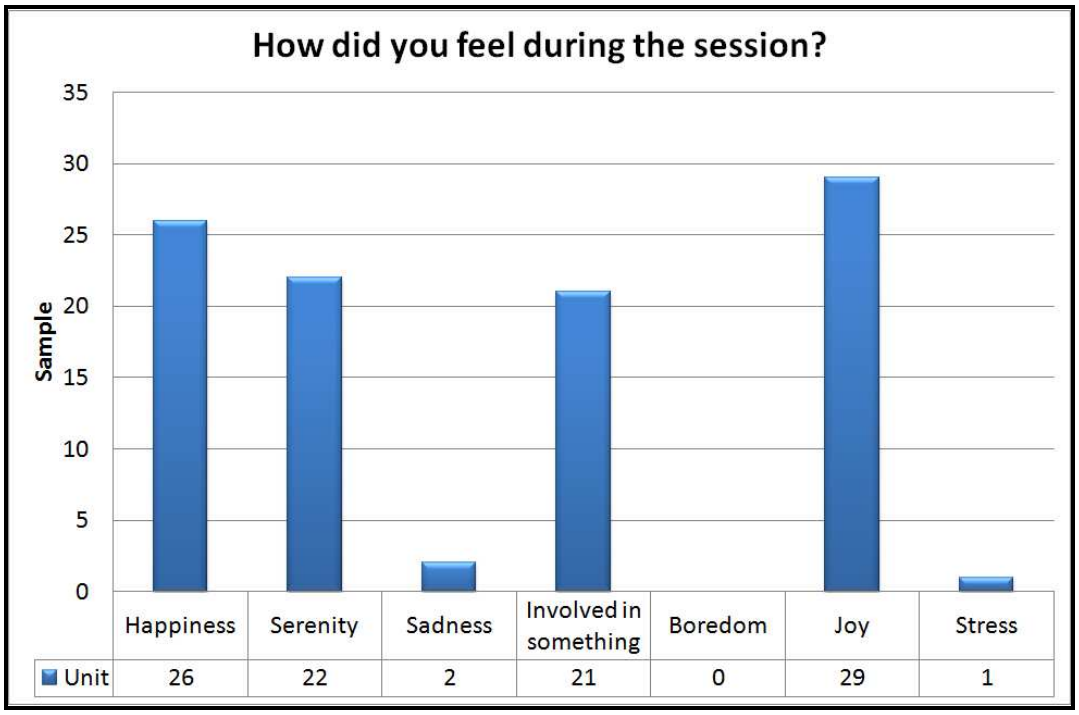


Figure 6.13 Feelings during the session

How did you feel after the session?

This chart (Figure 6.14) shows what the sample felt after the session. The sample had the opportunity to agree with more than one answer and also in this case could add comments. The options were ‘A feeling of happiness’, ‘A feeling of disappointment’, ‘A feeling of achievement’ and ‘other’. The option which received most approval from the sample was ‘a feeling of happiness’, as well as ‘a feeling of achievement’. Finally ‘disappointment because the session has finished’ also received broad consensus from the sample. As far as ‘other’ is concerned, people added comments about their feelings at the end of the session. Three participants wrote ‘I enjoyed myself’, one wrote ‘I did not want to come but it's nice’ and another ‘I feel good’.

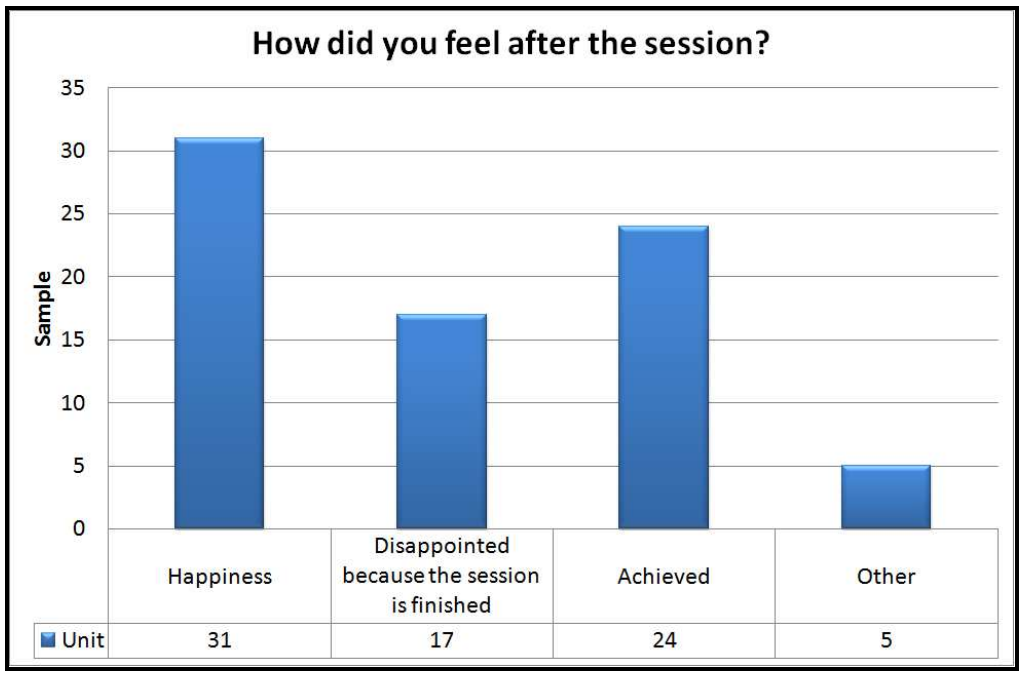


Figure 6.14 Feelings after the session

Do you think that singing is enjoyable?

Respondents were asked whether singing was enjoyable using the same value-grading system seen in other questions, where 1 is the lowest and 5 is the highest value (Figure 6.15). A total of 38 out of 46 people thought that singing is a very pleasant activity, one person believed that singing is not a pleasant activity, one person gave a rating of 3; the remaining believed that singing is a pleasant activity (a rating of 4).

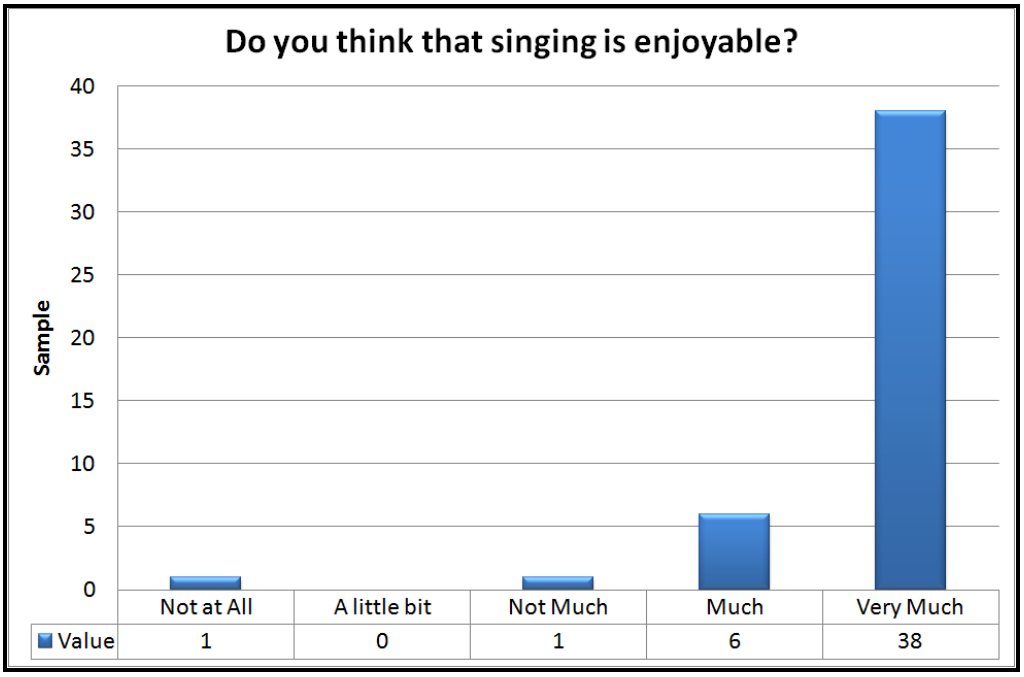


Figure 6.15 Do you think that singing is enjoyable?

Would you be interested in taking part in this kind of activity every week if it was possible?

The last question of the questionnaire asked the sample if it would be interested in participating in such an activity on a weekly basis (Figure 6.16). The majority of the sample (36 people out of 46) gave the highest value, in other words they would be very interested in participating in sessions such as those in which they had taken part; 4 people said they were interested in taking part in this kind of singing sessions. Only 2 out of 46 said that they would not be interested in the experience, and 4 were neutral.

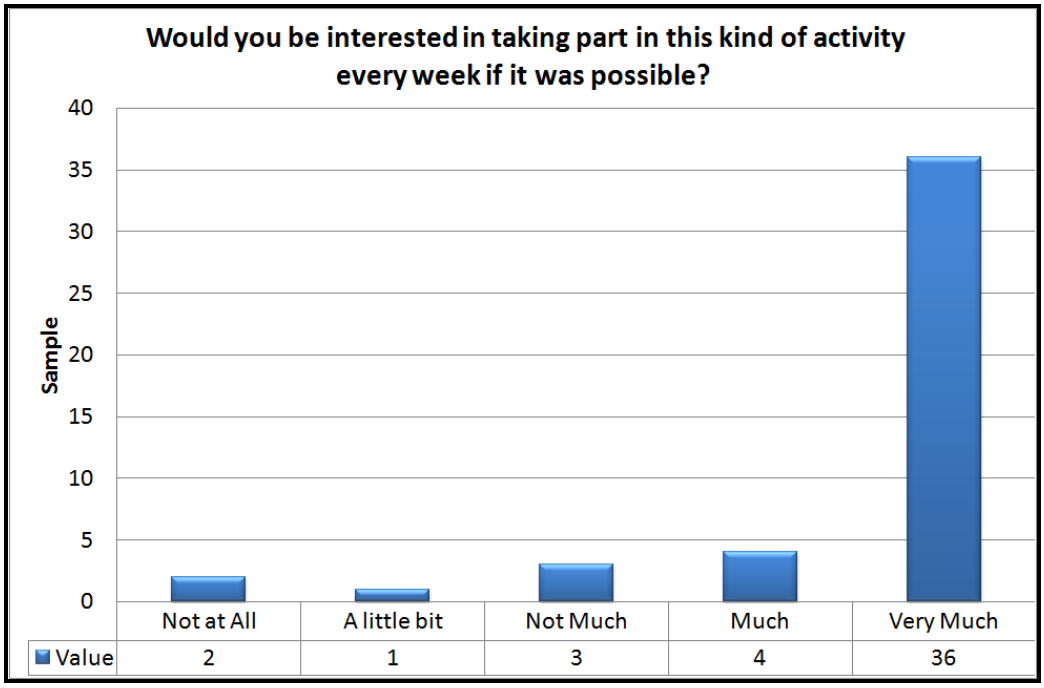


Figure 6.16 Would you be interested in taking part in this kind of activity every week if it was possible?

6.5. Summary of the main findings

This chapter reports the section highlighted of the results of Part A of the research. Its main aims were to discover the situation of older people in some districts of Rome and what place music and singing has had and has in the past and present life of this group of older people.

- The picture which emerges from the interviews of the professionals is a highly fragmented Italian family, where children are no longer able to help parents because they themselves have serious economic and financial difficulties.

- One aspect to consider is the role that ‘home’ has in the wellbeing of the older population in social-economic and emotional terms.
- Poverty and social isolation are widely spread throughout the older population and the need for emotional support and leisure activities is strongly highlighted.
- As far as music is concerned, older people show they were involved in music and singing more in childhood than later.
- As adults little space was given to music because of the daily tasks within their family.
- Education, income area and age had less effect on music consumption during life, although there are some differences among the groups.
- Few activities are carried out by the older population in their later years and these can be summarized as: work at home, attendance at the Centri Anziani, being a grandmother/grandfather and performing other activities (although they claimed that they did not have particular hobbies).
- The greater the age, the less this group does other activities or goes to the Centri Anziani.
- Where the level of education is higher, there is a decrease in attendance of the Centri Anziani with a parallel increase in the percentage of the ‘various activities’ heading.
- Interviews of older people showed they are mainly engaged in quite solitary activities, socially isolated, and often reporting a lack of interesting suggestions for their spare time.
- Pilot sessions showed that older Italians were interested in taking advantage of more regular singing activities.

Chapter 7.

Result Part B: Questionnaires, Observations and Focus Groups

7.1. Introduction

The results from Part B of the research undertaken will be reported in the following sections. Observation data and the questionnaires at the baseline and the end of the experience and follow up will be analyzed.

Data from questionnaire and the focus group to gather feedback on the experience of singing will also be presented.

7.2. Data analysis of the observations

The data below is the result of the observations carried out in the three venues (group S, group F and group T).

The following steps were taken to analyse the results of the observations:

- A table was created which displays the reactions of the participants to the individual songs in each of the venues,
- A bar chart of each observation was created showing the outcome of the songs as a sum of the values explained in the methodology,
- A graph was created to show a comparison of the average value of the three venues,

Bar charts show the trends in the venues, comparing the values of four songs in common.

Each song was labelled with a number (Table 7.1). Each item of the checklist was given a value between 5 and -1, 5 being the highest value and -1 the lowest (Table 7.2). As can be seen from the diagram shown here, the highest values were given to 100% participation and attention, while other data was given a lower percentage or gradation. A negative figure was given to less than 50% participation and the absence of positive reactions to the song and situation from the sample (e.g. no smiles or laughter).

Table 7.1 List of songs sung during observation

Number	Songs	Type of song
1	Arrivederci Roma	Popular Italian song
2	Chitarra Romana	Traditional song of Rome
3	Funicolì Funicolà	Traditional song of Naples
4	*Ma l'amore no*	Popular Italian song
5	Nel blu dipinto di blu	Popular Italian song
6	*Parlami d'amore Mariù*	Popular Italian song
7	*Roma nun fa' la stupida stasera*	Traditional song of Rome
8	Sora Menica	Traditional song of Rome
9	*Tanto pe' cantà*	Traditional song of Rome
10	Vecchia Roma	Traditional song of Rome
11	*Va' Pensiero*	From the Chorus of Nabucco by G. Verdi
12	Vecchio Frac	Popular Italian song
13	Venticello de Roma	Traditional song of Rome
14	Voglio vivere così	Popular Italian song
15	*Vola vola l'aritornello*	Traditional song of Abruzzo
16	Azzurro	Popular Italian song
17	Ave Maria	Classical song by F. Schubert
18	Abete di Natale	Christmas song
19	Astro del Cielo	Christmas song
20	Tu scendi dalle Stelle	Christmas song
21	La Santa Allegrezza	Christmas song

Table 7.2 Values given to the checklist

Code	Reactions	Points
A	100% Participation	5
B	75% Participation	3
C	50% Participation	1
D	Less than 50% Participation	-1
E	Attention	4
F	No Attention	-1
G	Smiles	3
H	Comments-Chatting	3
I	No Smiles or Laughter	-1

7.2.1. First group: Group S

During the first session observed, 6 songs were sung, and the average outcome value gained by the songs according to the values explained above was 7.2, where the maximum score is 15 and the minimum -3 (Table 7.3). The trend of the first observation shows a generally good level of participation, only one song attracting less than 50% participation. The

majority of the songs attracted people's attention; all songs but two were discussed and commented on after the performance, 3 songs received smiles at the end of the performance.

None of the songs appeared to elicit a negative reaction.
With respect to the second observation, there was a marked fluctuation in participation, with a considerable increase at the end of the session. Nearly all songs aroused smiles and chatting after the performance. As far as the presence or absence of attention is concerned, there was a split - half of the songs drew no attention or interest from participants while the other half did. The average outcome value was 9.6 (Table 7.3).

For the third observation, the average value is 13.0. During the session, songs received a good level of participation, and in just one case out of four the participation level was 50%. The sample paid attention to the remaining songs and the director. Conversely, the sample had a positive reaction to all songs.

With respect to the fourth observation, as a preliminary there was a considerable increase in the number of songs sung; in the first three observations, the number of songs was 4-5 on average. The number of songs rose to an average of 8-10 from the fourth observation onwards (Table 7.3).

The patterns show that there is a nearly perfect split into two groups. As far as the level of participation is concerned, one group of songs had 100% participation while the other one had 75%, and one had less the 50% of participation. With respect to the level of attention, although participation was quite high, the majority of the songs were given little attention by the participants. All songs generated comments and chatting after the performance. The average value of the session was 9.6.

During the fifth observation, the levels of participation and attention were high (the value for all songs but two), just like that of comments and chatting from the participants. As mentioned above, two songs had a low value with a low level of participation and no attention during the performance. The average value was 11.4.

Finally, for the sixth observation, the level of participation and attention was high for all songs with just 2 receiving a low level (50%) of participation. Members of the group often made comments and chatted at the end of each performance. The average value of the observation was 11.

The graph below shows the average value of each session, during observation at group S (Table 7.3).

Table 7.3 Values of each song for Group S

Venue	GROUP S										Total	Average value of the
Observation	SONGS	A	B	C	D	E	F	G	H	I		
1°	7		3				-1	3			5	7.2
	1			1		4		3	3		11	
	9			1		4			3		8	
	2			1		4			3		8	
	5		3			4			3		10	
	12				-1		-1	3			1	
2°	5				-1			3	3		5	9.6
	1		3			4			3		10	
	7		3				-1	3	3		8	
	16	5					-1	3	3		10	
	11	5				4		3	3		15	
3°	9			1		4		3	3		11	13.0
	11	5				4		3	3		15	
	7		3			4		3	3		13	
	1		3			4		3	3		13	
4°	5		3				-1	3	3		8	9.6
	11	5				4		3	3		15	
	16	5					-1	3	3		10	
	9	5				4		3	3		15	
	1	5					-1	3	3		10	
	17		3					3	3		9	
	18				-1				3		2	
	20		3				-1	3	3		8	
5°	7		3			4		3	3		13	11.4
	11	5				4		3	3		15	
	17	5					-1	3	3		10	
	16			1			-1	3			3	
	18		3			4		3	3		13	
	5		3			4		3	3		13	
	20		3			4		3	3		13	
6°	20	5				4		3	3		15	11.0
	17	5				4		3			12	
	7		3			4			3		10	
	11	5				4		3	3		15	
	18			1		4		3	3		11	
	1		3			4		3	3		13	
	9			1			-1		3		3	
	16		3			4		3			10	
	5		3			4		3			10	

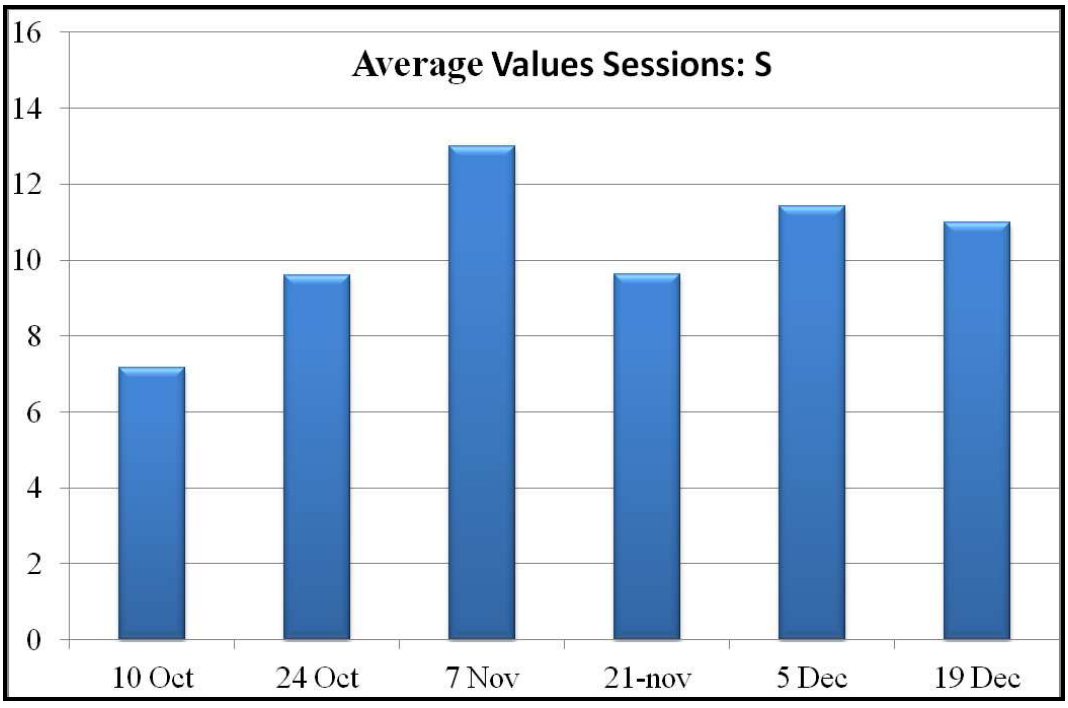


Figure 7.1 Average values of each observation session for Group S

The graph shows that values varied between the first and last observations. More specifically, the trend showed two changes - there was quite a marked increase from the

values registered during the first two observations and the third, from 7.2 to 13. Subsequently, during the fourth observation, there was a slight decrease (9.6) but this was still higher than the initial values. The second change was during the fifth observation, when the value reached 11.4; this was the highest attained throughout the whole observation. There was a decrease in the last observation with a value of 11 being obtained (Figure 7.1).

7.2.2. Second group: Group F

During the first observation, 4 songs were suggested and the average outcome value was 11.8, where the maximum score is 15 and the minimum -3 (Table 7.4). The trend of the first observation shows a generally high level of participation. All songs except one attracted participants' attention and all songs were discussed, commented on and smiled at after the performance.

Table 7.4 Values of each song for Group F

Venue	GROUP F										Total	Average value of the
Observation	SONGS	A	B	C	D	E	F	G	H	I		
1°	7	5				4		3	3		15	11.8
	9		3			4		3	3		13	
	2		3					3	3		9	
	5	5					-1	3	3		10	
2°	7	5					-1	3	3		10	11.5
	9	5					-1	3	3		10	
	1		3			4		3	3		13	
	5		3			4		3	3		13	
3°	7	5				4		3	3		15	8.6
	11		3				-1	3	3		8	
	6			1					3		4	
	5		3			4			3		10	
	2		3						3		6	
4°	1		3			4		3	3		13	10.0
	7		3			4		3	3		13	
	11		3			4		3	3		13	
	5		3								3	
	6		3				-1	3	3		8	
5°	11	5				4		3	3		15	9.9
	17	5				4		3	3		15	
	18			1			-1		3		3	
	21			1		4					5	
	7		3			4		3	3		13	
	19		3					3	3		9	
	1		3			4		3	3		13	
	6			1			-1	3	3		6	
6°	11	5				4		3	3		15	13.3
	17	5				4		3	3		15	
	21		3			4			3		10	
	19		3			4			3		10	
	6		3			4			3		10	
	7	5				4		3	3		15	
	1	5				4		3	3		15	
	9	5				4		3	3		15	
	18		3			4		3	3		13	
	5	5				4		3	3		15	

During the second observation, the level of participation was high; the group was divided over the amount of attention given to the songs, with half of them not attracting any attention from participants. All songs generated smiles, chatting and comments. The average value was 11.5.

During the session observed on the third occasion 5 songs were suggested. There was a generally good level of participation and in just one song was the participation 50%. With respect to the level of attention, it can be said that 2 songs drew participants' attention while observation during the other three did not highlight particular positive or negative aspects.

Nearly all songs aroused comments and chatting after the performance while just a few of the songs were greeted by smiles from participants. The average outcome value was 8.6.

For the fourth observation, the average value was 10.0. During the session, songs received a good level of participation with the majority also attracting a good level of attention. One song was not given a positive reaction by participants while all the others were welcomed by smiles, chatting and comments.

During the fifth observation there was a considerable increase in the number of songs sung. During the first three observations, the average number of songs was 5 but, from this session onwards, the average number of songs rose to 8-10. During this observation, it was noted that the songs attracted high, good and medium levels of participation. As far as the level of attention is concerned, attention was paid to the majority of the songs but 2 out of 8 were not given any attention by participants. There were comments and chatting after the performance for all songs yet only 6 generated smiles. The average value of the session was 9.9.

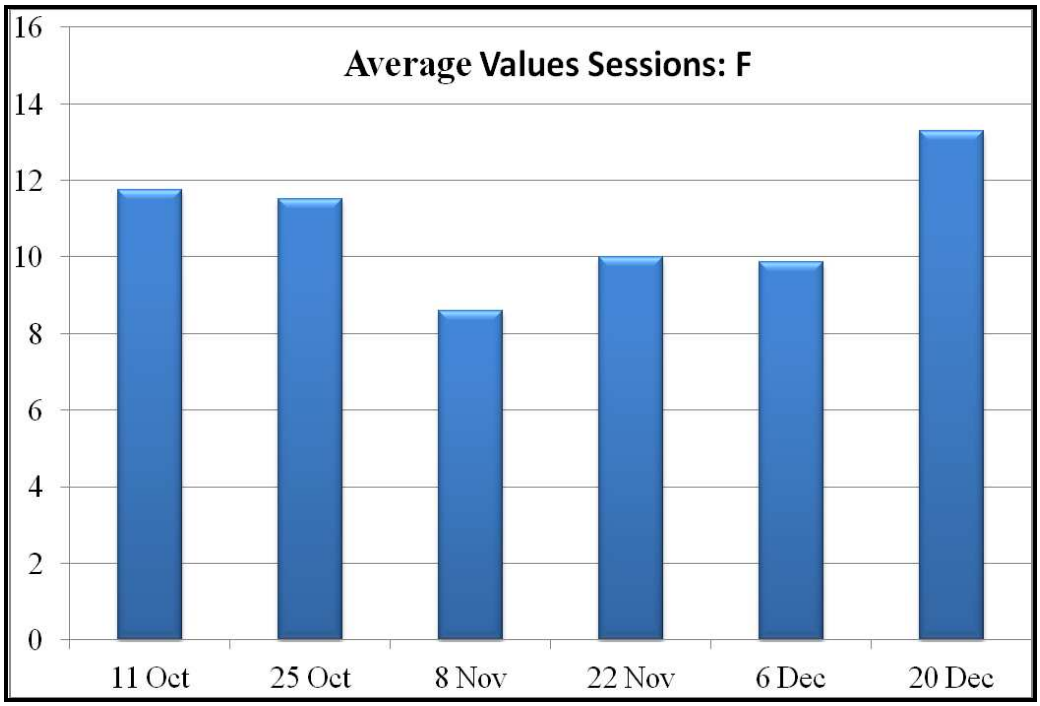


Figure 7.2 Average values of each observation sessions for group F

The level of both participation and attention was high in the last session observed. As mentioned above, no single song was given a negative value with respect to 'attention' during the performance. The majority of the songs were greeted with 'smiles' after the performance. The average value was 13.3.The graph above shows the average value during observation in Group F (Figure 7.2).

The general trend for this venue shows a high start value which subsequently fell and then returned to a higher level during the last two observations. In more detail, the first two observations have comparable values of around 11.5 then there is a rather marked decline during the third observation, which dropped to a value of 8.6. Later, in the fourth observation, there was a recovery, albeit not very high (10); subsequently, there was an increase during the last observation, with the value of 13.3 being attained.

7.2.3. Third group: Group T

During the first session observed, 3 songs were sung, the average outcome value gained by the songs according to the values explained at the beginning at the chapter was 11, where the maximum score is 15 and the minimum -3 (Table 7.5). The trend of the first observation shows a generally good level of participation, all three songs attracted people's attention; all songs but one were discussed and commented on after the performance, 2 songs received smiles at the end of the performance. None of the songs appeared to elicit a negative reaction.

Table 7.5 Values of each song for group T

Venue	GROUP T										Total	Average value of the
Observation	SONGS	A	B	C	D	E	F	G	H	I		
1°	7		3			4			3		10	11.0
	6		3			4		3			10	
	11		3			4		3	3		13	
2°	7		3			4		3	3		13	14.3
	5	5				4		3	3		15	
	11	5				4		3	3		15	
3°	1	5				4			3		12	8.0
	5		3				-1				2	
	11		3			4		3			10	
4°	1	5					-1	3			7	8.5
	6	5				4		3	3		15	
	11		3			4					7	
	9		3				-1		3		5	
5°	1		3			4		3	3		13	9.0
	16		3			4		3	3		13	
	5	5					-1	3	3		10	
	6			1			-1				0	
6°	7	5				4		3	3		15	13.0
	16	5				4		3	3		15	
	6		3			4			3		10	
	11		3			4		3	3		13	
	5		3			4			3		10	
	1	5				4		3	3		15	

For the second observation, the participation was high and all songs aroused smiles and chatting after the performance. As far as the presence or absence of attention is concerned, all songs gained a high level of attention (2 the maximum level and the third 75% of attention). The average outcome value was 14.3.

For the third observation, the average value is 8.0, according to the values explained above. During the session, songs received a good level of participation. The sample did not pay attention to the director in one case, while in the other followed the indications of the director. In this session, one song received comments and clapping and another smiles.

For the fourth observation two songs had 100% participation while the other two songs had 75%, during the fourth observation. With respect to the level of attention, although participation was quite high, in two songs the sample did not pay attention to the director. Two songs generated comments and chatting after the performance. The average value of the session was 8.5 (Table 7.5).

During the fifth observation, the levels of participation and attention were from high to very low while the comments and chatting from the participants were present in all songs but one. Two songs had a negative value with no attention during the performance. The average value was 9.0. One song has 0 as value (Table 7.5).

Finally, for the sixth observation, it should be noted that 6 songs were sung, and the level of participation and attention was high for all songs. Members of the group often had smiles at the end of each performance. The average value of the observation was 13 (Table 7.5).

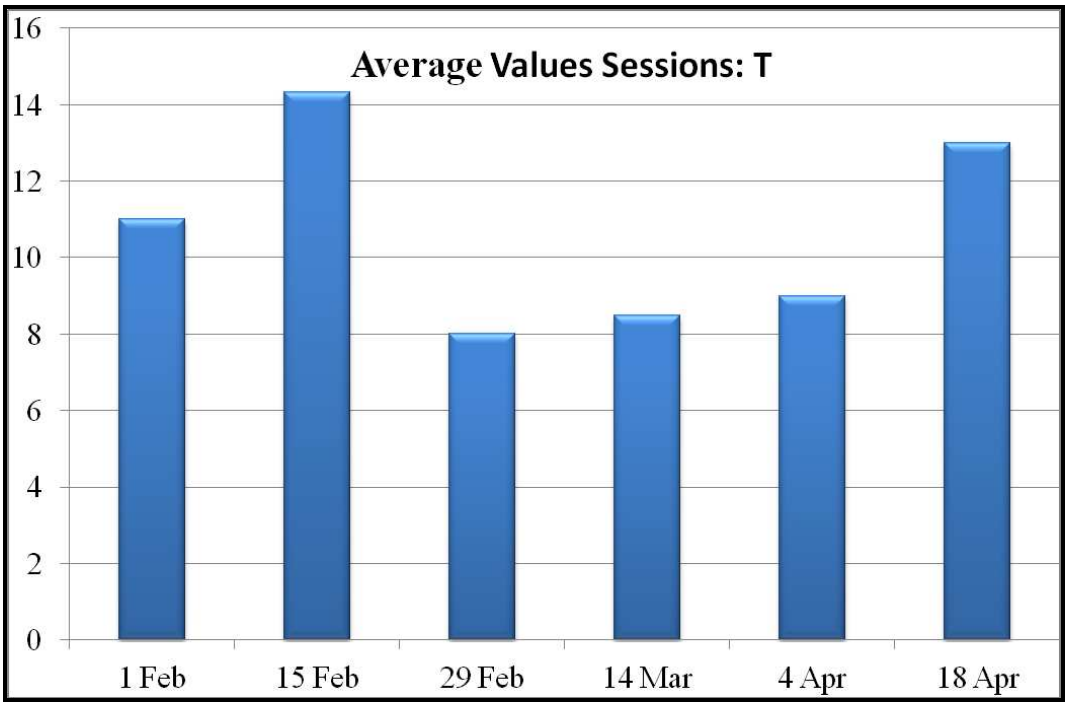


Figure 7.3 Average values of each observation sessions for group T

The bar chart above shows the average value during observation of the group T (Figure 7.3). The general trend of this venue shows a high start value which subsequently fell and then returned to a higher level during the last two observations. In more detail, there is a rise in value between the first two observations (values 11 to 14.3), then there is a rather marked decline during the third observation, which dropped to a value of 8.0. Later, in the fourth

observation, there was a recovery, albeit not very high (8.5); subsequently, there was an increase during the last observation, with the value of 13 being attained.

7.2.4. Comparison among songs in the different venues

The graph displays the trend in the observations of the three groups comparing all values derived from Tables 7.1, 7.2 and 7.3 which show the average values during observation of the three groups (Figure 7.4). The blue line shows the trend of the first group observed (S) while the red one shows the second group (F) and the green one is for the last group (T). All lines show a disordered pattern, with periods in which the values dropped considerably compared to the previous value and as many runs after marked elevation. As far as the blue line is concerned the final trend is negative against the previous value but positive compared to the beginning of the observations.

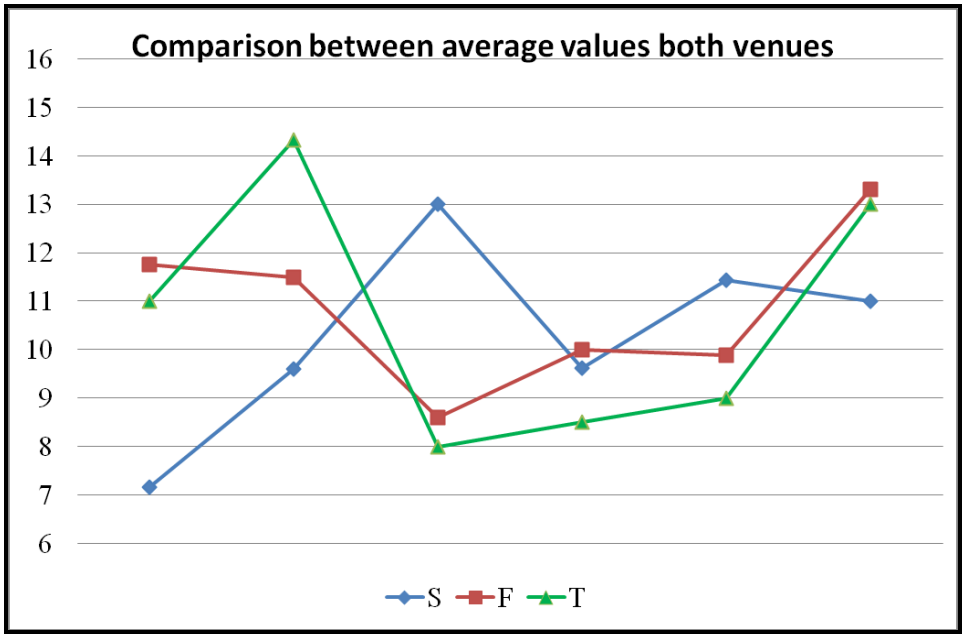


Figure 7.4 Comparison between average values for the three venues over six observations

With regard to the red line, at the beginning the values were higher compared with the other observations, then there was a fall in value during the third observation but, from that moment on, there was a steady climb until the value achieved by the last observation of the group of the first venue was exceeded.

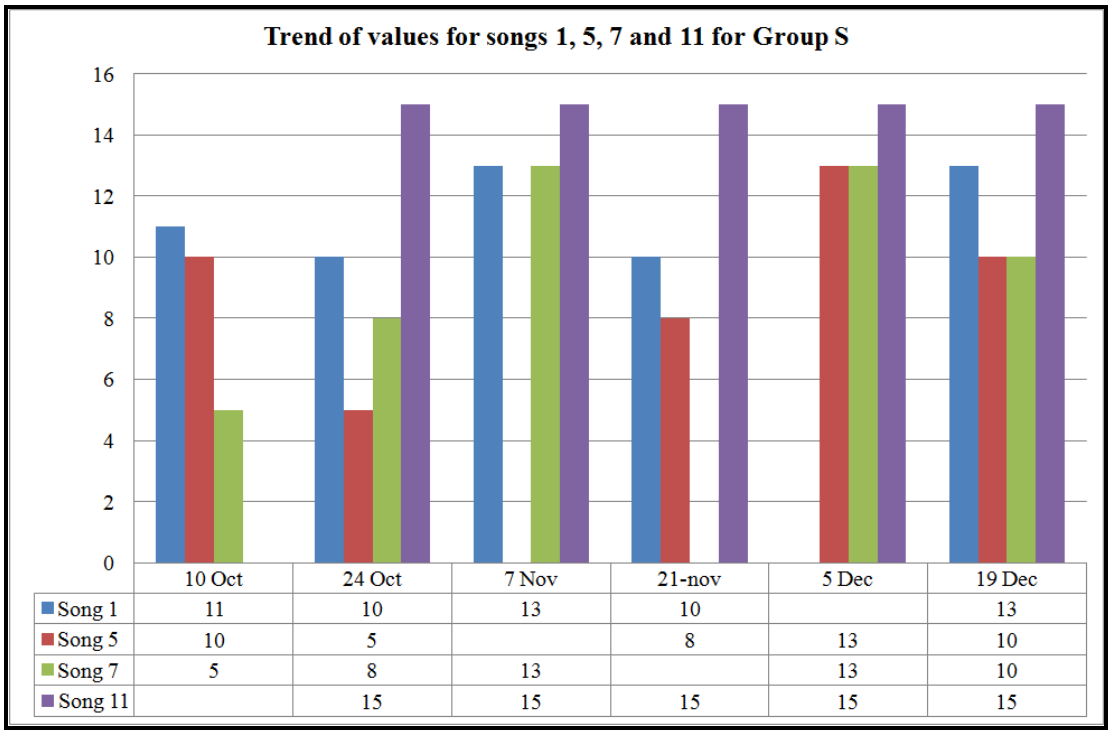
The green line has a similar trend to the red one, there is a start with quite a high value (11), a rise to 14.3 (the highest value of all) with a fall during the third observation. Then a climb, to a value of 13, higher than the start.

7.2.5. Comparison of songs

As preliminary, the scores are based on observation data, with higher score indicating higher levels of interest/participation in the sample.

Four songs (song 1 "*Arrivederci Roma"*, song 5 *"Nel blu dipinto di blu"*, song 7 "Roma non *fa' la stupida stasera"*, song 11 *"Va pensiero"*), with the highest values, were chosen to show what kind of reactions the sample had with respect to the songs over the period of observation. This is to assess whether the three venues have different attitudes towards the same songs.

The bar chart below displays the behaviour of group S with respect to the four songs chosen (Figure 7.5). Some have no value because they were not performed on the day of observation. As a preliminary, it can be said that all songs analysed had a positive trend over the period and Song 11 even maintained the same value (15) over the period. Song 1 had similar patterns during the whole period, while song 7 had a positive trend over the period, starting with an average value of 5 and reaching 10. As can be seen, there was a marked fluctuation for Song 5 although the value in the first and last observations was the same (10).

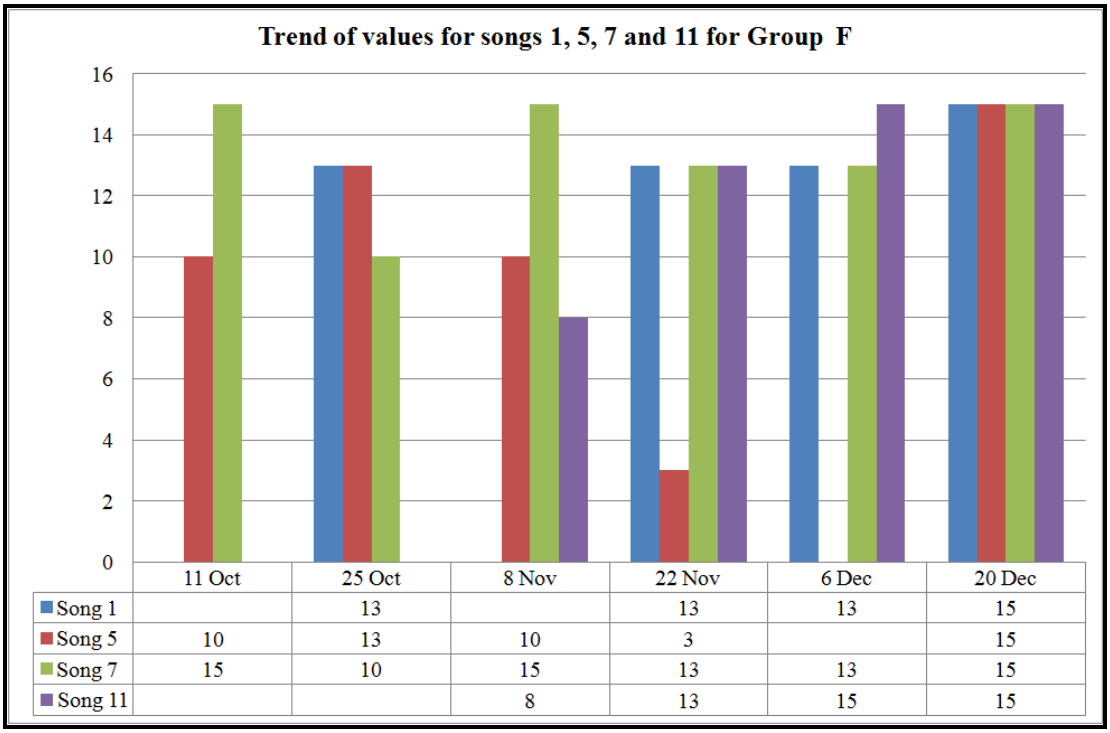


	10 Oct	24 Oct	7 Nov	21-nov	5 Dec	19 Dec
Song 1	11	10	13	10		13
Song 5	10	5		8	13	10
Song 7	5	8	13		13	10
Song 11		15	15	15	15	15

Figure 7.5 Trend of values for songs 1, 5, 7 and 11 for Group S

The bar chart below shows the behaviour of participants in group F with respect to the different songs suggested. Some have no value because they were not performed on the day of observation. As a preliminary, it can be said that all songs analysed showed a positive

trend over the period (Figure 7.6). With respect to Song 5, there was a fluctuation over the period, from 10 to 15, but it should be noted that during the fourth observation the value decreased visibly. There was also a marked fluctuation for Song 7 although the value in the first and last observations was the same (15).



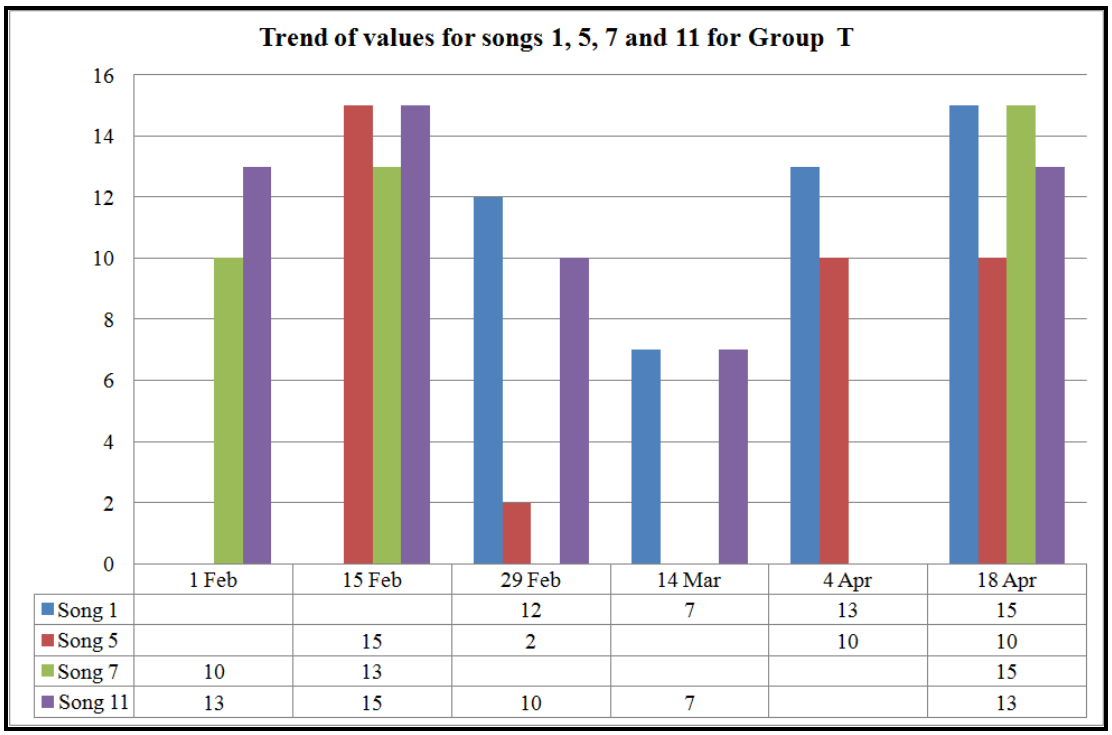
	11 Oct	25 Oct	8 Nov	22 Nov	6 Dec	20 Dec
Song 1		13		13	13	15
Song 5	10	13	10	3		15
Song 7	15	10	15	13	13	15
Song 11			8	13	15	15

Figure 7.6 Trend of values for songs 1, 5, 7 and 11 for Group F

The bar chart below shows the behaviour of group T with respect to the different songs suggested. Some have no value because they were not performed on the day of observation. As a preliminary, it can be said that some songs show a positive trend over the period while others have a negative trend (Figure 7.6).

A positive trend can be observed in song 1 and 7 while there was a negative one in song 5; with respect to Song 11, there was a fluctuation over the period, from 13 to 13 again passing from 15 to 7 rising at the end to 13.

The trend in the songs does not show similar behaviour on the same day of observation.



	1 Feb	15 Feb	29 Feb	14 Mar	4 Apr	18 Apr
Song 1			12	7	13	15
Song 5		15	2		10	10
Song 7	10	13				15
Song 11	13	15	10	7		13

Figure 7.7 Trend of values for songs 1, 5, 7 and 11 for Group T

7.2.6. Main findings of the observation

This section reported the results of the observation.

- The level of attention to the instructions given by the musicians grew with each session,
- No song aroused negative reactions from the sample,
- Traditional songs are those that attracted the greatest participation,
- The majority of the songs induced the sample to make comments and observations after the performance.

7.3. Questionnaire

The data reported in this section concerned the completed questionnaires at baseline, at the end of the intervention and at follow up. The questionnaires will firstly be analysed individually, i.e. firstly before the baseline questionnaire, then the one completed at the end of the experience and then a comparison of the first questionnaire and the second and the first and follow up will be presented.

As mentioned above, sessions were conducted in three different areas of Rome chosen according to the ageing index and the socio-economic level indicated in the last census (at

the time of setting up the research), as well as with respect to the venues that welcomed the experience.

Two different sized samples were considered, the sample made up of individuals who completed the baseline and the end of experience questionnaires correctly consists of 45 participants while the sample who correctly completed the three questionnaires, the first at baseline, the second at the end of the intervention and the third at follow up after 3 months is made up of 41 participants.

As mentioned above, the questionnaire could be divided into various parts - the first to gather demographic information, the second about the EQ-5D-3L, the so-called thermometer (VAS), and the last about York SF-12. There is also another part in the 'end of experience' questionnaire, about the experience in itself.
As far as age is concerned, the sample was divided into six main age groups (Figure 7.8).

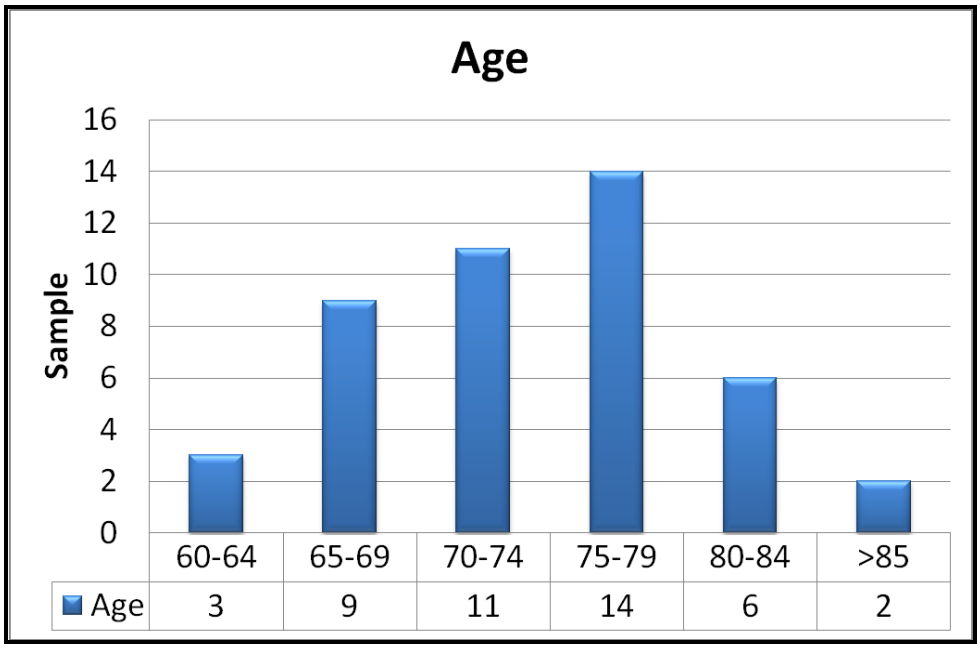


Figure 7.8 Age of the sample

The sample mainly consisted of females (n=41) compared to (n=4) of males (Table 7.6).

Table 7.6 Gender composition of the sample

Gender	Frequency	Percentage
F	41	91.1
M	4	8.9
Total	45	100.0

The majority of the sample lived alone (n=24) or with their partner (n=13) (Figure 7.9).

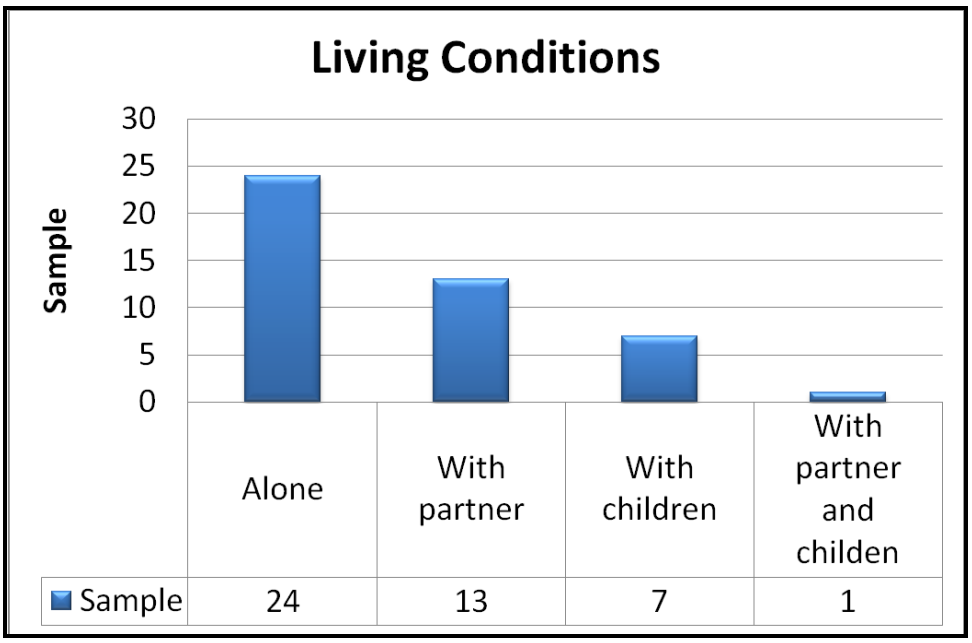


Figure 7.9 Living conditions of the sample

The level of education is generally low with more than half the sample only studying until the age of 14 (n=16) or 10 (n=11) (Figure 7.10).

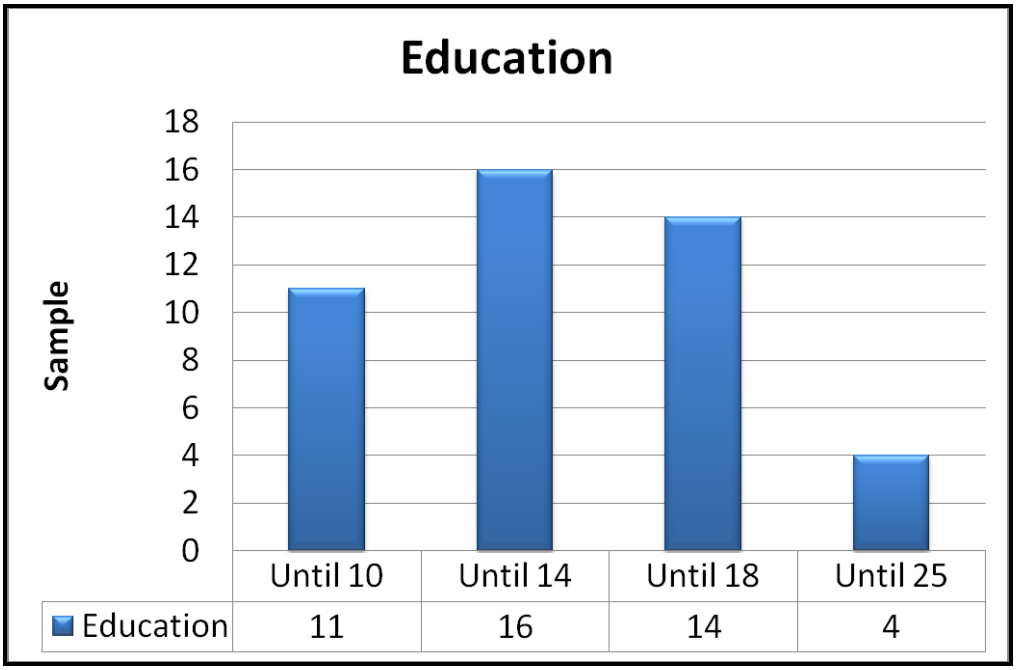


Figure 7.10 Level of education of the sample

7.3.1. Analysis of the questionnaire at baseline

A descriptive analysis of the data will be performed in this section.

The results from the EQ-5D-3L are reported in Table 7.7. The first 3 questions of the questionnaire, i.e., those related to mobility, self care and performance of usual activities, showed that the sample was generally in good health, the majority indicated 'I have no problems in walking about' (31 out of 45); 'I have no problems with self care' (44 out of 45), and 'I have no problems with performing my usual activities' (35 out of 45). The situation was somewhat different for the other two items of EQ-5D-3L where 15 participants answered 'I have no pain or discomfort', while the majority (26 out of 45 components) claimed 'I have moderate pain or discomfort'. In addition, 24 out of 45 members of the sample claimed not to be anxious or depressed but a good number of people (18) reported being moderately anxious and depressed and 3 reported 'extreme problems' of anxiety and depression.

Table 7.7 EQ-5D-3L Outcome at baseline

EQ-5D-3L	No Problems	Moderate Problems	Extreme Problems
Mobility	31	14	0
Self-Care	44	1	0
Usual Activities	35	9	1
Pain/Discomfort	14	26	5
Anxiety/Depression	24	18	3

The next part of the questionnaire refers to the perceived status of health using a thermometer rating scale from 0-100. This shows that the perceived health status of the sample is good, the average value is 72.1 out 100, while the median is 70 and, interestingly, the mode is also 70 (Table 7.8).

Table 7.8 Thermometer Outcomes at baseline

Parameter	Frequency
Valid	45
Average	72.1
Median	70
Mode	70
Std Deviation	16.4

As far as the York SF-12 is concerned, the sample displays a generally good level of perceived health. More specifically, 25 out of 45 claims to have a good level of health followed by a fair level (14 out of 45), poor and excellent health (1 out of 45) have the same value, and 4 participants said they had a very good level of health (Table 7.9).

Table 7.9 York SF-12 1st question at baseline

York SF-12	Excellent	Very Good	Good	Fair	Poor
General health	1	4	25	14	1

The next two questions on the York SF-12 refer to health and its effects on carrying out moderate activities (such as moving a table or pushing a vacuum cleaner) and climbing stairs. Here, the results for the first question show the sample is divided into two main parts, between 'Yes, limited a little', and 'No, not limited at all' while just 4 components of the sample for the first question and 5 for the second declared 'Yes, limited a lot'. (Table 7.10).

Table 7.10 York SF-12 Question 2-3 outcomes at baseline

York SF-12	No, not limited at all	Yes, limited a little	Yes, limited a lot
Moderate activities	20	21	4
Climbing stairs	20	20	5

As far as questions 4 and 5, which refer to physical health and performing work, are concerned 15-16 members of the sample answered 'None of the time' for both questions, followed in both cases by 'Some of the time' and 'A little of the time' (Table 7.11).

Questions 6 and 7 focused on emotional problems and, in both questions, 'None of the time' followed by 'A little of the time' have similar values around 16/18 participants; just one person answered question 6 and two people question 7 with 'All of the time'. Question 8 focused on how pain interferes with normal work. Here, the sample is more divided: 14 components of the sample answered 'None of the time'. There are a high number of answers for both 'Some of the time' (n=14) and 'A little of the time' (n=11) (Table 7.11).

Table 7.11 York SF-12 Question 4-12 outcomes at baseline

York SF-12 No.	York SF-12	None of the time	A little of the time	Some of the time	Most of the time	All of the time
4	Physical health	15	11	14	3	2
5	Performing work	16	9	13	5	2
6	Emotional problem	16	15	10	3	1
7	Emotional problem 2	18	16	9	0	2
8	Pain	14	11	14	4	2
9	Calm and peaceful	4	6	9	15	11
10	Lot of energy	0	8	11	15	11
11	Downhearted	12	13	13	5	2
12	Social activities	17	14	11	3	0

Questions 9 and 10 have a reversed Likert's scale compared to questions 4, 5, 6, 7, 8, 11 and 12. With respect to question 9, the sample is split into two main groups, the majority of the sample said it felt calm and peaceful 'Most of the time' (15) and 'All of the time' (11). The sample in question 10, which refers to energy, is divided into all groups but one with similar values 'All of the time' (11 out of 45), 'Most of the time' (15 out of 45) and 'Some of the time' (11 out of 45). In question 11, 12 components of the sample claimed it felt downhearted and low 'None of the time', while 13 out 45 said 'A little of the time' and 'Some of the time', 2 out of 45 said 'All of the time'. The last question of the York SF-12 focused on both emotional and physical status with respect to social activities with 17 out of 45 of the sample replying that their emotional or physical status interfered with social activities 'None of the time' while around 2/3 of the sample said that this interfered with social activities both 'A little of the time' or 'Some of the time'.

7.3.2. Analysis of the questionnaire at the end of the experience

As indicated above, the analysis to this point refers to the questionnaire carried out at the beginning of the experience. The questionnaires completed at the end of the experience after 12 weeks of group singing will now be analysed.

Table 7.12 EQ-5D-3L outcome at the end of the intervention

EQ-5D-3L	No Problems	Moderate Problems	Extreme Problems
Mobility	29	16	0
Self-Care	42	3	0
Usual Activities	36	9	0
Pain/Discomfort	13	29	3
Anxiety/Depression	30	14	1

As far as the results of EQ-5D-3L are concerned, the first 3 questions of the questionnaire, i.e. those related to mobility, self care and performing usual activities, showed that the sample is generally in good condition with the majority of the sample indicating 'I have no problem in walking about', 'I have no problems with myself care' and 'I have no problems with performing my usual activities'. Question 4 shows a division of the sample into two main parts 'I have no pain and discomfort' (13 out of 45) while the majority (29 out of 45) claimed 'I have moderate pain and discomfort'; with respect to question 5, the majority of the sample replied 'I am not anxious and depressed' while 14 components of the sample reported being moderately anxious and depressed. In the last two questions few people declared having extreme problems dealing with pain and anxiety/depression. (Table 7.12).

Table 7.13 Thermometer results at the end of the intervention

Parameter	Frequency
Valid	45
Average	73.8
Median	80
Mode	60
Std Deviation	18.2

The thermometer shows that the perceived health status of the sample is good, the average value is 73.8, while the median is 80 and the mode is 60 (Table 7.13).

Table 7.14 York SF-12 1st question outcome at the end of the intervention

York SF-12	Excellent	Very Good	Good	Fair	Poor
General health	0	5	24	13	3

As far as the York SF-12 is concerned, the sample still showed a generally good level of perceived health. More specifically, 24 components of the sample claimed they had a good level of health followed by a fair level (13); just 3 people said they have a "poor" level and nobody reported having an excellent level of health: 5 components of the sample said they have a very good level of health (Table 7.14).

Table 7.15 York SF-12 Question 2-3 outcome at the end of the intervention

York SF-12	No, not limited at all	Yes, limited a little	Yes, limited a lot
Moderate activities	23	18	4
Climbing stairs	23	18	4

In the next two questions (the second and third) of the York SF-12, referring to performing activities of moderate physical effort and climbing stairs, the sample was mainly divided between 'Yes, limited a little' and 'No, not limited at all'. More specifically, 23 out of 45, therefore the majority declared 'No, not limited at all' and 18 said 'Yes, limited a little' (Table 7.15) to both questions.

Question 4 asked 'How often have you accomplished less than you would like in regular daily activities due to your physical health' and the highest percentage of answers were for 'None of the time' (12 out of 45) and 'Some of the time' (13 out of 45); 'A little of the time' (17 out of 45) indicated a sample who does not have difficulties in dealing with daily activities. Similar patterns, although softened, are given by question 5, which asked 'How often have you been limited in performing any kind of work due to your physical health', with the highest number answering 'A little of the time' and 'Some of the time', followed by 'None of the time' (Table 7.16).

Table 7.16 York SF-12 Question 4-12 results at the end of the intervention

York SF-12 No.	York SF-12	None of the time	A little of the time	Some of the time	Most of the time	All of the time
4	Physical health	12	17	13	2	1
5	Performing work	11	16	15	2	1
6	Emotional problem	16	21	7	1	0
7	Emotional problem 2	14	19	11	1	0
8	Pain	12	13	18	2	0
9	Calm and peaceful	2	3	13	23	4
10	Lot of energy	1	3	21	12	8
11	Downhearted	8	18	16	2	1
12	Social activities	11	22	11	0	1

There was no value in questions 6, 7 and 8 for 'All of the time'. Questions 6 and 7 focused on emotional status, and in both questions, the highest number of components of the sample refers to 'A little of the time' (21/19). In question 6, a high number of participants claimed that they have emotional problems 'None of the time' (16 out of 45) and 7 participants said 'Some of the time'. Similar patterns can be found in question 7. Question 8 is focused on pain and 18 participants reported that the pain interfered with their normal work 'Some of the time'. In question 9, the majority of the sample claimed they were calm and peaceful 'Most of the time' (23 out 45) and 13 participants answered 'Some of the time'. As far as question 10 is concerned, nearly half of the sample (21 out of 45) reported having a lot of energy 'Some of the time', and 12 participants answered 'Most of the time' and 8 'All of the time'. Question 11 shows that the majority of the sample (18) claimed to feel downhearted and low 'A little of the time'. No one answered 'Most of the time' to the last question of the York SF-12 focused on both emotional and physical status with respect to social activities, and half the sample said that their emotional or physical status interfered with social activities 'A little of the time'. As far as 'None of the time' and 'Some of the time' are concerned, the other half of the sample is divided into two.

7.3.3. Analysis of the questionnaire at the follow up

The questionnaires completed as a follow up 12 weeks later will now be analysed.

As far as the results of EQ-5D-3L are concerned, the first 3 questions of the questionnaire, i.e. those related to mobility, self care and performing usual activities, showed that the sample is generally in good condition with the majority of the sample indicating 'I have no problem in walking about', 'I have no problems with myself care' and 'I have no problems with performing my usual activities'. Question 4 shows a division of the sample into two main parts 'I have no pain and discomfort' (10 out of 41) and (28 out of 41) for 'I have

moderate pain and discomfort'; with respect to question 5, the majority of the sample (23) replied 'I am not anxious and depressed' while 18 components of the sample reported being moderately anxious and depressed (Table 7.17).

Table 7.17 EQ-5D-3L outcome at 12 weeks follow up

EQ-5D-3L	No Problems	Moderate Problems	Extreme Problems
Mobility	32	9	0
Self-Care	40	1	0
Usual Activities	35	6	0
Pain/Discomfort	10	28	3
Anxiety/Depression	23	18	0

Table 7.18 Thermometer results at 12 weeks follow up

Parameter	Frequency
Valid	41
Average	72.6
Median	75
Mode	80
Std Deviation	13.5

The thermometer shows that the perceived health status of the sample is good, the average value is 72.6, while the median is 75 and the mode is 80 (Table 7.18).

Table 7.19 York SF-12 1st question outcome at follow up

York SF-12	Excellent	Very Good	Good	Fair	Poor
General health	0	8	18	15	0

As far as the York SF-12 is concerned, the sample still showed a generally good level of perceived health. More specifically, 18 components of the sample claimed they had a good level of health followed those with a fair level (15); nobody said they had either a 'poor' or an 'excellent' level of health while 8 components of the sample said they had a very good level of health (Table 7.19).

Table 7.20 York SF-12 Question 2-3 outcomes at follow up

York SF-12	No, not limited at all	Yes, limited a little	Yes, limited a lot
Moderate activities	17	21	3
Climbing stairs	21	17	3

In the next two questions (the second and third) of the York SF-12, referring to performing activities of moderate physical effort and climbing stairs, the sample was mainly divided between 'Yes, limited a little' and 'No, not limited at all'. More specifically, 17 out of 41 declared 'No, not limited at all' and 21 said 'Yes, limited a little' in the second question. Crossed patterns were found for question 3. In both questions 3 participants reported they were 'limited a lot' in their activities (Table 7.20).

Table 7.21 York SF-12 Question 4-12 results at follow up

York SF-12 No.	York SF-12	None of the time	A little of the time	Some of the time	Most of the time	All of the time
4	Physical health	16	9	13	3	0
5	Performing work	14	12	13	2	0
6	Emotional problem	18	11	11	1	0
7	Emotional problem 2	17	12	11	1	0
8	Pain	7	19	13	1	1
9	Calm and peaceful	1	5	15	13	7
10	Lot of energy	0	3	19	14	5
11	Downhearted	6	18	16	1	0
12	Social activities	13	13	14	1	0

For questions 4, 5, 6 and 7, no-one in the sample answered 'All of the time', which is the worst value. Question 4 asked 'How often have you accomplished less than you would like in regular daily activities due to your physical health' and the highest percentage of answers were for 'None of the time' (16 out of 41) and 'Some of the time' (13 out of 41); 'A little of the time' (9 out of 41) indicated a sample who has difficulties in dealing with daily activities. Similar patterns, although softened, are given by question 5, which asked 'How often have you been limited in performing any kind of work due to your physical health', with the highest number of components of the sample answering 'None of the time' then 'Some of the time', followed by 'A little of the time' (Table 7.21).

Questions 6 and 7 focused on emotional status and, in both questions, the highest number of components of the sample refers to 'None of the time' (18/17) followed by 'A little of the time' (11/12) and 'Some of the time' with the same value (11). Question 8 focused on pain and 12 participants reported that pain interferes with their normal work 'Some of the time'. The sample is split into two main groups with respect to question 9 - the majority of the sample reported feeling calm and peaceful 'Some of the time' and 'Most of the time'. As far as question 10 is concerned, half of the sample reported having a lot of energy 'Some of the time' and another part of the sample claimed it had a lot of energy 'Most of the time'; the lowest values referred to 'All of the time' (5) and 'A little of the time' (3) and 'None of the

time' (0). Question 11 shows that the majority of the sample (18) claimed that they felt downhearted and low 'A little of the time', 16 members of the sample declared 'Some of the time' while 6 declared 'None of the time'. Just one participant answered 'Most of the time' to the last question of the York SF-12, which focused on both emotional and physical status with respect to social activities. Around a third of the sample said that their emotional or physical status interfered with social activities 'None of the time' and 'A little of the time' while the majority of the sample (14) claimed 'Some of the time'.

7.4. Statistical description of the sample

7.4.1. Statistical description of the sample

A descriptive analysis of the questionnaire was carried out in the previous sections. The following tables report results from the questionnaires which were analysed using SPSS software. Standard algorithms were used to produce total scores and sub-scores. The tables below show the results at baseline (B), End of singing (E) and Follow up (F), the questionnaires are analysed taking into account age, living conditions, education and, lastly, the self-assessed thermometer at baseline as value parameters (Appendix 15). All these tables show minimum and maximum scores, mean and standard deviation for all the following items at baseline, end of singing and follow up:

- EQ-5D-3L VAS or thermometer,
- General health rating (item 1 of York SF-12),
- EQ-5D-3L tariff or index,
- Physical Component Score (PCS) of York SF-12,
- Mental Component Score (MCS) of York SF-12.

For the York SF-12, two component scores provide an indication of Physical Component Score (PCS) and Mental Component Score (MCS). To ensure comparability, these scores were derived using the same algorithms as used in the English Silver Song Club trial.
For the EQ-5D-3L , the items are weighted to give a health utility score with '1' indicating 'perfect health' and '0' representing 'death'.
According to Table 7.22, self-rated general health is, on average, good. More precisely, self-rated general health (thermometer and general health rating) shows a sample with a good health level at each assessment point considered with little difference among these values. It is important to remember that for the general health rating, value 1 is 'Excellent' and value 5 is 'poor'.

Similar observations can be made for EQ-5D-3L which has a positive trend over time, once again showing a good health level.

Table 7.22 Minimum, maximum, mean, standard deviations at baseline (B), end of singing (E), and follow up (F) of the measures employed

	Questionnaire	Minimum	Maximum	Mean	Std. Deviation
EQ-5D-3L Thermometer	B	30	100	72.1	16.4
	E	20	100	73.8	18.2
	F	50	100	72.6	13.5
General health rating	B	1	5	3.22	0.74
	E	2	5	3.31	0.76
	F	2	4	3.17	0.74
EQ-5D-3L Tariff	B	-0.24	1	0.71	0.28
	E	-0.02	1	0.74	0.24
	F	-0.02	1	0.75	0.23
Physical Component Score	B	26.11	48.15	38.9	5.6
	E	18.89	50.26	38.9	6.2
	F	24.44	48.25	39.6	5.4
Mental Component Score	B	17.88	74.43	50.2	12.4
	E	28.15	67.7	50.0	8.5
	F	30.66	66.40	50.0	9.0

Mental and physical component scores show a sample which has poorer physical health compared to mental health and a positive trend over time for physical component scores. In addition to thermometer health scores show an increase between baseline and the second questionnaire with a decrease in the follow up, while the EQ-5D-3L scores remain very similar.

7.4.2. Comparison between baseline and end of singing

In this section results from baseline and end of singing will be compared and analysed.

Table 7.23, Table 7.24 and Table 7.25 report the following parameters for the York SF-12 and EQ-5D-3L items and the total scores obtained by all the York SF-12 and EQ-5D-3L answers, i.e. mean and standard deviations of the first two questionnaires, the difference between the two mean values of each answer, the correlation between the two series of each answers and finally the t values for the paired t-test and the significance (2-tailed) of the two series of answers.

For the total sample, the York SF-12-PCS values were 38.9 at baseline and 38.9 after the end of singing while MCS values were 50.2 at baseline and 50.0 after the end of singing. For the total sample, the EQ-5D-3L score was 0.71 at baseline and 0.74 after the end of singing. The total scores did not show significant change over the course of the three months of singing but there are some changes in two individual items which indicate some improvements in mental wellbeing in the combined sample. These items (item 6 of York SF-12 and item 5 of EQ-5D-3L) relate to feelings of depression/anxiety, which appear to be lessened after the singing compared with the baseline assessment. As far as item 6 of York SF-12 is concerned, the mean value at baseline was 3.93 while at the end of singing (after 12 weeks), it rose to 4.16 just as the paired sample t-value is -1.70 and the significance (2-tailed) is 0.10. A similar trend can be seen for item 5 of EQ-5D-3L where the mean value at baseline was 1.53. At the end of singing (after 12 weeks) it became 1.36 (for EQ-5D-3L lower values = better health) and the paired sample t-value is 2.07 and the significance (2-tailed) is 0.04.

Table 7.23 York SF-12 at baseline (1) and end of singing (2): means and standard deviations, difference, correlation, paired t-test value and significance (2-tailed)

	Mean (Std Deviation)	Difference	Correlation	t	Sig. (2-tailed)
General health rating 1-2	3.22 (0.74) 3.31 (0.76)	-0.89	0.84	-1.43	0.16
Moderate activities limited 1-2	2.36 (0.65) 2.42 (0.66)	-0.67	0.66	-0.83	0.41
Climbing stairs limited 1-2	2.33 (0.67) 2.42 (0.66)	-0.89	0.70	-1.16	0.25
Regular activities accomplished less 1-2	3.76 (1.13) 3.82 (0.96)	-0.67	0.78	-0.62	0.54
Any kind of work limited 1-2	3.71 (1.20) 3.76 (0.96)	-0.044	0.67	-0.33	0.73
Accomplished less depression anxiety 1-2	3.93 (1.03) 4.16 (0.77)	-0.222	0.56	-1.70	0.10+
Worked less carefully depression anxiety 1-2	4.07 (1.01) 4.02 (0.81)	0.044	0.64	0.37	0.71
Pain interfered with normal work 1-2	3.69 (1.15) 3.78 (0.90)	-0.089	0.75	-0.78	0.44
Felt calm and peaceful 1-2	2.49 (1.25) 2.47 (0.92)	0.022	0.25	0.11	0.91
Had a lot of energy 1-2	2.36 (1.05) 2.49 (0.94)	-0.133	0.51	-0.90	0.37
Felt downhearted and low 1-2	3.62 (1.13) 3.67 (0.91)	-0.044	0.52	-0.29	0.77
Health interfered with social activities 1-2	4.00 (0.95) 3.93 (0.84)	0.067	0.48	0.49	0.63

+p≤0.10

Table 7.24 EQ-5D-3L at baseline (1) and end of singing (2): means and standard deviations, difference, correlation, paired t-test value and significance (2-tailed)

	Mean (Std Deviation)	Difference	Correlation	t	Sig. (2-tailed)
Mobility 1-2	1.31 (0.47) 1.36 (0.48)	-0.044	0.60	-0.70	0.49
Self-Care 1-2	1.02 (0.15) 1.07 (0.25)	-0.044	0.56	-1.43	0.16
Usual Activities 1-2	1.24 (0.48) 1.20 (0.41)	0.044	0.56	0.70	0.49
Pain/Discomfort 1-2	1.80 (0.63) 1.78 (0.56)	0.022	0.39	0.23	0.82
Anxiety/Depression 1-2	1.53 (0.63) 1.36 (0.53)	0.178	0.51	2.07	0.04*
Thermometer 1-2	7.21 (1.64) 7.38 (1.82)	-0.173	0.60	-0.75	0.46

*p<0.05

Table 7.25 Total score for EQ-5D-3L and York SF-12 components at baseline (1) and end of singing (2): means and standard deviations, difference, correlation paired t-test value and significance (2-tailed)

	Mean (Std Deviation)	Difference	Correlation	t	Sig. (2-tailed)
EQ-5D-3L Tariff 1-2	0.71 (0.29) 0.74 (0.24)	-0.030	0.51	-0.78	0.44
York SF-12 PCS 1-2	38.95 (5.56) 38.93 (6.17)	0.016	0.64	0.02	0.98
York SF-12 MCS 1-2	50.16 (12.42) 50.02 (8.51)	0.137	0.60	0.09	0.93

7.4.3. Comparison between baseline and follow up

Table 7.26, Table 7.28 and Table 7.27 analyse the same parameters for the York SF-12 and EQ-5D-3L items and the total scores obtained at baseline and after 24 weeks follow up. For the total sample, the York SF-12-PCS values were 39.0 at baseline and 39.6 on follow up while MCS values were 49.8 at baseline and 50.0 after follow up. For the total sample, the EQ-5D-3L health utility score was 0.70 at baseline and 0.75 after follow up. In this way, it can be said that no changes were apparent between baseline and the six month follow up. However, there is an item with a statistically significant difference between these two questionnaires. As far as item 3 ‘usual activities’ of EQ-5D-3L is concerned, the mean value

at baseline was 1.27 while, after follow up, it became 1.15 and the paired sample t-value is 1.95 and the significance (2-tailed) is 0.06.

Table 7.26 York SF-12 at baseline (1) and after follow-up (3): means and standard deviations, difference, correlation, paired t-test value and significance (2-tailed).

.	Mean (Std Deviation)	Difference	Correlation	t	Sig. (2-tailed)
General health rating 1-3	3.22 (0.76) 3.17 (0.74)	0.049	0.69	0.53	0.60
Moderate activities limited 1-3	2.34 (0.66) 2.34 (0.62)	0.000	0.57	0.000	1.00
Climbing stairs limited 1-3	2.34 (0.69) 2.44 (0.63)	-0.098	0.50	-0.94	0.35
Regular activities accomplished less 1-3	3.71 (1.15) 3.93 (1.01)	-0.220	0.52	-1.33	0.19
Any kind of work limited 1-3	3.66 (1.22) 3.93 (0.93)	-0.268	0.46	-1.51	0.14
Accomplished less depression anxiety 1-3	3.93 (1.06) 4.12 (0.90)	-0.195	0.54	-1.31	0.20
Worked less carefully depression anxiety 1-3	4.05 (1.05) 4.10 (0.89)	-0.049	0.51	-0.32	0.75
Pain interfered with normal work 1-3	3.63 (1.16) 3.73 (0.87)	-0.098	0.45	-0.57	0.57
Felt calm and peaceful 1-3	2.56 (1.29) 2.51 (1.00)	0.049	0.14	0.21	0.84
Had a lot of energy 1-3	2.37 (1.09) 2.49 (0.81)	-0.122	0.73	-1.04	0.30
Felt downhearted and low 1-3	3.59 (1.18) 3.71 (0.75)	-0.122	0.31	-0.66	0.52
Health interfered with social activities 1-3	4.02 (0.99) 3.93 (0.88)	0.098	0.55	0.70	0.49

Table 7.27 Total score for EQ-5D-3L and York SF-12 at baseline (1) and after follow-up (3): means and standard deviations, difference, correlation paired t-test value and significance (2-tailed)

	Mean (Std Deviation)	Difference	Correlation	t	Sig. (2-tailed)
EQ5 Tariff 1-3	0.70 (0.30) 0.75 (0.23)	-0.049	0.41	-1.81	0.28
York SF-12 PCS 1-3	38.97 (5.71) 39.62 (5.41)	-0.644	0.54	-0.77	0.44
York SF-12 MCS 1-3	49.84 (12.93) 50.00 (9.04)	-0.158	0.55	-0.92	0.92

Table 7.28 EQ-5D-3L at baseline (1) and after follow-up (3): means and standard deviations, difference, correlation, paired t-test value and significance (2-tailed).

	Mean (Std Deviation)	Difference	Correlation	t	Sig. (2-tailed)
Mobility 1-3	1.32 (0.47) 1.22 (0.42)	0.098	0.53	1.43	0.16
Self-Care 1-3	1.02 (0.16) 1.02 (0.16)	0.000	-0.03	0.00	--
Usual Activities 1-3	1.27 (0.50) 1.15 (0.36)	0.122	0.61	1.95	0.06+
Pain/Discomfort 1-3	1.80 (0.64) 1.83 (0.54)	-0.024	0.26	-0.22	0.83
Anxiety/Depression 1-3	1.54 (0.64) 1.44 (0.50)	0.098	0.50	1.07	0.29
Thermometer 1-3	7.23 (1.70) 7.26 (1.35)	-0.024	0.66	-0.12	0.91

+p≤0.10

7.4.4. Correlation between baseline, end of singing and follow up

In the following examination of Table 7.29, Table 7.30 and Table 7.31, the correlations between the values obtained from the questionnaires, i.e. general health rating, EQ-5D-3L thermometer, EQ-5D-3L tariff, PCS and MCS at baseline (Table 7.29), after the end of singing Table 7.30) and after follow-up (Table 7.31) are analysed. As far as Table 7.29 is concerned, the highest correlation at baseline is between the EQ-5D-3L tariff and MCS (0.684), there are similar values for the correlation between general health rating and all other values (around 0.600). After the end of singing, correlations are higher on average. The correlation between general health rating and PCS is -0.800 while those between the general health rating and all other values are the same of those at baseline (between 0.565 and 0.649 except for the one with MCS). The correlation between the EQ-5D-3L tariff and EQ-5D-3L thermometer (0.739) is also very high indicating a good relationship between all the answers of the EQ-5D-3L questionnaires and the EQ-5D-3L thermometer. All the values of the correlations at the end of singing are generally higher than those calculated at baseline indicating how the coherence of the answers of the end of singing questionnaires is higher than those at baseline. All the correlations of the EQ-5D-3L thermometer, EQ-5D-3L tariff and PCS are much higher while MCS is a little bit lower.

After follow up, correlations decrease to the baseline values. The highest value is -0.719 between the general health rating and PCS; while the correlations between the general health rating and all other values are also higher than those at baseline (between -0.361 and -0.661). (Table 7.31).

Table 7.29 Correlations at baseline between the general health rating, EQ-5D-3L thermometer, EQ-5D-3L tariff, PCS and MCS.

		General health rating	EQ-5D-3L Thermometer	EQ-5D-3L Tariff	PCS	MCS
General health rating	Pearson Correlation	1	-0.596**	-0.639**	-0.650**	-0.602**
	Sig. (2-tailed)		0.000	0.000	0.000	0.000
	N	45	45	45	45	45
EQ-5D-3L Thermometer	Pearson Correlation	-0.596**	1	0.301*	0.505**	0.408**
	Sig. (2-tailed)	0.000		0.044	0.000	0.005
	N	45	45	45	45	45
EQ-5D-3L Tariff	Pearson Correlation	-0.639**	0.301*	1	0.307*	0.684**
	Sig. (2-tailed)	.000	0.044		0.040	0.000
	N	45	45	45	45	45
PCS	Pearson Correlation	-0.650**	0.505**	0.307*	1	0.192
	Sig. (2-tailed)	0.000	0.000	0.040		0.207
	N	45	45	45	45	45
MCS	Pearson Correlation	-0.602**	0.408**	0.684**	0.192	1
	Sig. (2-tailed)	0.000	0.005	0.000	0.207	
	N	45	45	45	45	45

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table 7.30 Correlations at end of singing between the general health rating, EQ-5D-3L thermometer, EQ-5D-3L tariff, PCS and MCS.

		General health rating	EQ-5D-3L Thermometer	EQ-5D-3L Tariff	PCS	MCS
General health rating	Pearson Correlation	1	-0.649**	-0.565**	-0.800**	-0.333*
	Sig. (2-tailed)		0.000	0.000	0.000	0.025
	N	45	45	45	45	45
EQ-5D-3L Thermometer	Pearson Correlation	-0.649**	1	0.739**	0.641**	0.454*
	Sig. (2-tailed)	0.000		0.000	0.000	0.002
	N	45	45	45	45	45
EQ-5D-3L TARIFF	Pearson Correlation	-0.565**	0.739**	1	0.626**	0.481**
	Sig. (2-tailed)	0.000	0.000		0.000	0.001
	N	45	45	45	45	45
PCS	Pearson Correlation	-0.800**	0.641**	0.626**	1	0.237
	Sig. (2-tailed)	0.000	0.000	0.000		0.117
	N	45	45	45	45	45
MCS	Pearson Correlation	-0.333*	0.454**	0.481**	0.237	1
	Sig. (2-tailed)	0.025	0.002	0.001	0.117	
	N	45	45	45	45	45

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table 7.31 Correlations at the follow up between the general health rating, EQ-5D-3L thermometer, EQ-5D-3L tariff, PCS and MCS.

		General health rating	EQ-5D-3L Thermometer	EQ-5D-3L Tariff	PCS	MCS
General health rating	Pearson Correlation	1	-0.661**	-0.361*	-0.719**	-0.444**
	Sig. (2-tailed)		0.000	0.020	0.000	0.004
	N	41	41	41	41	41
EQ-5D-3L Thermometer	Pearson Correlation	-0.661**	1	0.460*	0.586**	0.416**
	Sig. (2-tailed)	0.000		0.002	0.000	0.007
	N	41	41	41	41	41
EQ-5D-3L Tariff	Pearson Correlation	-0.361*	0.460**	1	0.399**	0.245
	Sig. (2-tailed)	0.020	0.002		0.010	0.122
	N	41	41	41	41	41
PCS	Pearson Correlation	-0.719**	0.586**	0.399**	1	0.321*
	Sig. (2-tailed)	0.000	0.000	0.010		0.041
	N	41	41	41	41	41
MCS	Pearson Correlation	-0.444**	0.416**	0.245	0.321*	1
	Sig. (2-tailed)	0.004	0.007	0.122	0.041	
	N	41	41	41	41	41

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

7.4.5. Main findings from questionnaire analysis

This section highlights the results from the questionnaires. The main aim of this section is to highlight improvements in the self-rated health and wellbeing of the sample during the experience. In the light of the analysis made, the sample shows it is generally healthy, with no modulating factors. However, the more educated and those of wealthier areas seem to be healthier in comparison to the less educated and economically disadvantaged (Appendix 15). Overall, the sample reports being healthier with respect to mental health component scores on the York SF-12 compared with the physical health scores.

- The picture which emerges from the questionnaires is that, generally speaking, the sample has good mental health status with poorer physical status.

- The summary measures of health status remain very similar over the course of the study.
- As far as the income area is concerned (Appendix 15):
    - the wealthier areas have a generally better level of health in comparison with the less advantaged area. This is with respect to the thermometer value and the EQ-5D-3L values while there are no marked differences with respect to the general health rating (Item 1 of York SF-12).
- As far as age is concerned:
    - the younger part of the sample shows it is healthier overall than the older part.
- As far as living conditions are concerned:
    - participants who live alone show they are healthier overall than the participants who live with somebody; the thermometer and the mental component scores are higher, values of physical component scores and EQ-5D-3L are similar and the general health rating is slightly lower.
- As far as education is concerned
    - participants who have a low level of education have a lower level of health in comparison to the more educated. They only have better scores in general health rating.
- As far as the total scores are concerned for the period between baseline and end of singing (first follow up at 12 weeks), these did not show significant change over the course of three months of singing but there are some changes in two individual items which indicate some improvements in the mental wellbeing of the combined sample. Both of these items (item 6 of York SF-12 and item 5 of EQ-5D-3L) relate to feelings of depression/anxiety which appear to be lessened after the singing, compared with the baseline assessment.
- As far as the total scores are concerned, no changes were apparent for the period between baseline and the 2nd follow up (24 weeks/6 months). However, there is one item with a statistically significant difference between these two questionnaires. For Item 3 of EQ-5D-3L (usual activities), the mean value at baseline was 1.27 while it became 1.15 after follow up just as the paired sample t-value is 1.95 and the significance (2-tailed) is 0.058.
- Correlations between the values obtained by the questionnaires, i.e. general health rating, EQ-5D-3L thermometer, EQ-5D-3L tariff, PCS and MCS at baseline after the end of singing and after follow-up show a consistent and generally statistically significant pattern of relationships.

The following section will display results from the questionnaire handed out at the end of the experience, aimed at detecting feelings and comments about the singing activities.

7.5. Agreement of the experience questionnaire

In the questionnaire completed at the end of the intervention, there were some open questions requesting comments about the experience, singing and health mirroring those already raised during the pilot sessions. The results are set out below.

The graph below (Figure 7.10) displays the results of the question 'Have you enjoyed the experience?' The sample could answer grading the level of enjoyment from 1 (not at all), 2, 3, 4 and 5 (very much). Almost all the sample (33 people out of 45) answered with a score of '5'. Nobody gave the lowest scores i.e. 1 or 2. With respect to the remaining components of the sample, one person gave 3 as a score and then 11 people gave a score of 4.

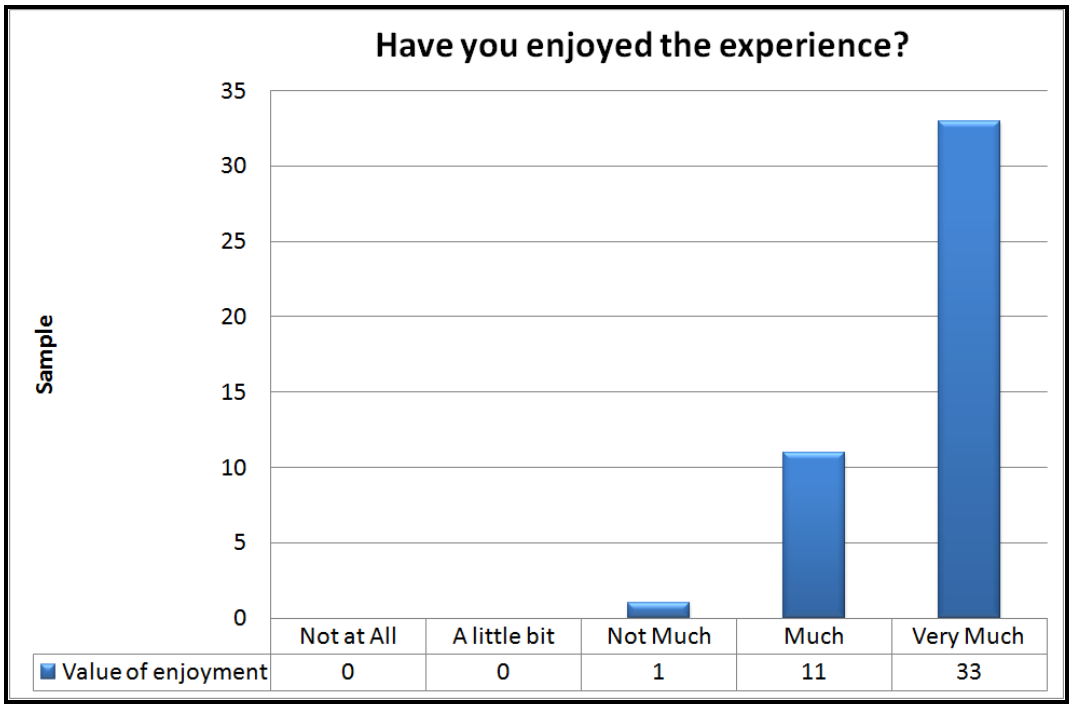


Figure 7.11 Level of enjoyment of the experience

Figure 7.12 shows the result of the second question of the questionnaire 'Which aspect of the experience did you find most enjoyable?' (Figure 7.12) The sample could choose more than one aspect or just the answer 'all the above'. People were also given the opportunity to add other aspects not listed by the author. The variables were 'singing', 'listening to music', 'sharing moments with others', 'all the above' and 'others'. The variable most preferred by the group was 'singing'. The sample then highlighted that the most enjoyable aspect was being able to share these moments with other people. There was also an appreciation of 'all the above'. Nobody added other dimensions.

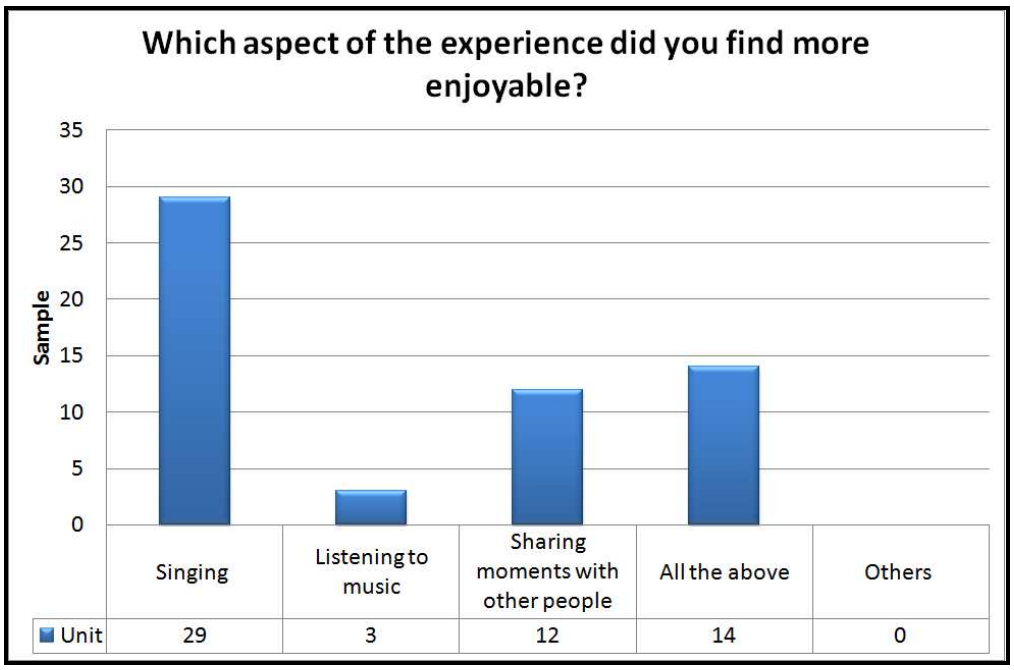


Figure 7.12 Which aspect of the experience did you find most enjoyable?

The graph below (Figure 7.13) shows the results of the question 'How did you feel during the experience?' The sample had the opportunity to choose more than one variable, and also in this case could add comments. No-one responded that they had felt bored or stated they felt stressed during the experience while a small number felt a sense of melancholy. The variables which received greatest consensus were a 'sense of happiness' and 'serenity' during the experience. In addition nearly a third of participants agreed that they had 'a feeling of involvement in something.'

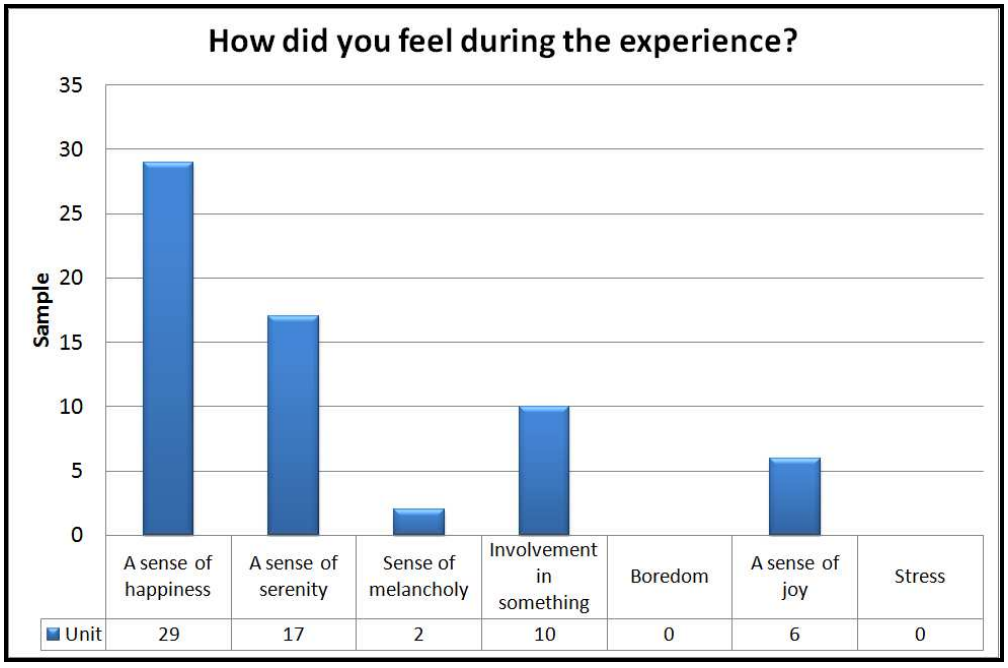


Figure 7.13 Feelings during the experience

Figure 7.14 Feelings after the experience

The graph above (Figure 7.14) displays the results of the question 'How did you feel after the experience?' The sample had the opportunity to indicate more than one variable, and also in this case could add comments. The proposed variables from the questionnaire were 'A feeling of happiness', 'Disappointment because the session is finished', 'A sense of achievement' and 'other'. As far as 'other' is concerned, people did not add comments about their feelings at the end of the experience. The sample is split into two main groups; indeed 19 individuals said 'a sense of happiness' and the same number of individuals said they felt 'disappointment,' while 14 stated 'a sense of achievement.'

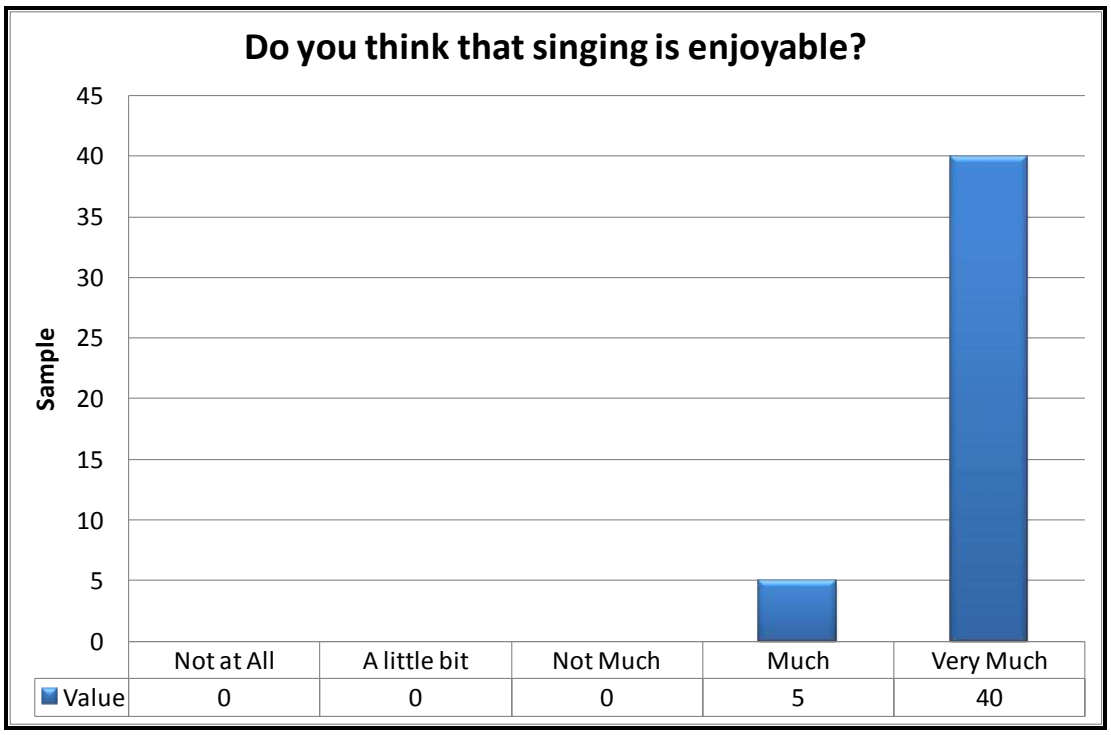


Figure 7.15 Do you think that singing is enjoyable?

The graph above (Figure 7.15) displays the results of the question 'Do you think that singing is enjoyable?' Respondents were asked whether the activity of singing was enjoyable, where 'not at all' is the lowest and 'very much' is the highest value. The whole sample considered that singing was an enjoyable activity; more specifically, 40 out of 45 people thought that singing was a very pleasant activity while the others believed that singing is a pleasant activity.

The last question of the questionnaire asked if the sample would be interested in taking part in such an activity on a weekly basis in the future (Figure 7.16). Most of the sample (41 people out of 45) gave the highest value, in other words they would be very interested in taking part in sessions such as the ones they joined; 4 people claimed they were interested in taking part in these kind of singing sessions.

There were also some open questions about the experience. A good number of people stressed the desire for the project to continue 'I wish the experience would continue'; the majority of the sample liked the overall organization and 'would not change anything in the experience'. Some participants underlined that the experience made them happier and peaceful and gave them joy; one person wrote 'my mood and my abilities have improved with this project and it is good for my health'.

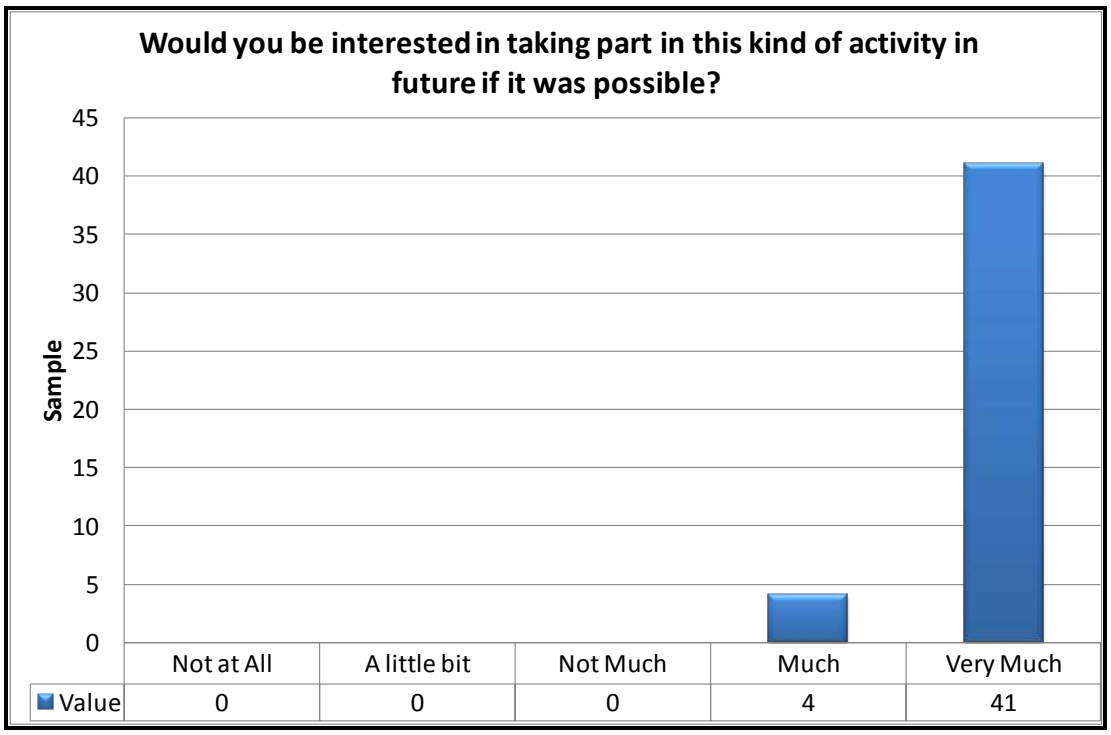


Figure 7.16 Would you be interested in taking part in this kind of activity in future if it was possible?

7.5.1. Main findings from the brief questionnaire about the experience

The experience was really welcomed by the participants who expressed their interest and enjoyment on several levels. The two major aspects of interest and enjoyment in the entire experience were:

- 'Singing' i.e. the physical and emotional experience of singing itself
- 'Having the possibility to share moments with other people'.

7.6. Focus group outcomes

7.6.1. Introduction

Two focus groups were set up in two venues involving about 15 participants from venue S (6) and venue T (9). The participants were all female with an age range between 65 and 93 and they were held in July and September 2012. The main aim of the discussion was to gather information on two main issues:

- Impact of the experience on the life, wellbeing and quality of life of the participants;
- Impressions-opinions about the experience as a whole (timing, repertoire and so on).

The focus group was conducted in an interactive circle to allow each participant to express opinions and feelings about the experience for around 35 minutes; the researcher took notes during the interview.

The focus group was considered an effective way of allowing participants to give their own perception of the whole project, and was used as not all participants gave opinions in the second questionnaire. Further, focus groups facilitate "communication and promoted an exchange of ideas and experiences" (Robson, 2002 p. 286), and are a "useful strategy either as stand-alone data gathering strategy or as a line of action in a triangulation project" (Berg and Lune, 2011, p. 158).

The researcher first asked a question:

a) What do you think about the experience?

This question was followed by further prompts:

a) What about your feelings during the experience? And after?
b) Which kind of impact did it have on your life?
c) What is your opinion about the structure of the experience?

The focus groups revealed a number of themes (Figure 7.17), among which, a general sense of wellbeing, both mentally and physically stands as a result of singing. Additional feelings emerged, the most important of which were a sense of camaraderie as well as the sense of fulfilment.

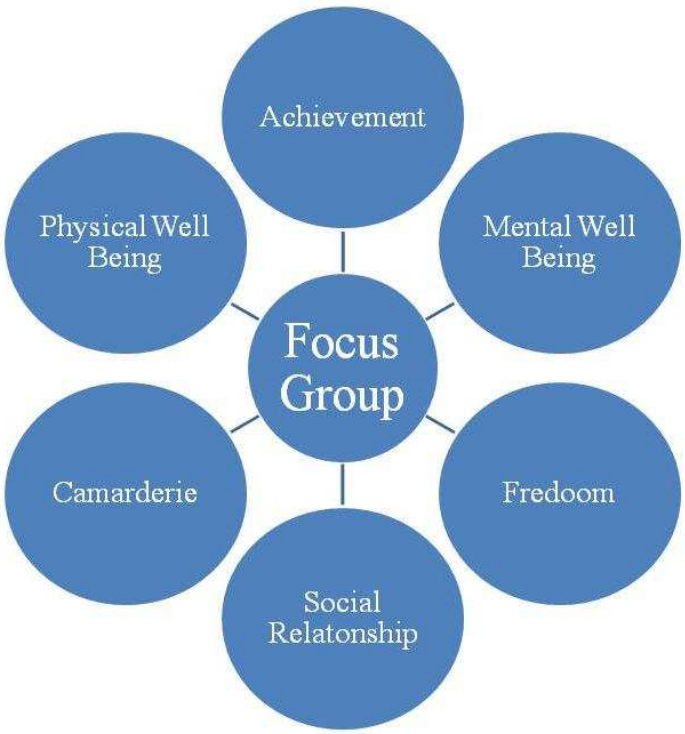


Figure 7.17 Output of Focus Group

7.6.2. Mental wellbeing

With regard to mental wellbeing, participants stressed the sense of joy, relaxation and general wellbeing that they received during the experience and also that this same feeling

faded when the experience had its conclusion. A general sense of joy that continued even at home after the session and is exemplified by the fact that participants continued to sing at home, as well as looking for the lyrics of the songs sung in the group.

"I realised how important it was for me psychologically when it finished, I felt better" (Woman 1, Group S)

"[Singing] is good for the heart and soul" (Woman 4, Group T)

"I was happier" (Woman 2, Group S)

"I was really pleased" (Woman 1, Group S)

"It's certainly very relaxing" (Woman 1, Group T)

"It was really positive, at home I sang the songs again and I enjoyed myself again. I remembered lots of songs of when I was young and I went back in time". (Woman 2, Group T)

"I didn't really believe in it but then I really enjoyed myself." (Woman, Group T)

7.6.3. Physical wellbeing

With regard to an improvement in the physical health, this was emphasized both by asserting a general sense of physical wellbeing as well as indicating that they coughed less and also being more at ease in the physical movements or tackling a flight of stairs with peace of mind and less fatigue.

"Less coughing" (Woman 2, Group S)

"I wasn't stressed at all" (Woman 3, Group S)

"It's good for the health" (Woman 5, Group T)

"I climbed the stairs more easily" (Woman 1, Group S)

7.6.4. Social relationships

In addition to factors closely related to physical and mental wellbeing/health, the focus groups revealed that the experience was positive for another series of aspects. First there was a sense of wellbeing resulting from being together, being able to share moments through singing for a common goal.

"You meet people and then you're there for each other" (Woman 4, Group T)

"This experience has brought us together and been the start of lots of friendships" (Woman 2, Group S)

"We were in a group" (Woman 4, Group T)

7.6.5. Self expression and fulfilment

A second aspect which came up during the focus group was a sense of freedom. A number of participants underlined the sense of freedom they felt during the experience as well as the opportunity to express themselves.

"(The experience was) great and made me carefree" (Woman 2, Group S)

"Singing sets you free" (Woman 3, Group S)

"Free singing, was so good for me!" (Woman 4, Group S)

"We could let off steam freely" (Woman 6, Group S)

"I felt free to really be myself" (Woman 3, Group S)

In addition to the above, there was a strong sense of fulfillment, both from participants who stressed the certainty of being tone deaf (so far) and by those who did not have this kind of conviction but still remained incredulous at being able to sing for an entire hour.

"I was tone-deaf at school but here no!!!!" (Woman 7, Group T)

We were good on this! (Woman 4, Group T)

7.6.6. Relationship with directors

The participants appreciate the organization, the repertoire and the directors. Many participants agreed on the general organization of the sessions, some proposed having more sessions (more than once a week), some to lengthen the session while one woman would like to avoid the break in the middle of the session because in her opinion it was distracting.

"The timetable was fine. Next time, please twice a week". (Woman 7, Group S)

"I'd lengthen the session, two and a half hours, perhaps without the break which distracted me." (Woman 7, Group S)

As far as the repertoire is concerned, this was highly appreciated.

"Absolutely wonderful repertoire" (All participants)

"I'm from Ciociarìa and I like singing songs in the Rome dialect" (Woman 8, Group T)

With respect to the directors, starting from the fact that they were a middle-aged woman and a young man, both, although very different, were well-liked during the sessions. In particular, the participants underlined that the two directors were competent and patient at the same time, giving them the opportunity to be able to deal with the repertoire and to create a pleasant sound during the performance.

"Both directors were wonderful, so patient with us!!!" (All participants)
"The last concert was great!" (Woman 3, Group T)

In addition to what has been said so far, there were opinions with respect to the conclusion of the experience demonstrating general disappointment.

"It ended too soon." (All participants)
"I came willingly, I stayed even more willingly and I was really, really upset when it ended" (Woman 1, Group S)
"I couldn't wait for Wednesday" (Woman 8, Group T)

There was no reported significant criticism or difficulty, except from a participant who stressed the difficulty (during the session) of reading and singing at the same time, despite the fact that the songs were very popular and well known.

"I found reading the words and singing at the same time difficult" (Woman 9, Group T)

7.6.7. Main findings of focus group

The conclusions that can be drawn from the focus group are varied:

- there are some strictly related to the physical and mental self-perceived wellbeing by the participants,
- others are connected with the whole experience in terms of contentment and happiness,
- the chance to express themselves and to be with others and creating a sense of group belonging.

7.7. Overall findings

The overall results of Part B show that:

- Participants enjoyed the experience on several levels,
- Participation and attention improved during the 12 weeks,
- There was a statistically significant decrease in the levels of anxiety and depression,
- There was a statistically significant increase in dealing with usual activities,
- Participants reported a general improvement in wellbeing and health as a result of the experience.

Chapter 8.

Discussion

8.1. Introduction

The aim of the whole research was to explore the effectiveness and transferability of introducing a health promotion intervention based on singing, developed in South England very successfully, to a very different context, namely Italy. The aim of the singing groups is to tackle social isolation, improving wellbeing and quality of life through the use of singing. The research carried out in Italy was divided into two main parts - Part A was focused on exploring the status of older people living in Rome and their interest in music and singing nowadays and in the past. It also focused on their interest in taking part in the experience of singing, as well as exploring the position of older people as seen by local politicians and social workers. Part A was carried out by one-to-one semi-structured interviews. Moreover, pilot sessions followed by a purposely-devised questionnaire were held. Part B then focused on looking at the effects of weekly singing sessions in three groups based in three different area of Rome.

This chapter focuses on discussing the findings of the whole research and mirrors the structure followed by the study. In the first section the results of Part A will be discussed; the next section will discuss the results of Part B and a brief triangulation of Part B data will be carried out. An overall discussion of the findings of both parts of the research will be carried out in order to give a wider view of the findings of the study. The implications of the study will also be highlighted as well as making recommendations and indications for further research, indicating the study's limitations. The next section will critically analyze the methodology. Finally, an overall conclusion will be drawn.

8.2. Part A

The interviews conducted with professionals demonstrated that there is a very profound need for health promotion policies towards the older population. According to the explanations of the professionals, the Roman population is going through a period of deep economic and social crisis which is mainly reflected in the condition of older people. In general, the poorer social strata of the population are paying the heaviest price for the lack of economic resources and also social and health care policy that perhaps did not expect this type of scenario. Institutions are called on to answer a number of questions that they were probably not ready to listen to and solve. All this is determining a general failure of health social care

policies in Italy. Interestingly, while the Italian political programmes do not give large space to the wellbeing and quality of life of the population, according to the laws commented above, social workers and politicians feel a very strong need to develop programmes and projects of a more holistic nature in the specific case for older people, probably because all respondents are much closer to the population although at different levels. The data gathered during the interviews suggests that these programmes should fully involve the health and wellbeing of the individual.

As has been seen, the White Paper on Welfare (Ministero del Lavoro, della Salute e delle Politiche Sociali, 2009), underlines the need for the preservation of social and intellectual functions in older individuals but, once again, the family is seen as a social nerve centre of the apparatus. This appears to be a serious problem as, the government does not appear to take into account the social changes that Italy is undergoing. Social changes have to be the real motor of adequate social and health care policies; health policies not connected to social change are unnecessary and a waste of resources. The social changes that policy makers should primarily take into consideration include, as expressed in the literature, the real status of older people today, positively and negatively. With regard to the latter, the number of older people suffering from long-term diseases profoundly changes the scenario. However, older people today specifically desire and want to have an active life as long as their health allows this.

In agreement with the view taken by Goll (2010), countries on the northern side of the Mediterranean, including Italy are based on two pillars - one is the family, and the other is the predominantly Christian mould of social solidarity. In the light of this, it is not surprising that the interviews conducted revealed that the fragmentation of the family is a huge problem that affects professionals (politicians and social workers) just like the older people themselves. Next to this, there is a fact that in the Italian social landscape voluntary work has great importance. In Italy, it is widespread and a significant help in solving a number of problems, not only with regard to welfare but also for items such as the organization of social and recreational activities for the young or the older. In agreement with findings from a study conducted in 2011 (Astra Ricerche, 2011), there has been a decrease in the number of volunteers as well as donations to non-profit sectors; this is due to a number of factors, the most important among them being the economic crisis.

8.2.1. Interview with professionals

In considering the outputs of the interview of the professionals, a number of subjects should be reminded, i.e. the growth of the older population social isolation, poverty, importance of leisure activities and Italian social structure.
On the one hand, the data collected during the interviews of the professionals (politicians and social workers) shows a rather worrying situation with respect to the status of the older people in the city of Rome. On the other, it was consistent with what is claimed by the literature. In some cases, politicians raised different issues in comparison with those highlighted by the social workers; this is probably due to their different approach to the problems of older people. Social workers have more direct contact with the individuals and are also more involved in practical issues which play an important role in older people's wellbeing. Nevertheless, the three main themes emerging from the interviews with both groups of professionals were: poverty, social isolation, and the problems arising from the growing number of older people.

The professionals underlined that "poverty brings great discomfort, fear of the future and disease" this is in accordance with what Cattel (2001) included as effects of poverty - "loss of self esteem, stigma, powerlessness, lack of hope and fatalism" (p. 1501). Poverty and social exclusion are connected and interdependent and, as a consequence, a person who is experiencing poverty will also experience social isolation and social exclusion. Poverty is a multifaceted concept that affects an individual completely, removing the possibility of sharing with others moments or experiences and leading to a growing level of social isolation and social exclusion.

The situation of poverty which had already afflicted the older Italian population, due to the fact that pensions have reduced in value, has been exacerbated by the economic crisis (de Belvis et al. 2012). This has transformed the retired who were near the threshold of poverty, into a situation of not being able to pay the rent and not being able to take advantage of the help of their children also severely affected by the economic crisis both aspects can be reconnected to the concept of the "pauvreté disqualifiante" developed by Paugam (2001).

One of the main consequence of the current economic situation has been the establishment of a kind of war among the poor for the resources available, creating difficulties between citizens in the poorest areas, all of them on great need.
Poverty among older people is mainly due to the aging process worsened by the European and worldwide economic crisis; the pensions systems have to deal with an aging society (so there are fewer individuals contributing to the system) and, at the same time, there are fewer

workers contributing to those systems, because of a contraction in the number of jobs. Obviously, a decrease in the number of workers means there is a lower possibility of contributing to the system. Therefore, there is a growing number of individuals who are taking money from the system to which fewer individuals are contributing. In this way, both society and the social security system could collapse.

According to the statements made above about the minimization and maximization (Baltes and Baltes, 1993) of the losses by older people, and in the light of what has been said by politicians and social workers, it appears clear that poverty inhibits the processes of successful ageing. Poverty affects such a wide range of aspects of life that where there is severe poverty, it is impossible to deal with them effectively. From data gathered during the interviews it became apparent that, when talking about older people and poverty, it is no longer possible to recognize a specific area of Rome or a socio-cultural group but we are dealing with a group of individuals who have only the fact that they are older people in common without other socio-demographic characteristics. Poverty affects all areas, even the most wealthy in Rome, although clearly in a different way. Some interviews underlined that, in the wealthier areas, there are pockets of poverty due to the fact that the Municipi are extensive and densely populated or there is an older population strongly attached to the idea of living in the centre of the city but no longer able to afford the rise in prices, while in the less wealthier areas, the crisis is even more severe and the income provided by pensions is even lower.

According to the data of the study poverty is connected to two main issues - the first is housing and the other is attached to leisure activities and their importance in the lives of the older people.

Housing for all individuals is something important and it is a fundamental prerequisite of health, therefore lack of housing or difficult access to housing leads to poor health. (Benezeval, Judge and Whitehead, 1995; Anderson, 1999; Dunn, 2002). The ENABLE-AGE (2005) research, which looked at the home environment as a determinant for autonomy, participation and wellbeing in very old age, shows that ageing at home is connected with a number of positive factors such as “action, identity, dignity and survival in very old age” (p. 4). Therefore, not ageing at home can have a number of problems as a consequence. The above is aligned with the comments of a social worker interviewed, that the older person often decides to go into a nursing home within the city, because the search for a house at an affordable price is impossible without moving a long way from the city and going to live in satellite towns resulting in the loss of the few remaining contacts. Therefore, data collected suggests that leaving their home drives older people to losing a number of specific aspects of

their life such as the neighbourhood, the usual area of living and social connections, thus also losing important aspects of wellbeing at the same time.

With respect to leisure activities and all the successful ageing process, as has been leading an active life leads to having an healthier life in the last section of life (Saczynski et al., 2006; Hao, 2008). Social workers underlined that many older people "have money just for the bare necessities and sometimes not even for that". According to Huxley and Thornicroft (2003), this leads to the enlargement of social isolation and exclusion because poor people do not have access to a series of recreational activities due to the fact that they do not have the effectively possibility of spending on 'unnecessary' things, as recreational activities may appear, but according to Bygren (et al., 1996) are not.

According to the interviews with professionals (politicians and social workers), the general growing needs of the older population is leading the Municipi to encounter difficulties in delivering leisure or social activities to older people this because they have had to focus all their resources on helping to meet the basic needs of older people (help for rent, social and health care assistance and so on). Professionals underlined that older people ask for recreational activities as a means of leaving the routine of everyday-life behind and as a way of feeling less isolated and having the chance to form and build relationships which would influence their perception of wellbeing.

All recalled data lead us to conclude that there is a clear request from older individuals for social and recreational activities. Obviously, they themselves recognize these activities as necessary and useful for their wellbeing as well as reconfirming their vitality. The literature which analyses the quality of life and wellbeing as seen by the older population suggests this and, in turn, this has been further confirmed by the interviews conducted.

Another aspect underlined by the professionals as one of the most serious problems affecting the older, is social isolation. According to data collected during Part A, social isolation is linked to a number of other themes such as the fragmentation of the family, loss of the sense of community and the aforementioned sense of there being no hope for future. Interestingly, taking into account the taxonomy set up by Nicholson (2009), it can be said that, during the interviews, the professionals highlighted precisely those aspects so clearly indicated by the aforementioned scholar. The interviewees explained that older people experienced a lack of relationships at different levels - no meaningful relationships, few relationships and no relationships at all. The real possibility of having relationships decreases with age, an older person can experience increasing difficulties in reaching venues (Centri Anziani or friends'

homes, for instance), and therefore, their social isolation increases in time. Retiring is embodied in the facts as an exit from the production cycle, and this is one of the elements of the social isolation of the older. In comments on interviews with the participants, we will see that the leaving the production cycle has a strong recoil and it is a stimulus of the decision to join the Centri Anziani real centre of aggregation.

In a country such as Italy, where the support given by the family is fundamental and, until a few years ago, probably diluted the social isolation of older people often naturally connected with older age, family fragmentation is having a very strong impact. The family in Italian society is an informal social network that, as explained above, has served to protect against almost every social problem. Notwithstanding the foregoing, it should be noted that the same professionals insisted that when the family exists 'it is essential' as informal support (from both side, i.e. for children for the role of grandparents and for the older people as help).

According to Tomassini (et al., 2007), both informal and formal support is a "key dimension of wellbeing in later life" (p.846) and the authors identify informal support as including: social embedding, emotional assistance and instrumental assistance. Older people in Italy have a family-based culture, and older Italian individuals have spent their whole life imagining their future as older people surrounded by children and grandchildren. Bordone (2009) said "in strong family system, children provide support to their older parents" (p. 362) therefore it is hard to accept the situation that is now occurring, leading to discomfort and sadness.

In addition to the sadness of this situation, this fragmentation has a strong impact on the management of older people by and within the Italian health and welfare system. The family breakdown is a huge problem which professionals felt strongly, and is probably due to the fact that the health care of older people in Italy was almost completely delegated to the family, both for purely economic and eminently cultural reasons. Currently the dramatic rise in the number of older people and older people with diseases that have a very long course, has confronted both politicians and health and social care services with huge problems.

As far as the loss of sense of community is concerned, this issue is connected with the problems of evictions, in agreement with the data gathered, the loss of housing, has a domino effect, because older people are having to seek a home far from their roots, and the few things (the neighbourhood, for instance) which gave them security. Furthermore, as Dalla Zuanna (2001) underlined, in Italian culture, especially in the Centre and South of Italy, children live with their parents longer with respect to other European nation, and this favours family ties; losing their house means losing their family and their friends. Older people lose family ties, they lose their points of reference, and social workers emphasized the fact that many older people do not have any kind of relationship, and there is a growing number of

older people who confess that they do not speak to anyone for weeks, in addition to this, disease excludes even more. In agreement with the views expressed during the interviews with social workers, if an older person falls ill, especially with a communicable disease such as influenza or a gastrointestinal problem, they cannot rely on their peers. A kind of fear of falling ill themselves keeps friends away; it is a sort of social egoism determined by the fear of losing independence so those who become ill will, in many cases, experience an increase in social isolation. This is confirmed by the views expressed by Victor and colleagues (2005) that living alone, being alone and social isolation are concepts that overlap. A banal influenza experienced by an older individual who lives alone increases or raises other elements of social isolation such as the loss of independency or social support from peers.

The data recalled above suggests that the health status of older people is a cause and consequence of their social isolation. Older people with poor health cannot go out and have contacts, so older, ill individuals suffer from double isolation - from their peers and because of the illness, social isolation undermines their health (Figure 8.1).

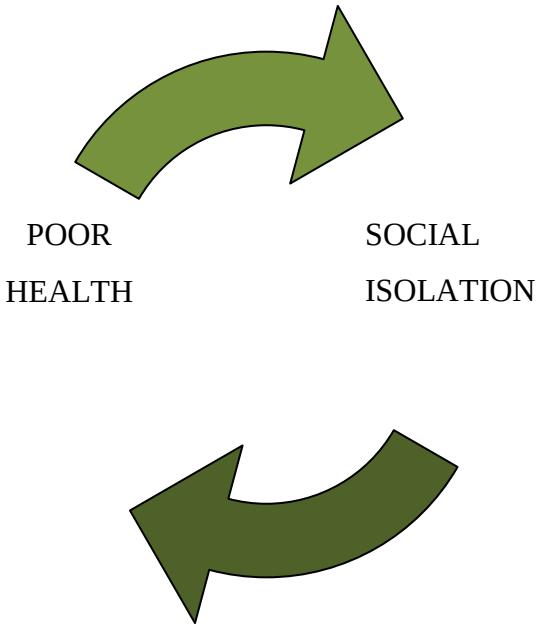


Figure 8.1 Connection between poor health and social isolation

Those who are less educated and often the poorest do not have the opportunity to receive input from the outside and isolate themselves more and more because they become unable to identify their needs, and ask for help. In the light of data recalled here, and considering that there is general agreement in the literature (Fratiglioni et al., 2000; Akbaraly et al., 2009) that social isolation in old age has been associated with the risk of developing mental decline and memory loss problems, social isolation leads to a whole series of implications that are relevant to public health, social care and health promotion.

A problem that is affecting more and more people is the phenomenon of so-called 'homeless at home' (e.g. people of people living like down-and-outs in their own homes) in the absence of any family ties or contacts with neighbours. These once sporadic cases are now increasing and are a real submerged need and mean that older people lack the sense of community that was still very strong present in the socio-cultural circumstances of older Italians until 20 years ago.

The third theme underlined by professionals is the high number of older and oldest old people in the city of Rome. As Bernard (2000) points out the lengthening of life leads to a number of problems connected with the economy of a country, such as pension provision and spending on health and social care.

Aging of the population has led de facto to a completely new situation, namely the coexistence of three-four generations at a time - great grandparents, grandparents, children/parents and grandchildren. In particular, attention is focused on the children of grandparents, defined by literature as the 'sandwich generation' because they have to take care of older relatives and are themselves parents of adults who are also severely affected by the economic crisis. The interviews detected that this generation is crushed by the weight of responsibility caused by the economic crisis and the poor quality of life.

As mentioned previously, this new scenario could be thought to be beneficial for older individuals as there are more people who can take care of them. However, data shows quite clearly that this situation leads to a huge number of problems in Italy. As has been said, the country has traditionally delegated the organization and development of care and support for the most vulnerable (disabled and older people) to the family. In the past, the family could deal with this duty but, nowadays, social changes make it very difficult; big families do not exist anymore and older, chronically sick individuals can be ill for a very long time therefore it is much more difficult to take care of them. The enormous number of problems which have to be addressed by the family becomes a highly complex situation for everyone (parents and children) and, as a consequence, all these players have poor quality of life and wellbeing.
Older children, as said by a social worker "no longer have either the physical or economic strength to help old parents". The lengthening of life has led to a lengthening of the needs of this section of the population, and the funds available to governments for the support of older people are effectively drained by the needs related to health, nursing care and so on. As a consequence there is a complete lack of money to fulfil other needs, such as the organization

of recreational activities, so necessary for individuals, especially if they are close to falling into social isolation and related problems.

The issues raised by the professionals interviewed reflect the concerns of European and worldwide for this section of the population. It is particularly interesting to discover that those who take care of older people understand the strong power of leisure activities as a tool for improving their quality of life and wellbeing, not only in response to the requests of older people as related by a social worker, "they will do any kind of activity to avoid loneliness", but in recognising that culture can function as an intervention for health promotion.

8.2.2. Interviews of older people

The interview with the older people included an overview of their entire life and asked about the role and importance of music and singing in their lives in the past and currently as well as a section which is related to their daily occupations. The objective was to evaluate the importance of music in their old age and also in their lives, and discover what a typical day of an older Italian individual is in various areas of Rome. The majority of respondents were between 70 and 79 years, female, and divided between people living with partners and people living alone; the level of education was quite low.

Older people interviewed were more than happy to participate in the interviews, although they tended to go off topic and wanted to communicate their life story beyond the role of music. The impression of the author was a strong need to communicate both about their past lives (famine, war, poverty) and the problems of their current lives (spouses with Alzheimer's disease and its consequences on daily life, children jobless or sick, etc.). For this reason, the interview was much more emotionally moving beyond what they just said about their musical experiences during their lives.

Older people's everyday life

As for day-to-day living, they divided their life between the home and related occupations, following the strong Italian culture to go to market every day to shop and prepare the meal and also visit the Centri Anziani. As far as the modulating factors are concerned, three are most prominent: a higher level of education, the age group (the younger compared with the oldest) and socio-economic area. Data suggests that these three subgroups show a greater openness to different activities during the day and are not confined to the narrow task of cleaning the home, preparing meals and visiting the Centro Anziani. In addition they become involved in wider leisure activities including going out to the cinema, theatre and concerts and have relationship with relatives (i.e. grandchildren). Furthermore, this data confirms

what was said before with respect to the fact that the less wealthy and less educated sections of the older population have less possibility of accessing stimulating leisure activities.

With regard to the lives of the older respondents, it is interesting to note the role played by the Centro Anziani in their lives, and other modulating factors with respect to how they spend their days. These Centri (in which there are two main occupations, i.e., the card game and the dance, twice a week) are a real focal point in the lives of older people because they give them the chance to access a range of free activities (indeed the Centri Anziani organize other activities such as little trips around Rome or computer lectures) and be with peers of the same area. Centri Anziani are easily accessible, often very close to public transport and cover all Rome, each Municipio having a variable number of Centri Anziani.

The reasons that lead older people to rely on Centri Anziani, in accordance with the data collected during Part A, are varied but the main one is the loss of a sense of community, resulting from societal changes and the lack of the so-called good neighborhood as well as retirement. The loss of the friends of a lifetime and the perceived need to have news is definitely important. Nevertheless, the interviewees underlined that it was the lack of purpose after retirement that was the fundamental driving force that brought them to go to the Centro Anziani.

Most of the women interviewed pointed out that the main reason for going to the Centro Anziani was to avoid the loneliness and depression that was growing in their spouses. Furthermore, a good number of older people interviewed said they went to the Centri Anziani not so much for the game of cards (one of the main activities offered) or to do something specifically but “just to be there” or to watch television with someone rather than at home alone. In general, women over the age of 75 have never worked outside the home, especially the less educated; many were housewives or seamstresses but always in the home context, therefore they feel the effect of retirement less. The same cannot be said for men who, with retirement, lose a huge slice of wellbeing, especially if they have not developed any hobbies or other resources during their lifetime. As mentioned above, beyond the purely economic issues, retirement is a real watershed between adulthood and old age, a person enters the older population not so much because of an age threshold but through their legal status because he/she is retired. Interviews demonstrated the psychological power of the moment. The lack of wellbeing of their partners felt by the women interviewed is recognized by Drentea (2002) who says that “retirement is associated with lower sense of wellbeing” (p. 169).

Starting from the fact that the Centri Anziani is nearly completely for free and is really a source of recreation for older individuals, it is important to underline that most of the people attending it have a very low level of education and do not have many other resources for their spare time. All data collected during the interview allowed us to say that those who are slightly better educated are interested and involved in other activities, and go to the Centri Anziani less often. Professionals claim that the more educated people are, the more likely they are able to enjoy leisure activities; further, they reported it was easier for the most educated people to have and share common interests and therefore have more possibilities of building friendships.

One aspect that should not be overlooked in the analysis of the use of the Centro Anziani by older people is that they are directly supervised by a President and a group of advisers. These figures are proposed and voted for by older people within the Centro Anziani. This aspect is very important because it contributes more to the quality of life for men than for women. Men are, therefore, involved in 'managerial' roles, where they can find overall satisfaction and self-fulfillment that certainly have an impact on their wellbeing. This agrees with what a politician stressed during their interview on the fact that older people have a lot of time to spend, time that should be occupied in a useful and effective way, so the existence of the Centri Anziani is crucial. What kind of social offer would the older economically disadvantaged/poor have if the Centro Anziani were missing? The question is not trivial, but essential, because it leads to further reflection - not all older people are involved in Centri Anziani, probably because a number of them are able to develop interests and carry out a range of activities outside something organized by the institutions. Others, who are cut off from Centro Anziani, do not have the financial ability to deal with unnecessary expenses, so they are dangerously close to possible social isolation and loneliness and their consequences.

Older people's interest in music and singing during life

The data gathered suggests that most of the older people had generally enjoyed music during their life and, at times, music had been more important than at others, but listening to music is an important aspect of their whole life. The radio was and is the main mode of use; it is the cheapest, most accessible and easiest to use (television must be watched while the radio only listened to). The family has had major importance in introducing music, both in making it known and also in cultivating this interest, more between parents and children than between brothers and sisters.

The house was where music was most commonly listened to. The sample remembers the family staying together in front of the radio, or with a relative who could strum an

instrument; the memory is experienced in a different way as, for some, there is the enthusiasm of the story, while others prefer to record the fact, but do not get lost in details, probably because this brings sadness. Once again, the family is the main 'venue' for the enjoyment of music, determined by the historical moments to which they referred, as well as the economic condition. The income area is the most modulating variable with respect to childhood and adolescence; participants from the lower income areas were those who had a rarer but simpler approach to music (father or mother who played some simple instruments).

While all interviewees saw music as important in their lives, an exception was the period of adulthood, where most of the sample reported not being interested in music at that time because they were too busy 'living', that is, too absorbed by everyday life and work. The data displays that this is practically a commonplace throughout the sample even at the time when it is divided by education level, age, except for participants who belong to the more economically advantaged area. Therefore, the data allows us to conclude that individuals from those areas probably had time, money and even a psychological condition of greater security to enjoy music, while those living in a more disadvantaged areas were too involved in everyday problems to have had the opportunity and time for listening to music.
According to the results displayed above, during adulthood, some among the less educated and those from economically disadvantaged areas declared they drew benefit from music while working while none of those who belongs to wealthier areas and/or with a higher level of education did. This may reflect the fact that music can be used as company during a manual job in which mental activity is less important. In addition, music is something completely separate from the professional life for those with higher levels of education or who are living in wealthier areas, probably something that they enjoyed during their spare time after job hours.

This reflects what has been said above when respondents were amazed by the question raised by the author with respect to their musical experiences in childhood. The most common response was "What on earth are you going on about? I sweated my guts out let alone even thinking about music!" This kind of answer implies that music is perceived as something distant and elitist for a small audience who can afford it, both from the more and less educated. However, once participants had understood the meaning and content of the question, they were much more keen on answering and they realized that they had a relationship with the music on many different levels (father or brother who sang, uncle who played the guitar, a band of the country, a kind of story-teller, and so on) and this was true since childhood.

The perception of loneliness experienced by participants was evident when they were asked with whom they listened to music in the older section of life. During the first three steps of life, i.e. childhood, adolescence and adulthood, the sample claims to have enjoyed music with someone. In childhood, more with the family of origin, in adolescence with family and friends and, into adulthood, with their family, partner, while in older age, 27 people out of 40 state 'alone.' Two elements are evident - music is very important in old age, and this is in line with previous literature (Cohen, 2009; Flowers and Murphy, 2001) and when participants return home after the Centri Anziani, they are alone.

The data gathered suggests that singing is an activity that involved fewer respondents during the lifetime. They had been present in childhood and adolescence but it was almost absent in adulthood and in the older section of life. The respondents were not able to give answers regarding adulthood, while, as regards old age, they did not answer, partly because they were tired by the interview and partly because they thought that they had nothing to say. The less educated group is the one that was most involved in singing during childhood; this is again correlated with what has been said above. The socio-economic condition is a really crucial aspect - during adolescence they claimed that they did not sing, this was most likely due to the fact that they were probably already engaged in work, once primary education had ended.

According to what was said during the interviews, one element that was certainly instrumental in involving a large number of participants during childhood and adolescence in singing was the so-called 'Fascist Saturday'. As indicated above, this was set up by Benito Mussolini through Royal Decree Law 1010 of 20 June 1935.
The groups were closely connected with schools, where activities took place and this is why the more educated and older people cited the Fascist Saturday as a time when they used to sing while it is not even mentioned by those with a lower level of education or younger than 75 for obvious age related reasons.
It is quite difficult assess what the thinking of the sample was with respect to that experience; they probably had mixed feelings, on one side they remembered the experience with pleasure and, at the same time, they are now perfectly aware of the hidden meaning of the Fascist Saturday and they feel irritation to some extent. Generally speaking, the compulsion underlying the Fascist Saturday does not diminish the pleasure with which these moments are remembered by the respondents. Some showed genuine enthusiasm at the memory, and a possible interpretation for this could be based on the fact that it was a fun opportunity in a world and time where there were few opportunities to have enjoyment. This is reflected by the fact that none of those belonging to the group of wealthier areas went to the Fascist Saturday and the fact they claim to have sung occasionally. This could lead to the

fact that may be those living in the more advantaged areas have, for the main, more opportunities to enjoy leisure activities compared with the those belonging to the less advantaged areas.

Older people's interest in music and singing at present

The main objective of going back over the life of the respondents and their musical experiences was to evaluate the role of music and singing in their life and in old age. Childhood, adolescence, adulthood and old age, from the younger to the older ones, were retraced. During the interviews, it was interesting to note that a large proportion of respondents did not initially understand what the author meant by listening to music; many of them replied that, given the economic condition of the family, they did not have contacts with music until the arrival of television or, for the younger people in the groups, the record player. The author's intention was to identify every type of musical experience even within the family from an uncle or father who used to sing. This leads the author to think that music is probably still perceived as something cultured and expensive and not as free and easy-to-use and a tool which can be used by everybody to fill time or generate good moments.

Music currently plays a vital role in the lives of older people in the light of the data collected. It is certainly one of the tools they use to provide a sense of company. Most of them said they used the radio, which is a means of easy access and is not expensive, and listened to music every day. Many older people also use television both as company to listen to "some voices" and declared that "My television is switched on all day long". Even compared to the time when music is enjoyed, it is interesting to note the fact that exactly half of the sample claim to hear music 'when I have time' implying an activity which is usual, customary, and used with the clear intent to occupy the time pleasantly. Remarkably, the data allows us to say that the function of music is, as said before, to company effect, the majority of the interviewed claims that just switch on the radio in order to listen music. Again, the least educated and those from the less wealthy areas are those who listen to music most and, again, this is probably due to the absence of other stimuli, such as reading a book or watching a film, or outputs (which as we have seen before are the prerogative of those who are more educated or who are living in wealthier areas).

As a result of this, it is not surprising that the less educated older people declare that music is more important to them now than in the past. From this point of view, it is very interesting to consider how life might have been an effect on the perception and need for music. According to the data, a possible interpretation is that the less educated older people will have done an harder work, less intellectual and more physical, it is possible that this part of

the interviewees enjoy moments of relaxation and personal joy of enjoying music that is nearly for free (radio).

Listening to music is particularly associated with old age because it is an activity that can be carried out even in conditions of poor health, as stated by Cohen, Bailey and Nilsson (2002). In addition, the opinions reported in the interviews are in line with what was underlined by the above mentioned authors, namely that older people love music, listen to it every day and see music as an important thing. Furthermore, the majority of the respondents emphasized that music now has an even more significant role due to the flexibility of the media, which can be used by anyone, even in contexts of poverty.

To sum up, all the data allowed us to say that it is very important for respondents to have music as company, a voice, claiming to accept what is played by the radio, especially the less educated, without making a specific choice. Music is not strongly connected to the mood but is something that goes beyond, it is probably a need to feel surrounded by something and certainly a way to avoid the silence of the house. More than half of the sample declared that music is more important now than in the past.
Listening to music has a greater impact on older respondents compared to singing. This is due to the fact that listening is an activity that is less physically involving and can make some people feel less vulnerable, while singing is an activity which puts you in the front line. Most of the interviewed declared that they did not sing, and the older people ruled it out completely. The complex of not knowing singing and being out of tune, carried forward from childhood, leads the majority of respondents to say that they prefer the passive activity of listening to music compared with singing. Among the few who expressed a preference for singing there was a gentleman who said: “I always sing to myself through anger, to drive away the bad thoughts, to have fun, but what would life be without singing?”

The statement about the sample being very excited about taking part in the singing experience is strongly connected with all the data collected during interviews of social workers and politicians and in sharp contrast with the results related to singing habits. The connection with the desire for participation and involvement in recreational activities found and witnessed by social workers and politicians proves to be real as shown by the answer on participation in the study. Only 3 out of 40 people surveyed rejected the proposal, while 37 although with different reservations accepted willingly.

There are a number of elements that play a key role in choosing whether or not to sing - personal attitudes, past experiences, culture, although these are certainly not the main

aspects. Research conducted by Chong (2010) was taken into account during the development of Part A; in his research the author estimates that there are a number of obstacles to singing and that not everyone has the desire to sing. As discussed previously, singing has a very intimate dimension. For this reason, the question about the study as a possible experience was made hypothetically so that no-one felt that their answer was forced. According to the findings of the pilot session, it can be stated much relies heavily on the offer, i.e. proposing the activity and make it known to participants.

A strong limit to the interviews carried out with the older people is that almost all of them were found at the Centri Anziani, so the older people were more or less in a context of inclusion, although this was not so evident from the interviews, and considering the overwhelming weight that the Centri Anziani has in their lives it is possible to determine that when an individual with socio-demographic characteristics similar to those of the respondents may not be able to go to the Centri Anziani is automatically excluded and then he/she lives in social isolation.

In the light of what we have seen so far, the results tell us that the status of older people who do not have strong economic resources and a solid family is very fragile, both from a physical point of view as well as social and mental health. This is well supported by the general agreement of literature which indicates that the same elements lead to reduced wellbeing and loneliness in the older population. The enthusiasm shown by both the professionals and older people when singing groups were mentioned demonstrates the need expressed and unexpressed of the Roman population for interventions aimed at the development and improvement of wellbeing. The interest in music was demonstrated by all the data collected in Part A where music has a vital role in these individuals' lives now and although to a lesser extent in the past, as well as by professionals who, for example, found that older people are ready to co-finance musicians during dancing sessions in Centri Anziani just to have the opportunity of hearing live music rather than from a CD player.

8.2.3. Pilot sessions

The pilot sessions were used to assess a variety of aspects of organization and response from users, and they served to confirm the interest in getting involved in recreational activity noted during the interviews with older people. Participants in these sessions reflect the sample of interviews with respect to the level of education, age and female gender. The only difference is that, in the pilot sessions, the sample mainly consisted of people who live alone.

The most interesting aspect consists of the answers to direct questions on singing and is linked to the two-hour experience. In relation to their current life, the sample in the interviews reported a lack of interest in singing, but after having the opportunity to sing, the participants discovered a new world. The manifest enthusiasm from the sample can be drawn from the affirmative answers to more than one question ('have you enjoyed the session'; 'do you think singing is enjoyable'; 'would you be interested in taking part in this kind of activity every week if it was possible').

Beyond the clear interest in the type of activity that also reflects what was said in the interviews of professionals who were certain that the initiative would be successful, the sample indirectly reaffirmed, during the pilot sessions, in the light of the collected data the need for company and involvement in activities that potentially involve more participants; they are probably less interested in solitary activities that could be carried on at home. This is shown quite clearly because the sample indicated "sharing moments with others" as one of the most enjoyable aspects of the experience. Furthermore, they indicated mainly positive emotions such as happiness, serenity, involvement and sadness because the session had terminated connected with the experience during and after. The pilot session provided a reliable foundation for developing the main singing groups, the focus of the following chapters.

8.2.4. Conclusion

A number of conclusions can be drawn from the data collected during this first part of the research. The aim was to discover the status of older people. A significant limit of the interviews carried out with the participants is the fact that almost all were conducted at Centri Anziani, which means that the participants were more or less in a context of inclusion. The data suggests that older people who cannot join Centri Anziani can fall in a condition of social isolation in the light of the fact that older people's life is made up by very few elements (home care, go to the market, prepare meals and go to the Centri Anziani) among which spending time in this facility is the main.

The data from the interviews shows that retirement is a key moment in individual life, moving out of the production cycle has a strong backlash and is the reason for the decision to join the Centri Anziani as a real centre of aggregation. The fear of losing independence or social contacts is palpable, as soon as they feel they are no longer able to have social contacts they look for solutions.

According to the data collected during PART A, music has a great importance in the life of the older because it evokes memories and distracts from bad thoughts and gives them

company. Older people do not choose the music they listen to, most of them seem to use the radio and accept what the radio plays; the use of radio or television as a form of companionship, to listen to voices in the house, is still a very strong signal of solitude and social isolation, where music replaces the voices of family, partner and life 'before'. Singing had played a part in the lives of older people primarily during childhood and adolescence and was not a part of their lives as adult or older people. Once older people had the opportunity to experience group singing, however, there was considerable enthusiasm for it, and they expressed a willingness to take part regularly.

8.3. Part B

8.3.1. Introduction

This chapter will discuss the results of Part B, i.e. all the results arising from the singing groups during the 6 months of the experience, collected using a mixed method approach of observation, standardized questionnaires, questionnaire devised for the purpose and a focus group. The aim of Part B was to establish the health status of older individuals and the effects of this kind of experience on a group of people who still live in society as active participants. The specific objectives of Part B were:

- To assess participants' reactions and their perceived wellbeing before and after the experience of regular group singing, and after 3 months of follow up period.
- To assess issues of organization, repertoire and delivery in terms of effectiveness and transferability and their differences with the English experience.

Initially, and recalling what has been underlined in the literature review, research on singing and older people has lead to similar results and this study is mainly consistent with the literature mentioned above. The data gathered to assess the health status, quality of life and wellbeing of the participants in the singing group had a twofold objective - on one hand to assess the effects that the experience of singing had on participants and, on the other, to compare these results with those of the study carried out in England with the same measures (Coulton et al., in press). The purpose of the focus group was to assess the experience of the older people during the study and to identify any significant issues with respect to introducing the English model in Rome.

The primary objective of the observation of the singing sessions was to evaluate the behaviour and how much participants effectively took part during the experience. The sample, as indicated above, was recruited through Centri Anziani and was, therefore, made

up of individuals who were able to reach the venues either on foot or using public transport. The older people recruited for the research were without cognitive problems. The sample can certainly be defined as being made up of high functioning older individuals.

8.3.2. Discussion of observation results

Four main results are highlighted by the systematic observation of the sessions:

- The level of attention to the instructions given by the musicians increased with the sessions,
- Songs generally aroused positive reactions from the sample,
- Traditional songs attracted greater participation,
- The majority of the songs induced the sample to make comments and observations after the performance.

The data collected during the observation sessions revealed a number of substantial suggestions. First, participation often started quite timidly but saw an increase in involvement and participation over time. This was particularly true for groups S and F but was less noticeable in group T. This is probably due to the fact that, the previous year, this group was involved in a number of seminars focused on music education and, for this reason, they were able to enjoy the experience more right from the start; this was fairly evident from the beginning of the singing sessions and interviews. The people interviewed in the T venue were those who understood the intent of the interview better and answered in a more engaging way during the actual interviews; further, almost the whole of group T were interviewed during Part A. In addition, compared to the other two venues, the venue where group T met provides a support structure for older people and a so-called multi-service centre, in the morning, the centre is focused on carrying out practical activities and bureaucracy as well as directing older people to the correct social and health care facility, and then during the afternoon, it offers some recreational activities.

Group S was the one with the largest number of participants and in which it was more difficult to maintain concentration. The group size was beneficial from the point of view of sound (a larger group produces more sound) but was much more complicated to handle for both directors and the author in terms of the explanation of issues related to the completion of the questionnaires, for instance. In the bar chart displaying the average values of observation for Group S (Figure 7.1) the starting values are low and increase over time. Group S detaches quite significantly from the other two groups – an evaluation of the graph which shows comparison between the average values for the three venues over six observations (Figure 7.4) clearly indicate that the groups F and T have a similar trend (except for the beginning).

The trend of the aforementioned groups decreases during the third observation, which is equivalent to the sixth session i.e. half way through. It is difficult to assess why there was this decline, a possible explanation could be weariness on the part of the participants. What was lacking was not so much attention, understood as listening to information given by the directors, but participation which declined slightly. During the sessions, Group T sang fewer songs because it was the group that most requested and/or agreed to repeat a song where it was not going well; this aspect also proved to be a difference in approach among groups, this, too, is probably connected with the experience on music education.

Despite some substantial differences in the behaviour of the groups as highlighted above the data allowed us to say that there is a clear common level of joy and comments. None of the songs 'was passed over in silence'; every song merited a story, an anecdote or a comment from the participants, as well as a lot of questions being asked. Interestingly, the questions raised in a session quite often became a topic of discussion in the next. If a participant raised a question about a song or showed curiosity in it, the following week another participant gave the information or brought the question up again. All this data shows that, for our participants, the benefit of a session had lasting effects during the whole week, and the interest of participants during the session leads to two main reflections:

- The songs were closely connected with participants' own personal stories and evoke a number of memories and anecdotes about their lives;
- Participants had a need to communicate with others in the group and to tell their own stories.

There was clear evidence, according to data collected during observations of the need to communicate not only through their behaviour as 'singers', through their participation, but they also wanted to be leaders in their entirety during the sessions. All this is consistent with the fact that all of the songs (except one of which will be described later) generated positive comments. This underlines to what extent all of the songs were full of meaning, being part of their lifetime story as they carried historical connotations or very strong memories from the past. Positive emotions, maybe melancholy, but in a very positive way, a positive attitude and joy.

Only one song was not accepted by the sample. It is important to emphasize that the songs sung by the Italian group were the songs of their youth, some were traditional (strongly connected with the area) but not childish songs or old lullabies, this choice was continued in the light of what was deduced during interviews. Returning to the song not accepted, this was a Christmas song and was the only one that raised concerns being defined by more than

one participant 'as childish/infantile'. Again with respect to the repertoire, data gathered clearly testified that the songs that had the greatest impact are generally those 'about' Rome and the "*Va' Pensie*ro". Participants developed a high level of self-esteem because the "*Va' Pensie*ro" is one of the best known choruses in Italy and, of course, all participants knew that it was written by Giuseppe Verdi. This gave them, on one hand, respect and awe and, on the other, a sense of fulfilment and self-esteem when they discovered they were able to sing such an important and challenging song. This finding lines up with the literature "singing is a means for both self expression and fulfilment" (Zanini and Leao, 2006 p. 1).
One aspect that should certainly be taken into account is the pride of the Romans as citizens of Rome. They are very proud of their city and being part of that area. Italy is a country where belonging to a village/town/province, and so on, rather than being 'Italian', and pride in being 'Milanese', 'Roman' or 'Umbrian' is still strongly felt. This is due to historical reasons; the unification of Italy dates back to less than 200 years ago whereas the history of the area dates back thousands of years. This is to stress an individual socio-cultural aspect that was important during the research.

"Arrivederci Roma" and "*Roma non fa' la stupida 'sta sera*" are songs that have become part of the Roman tradition, but only date back to the late 1950s and early 1960s (as well as "Nel blu dipinto di blu", better known as "Volare"). Of course, these are connected with their youth and a nostalgia effect/memory which contributed to generating high interest from the participants who sang with great delight.

Certainly the data of the observations shows a high degree of participation and enjoyment by the sample. There was a growing awareness and desire to improve the quality of their singing, which could certainly not be seen at the beginning, or existed very superficially, especially in group F. For the most part, the songs chosen were lyrical, expressive, moving and emotional. Some (such as the "*Va' Pensiero*") also have historical significance, especially for the target group. In the light of the spontaneous comments gathered from participants during the break or made after the performance, it is certainly plausible that nearly all the songs aroused a huge number and variety of feelings such as joy and melancholy but also memories and fun. In the end, it is interesting to note that there were no major differences in the reactions among the three groups. There was agreement and interest in the same songs from all groups, demonstrating that the songs were so emotional that they were not likely to generate different reactions.

8.3.3. Questionnaires

First of all, the results of the questionnaires provide an indication about the effects of participation in singing sessions. There were two statistically significant results in three items in the two periods (baseline and end-of-singing and baseline and follow up), and a series of results which are not statistically significant but give an indication of general improvement in participants of wellbeing and health. The sample mainly consisted of women, with a prevalence of the 70-80 age group, half of whom lived alone while the other half lived with someone (partner or children); they generally have a low level of education. The fact that the sample is mainly women is because, in general, women are more interested in attending both Centri Anziani and taking part in the activities. The survey carried out in Part A of the research shows that the Centri Anziani are attended by both genders, but, however, women are actively involved in many activities while men tend to play cards and have little involvement and/or participation in activities.

As has been seen in the results, there is a general correlation among the items analysed of the EQ-5D-3L and York SF-12 with the exception of the values of MCS and PCS. This is detectable, especially in the second questionnaire (end of singing), in comparison with the third questionnaire (follow up) where there is a low correlation (however generally positive). This is mainly due to two reasons - on the one hand, the first two questionnaires were completed during the experience, while the third was completed three months later, so perhaps the attention of participants had fallen. In addition, the third questionnaire was completed by the T group in mid-July 2012 when there were very high temperatures in Rome and participants proved to be very tired due to the lack of sleep, the heat and the general discomfort that they felt.

Before embarking on the discussion of the results of the standardized questionnaires and the more qualitative ones on the agreement of the experience, it is important to evaluate the results of the two questionnaires on the health status of participants at baseline, and which was the starting point. Although the sample was smaller, it is interesting to note that the results are similar to those of another study conducted on an Italian population (Savoia et al., 2006) with the same version of the EQ-5D-3L and the SF-12 questionnaires, although not in the York version. The results are shown for groups of age, gender, occupation, educational level and marital status (Savoia et al., 2006).
In the Italian study (Savoia et al., 2006) all ages are analysed (n=1.622). However the most important values to analyse to compare the two set of results are those of people in the following age groups: 65-74 (n= 205) and over 75 (n=173). As far as the EQ-5D-3L tariff and thermometer are concerned, the values are quite similar 0.71 for this research and 0.80

for the younger people of the study analysed and 0.70 for the older in EQ-5D-3L tariff; for the thermometer the results were 72.6 in our research, and 74/68 for the younger and older people of the Savoia and colleagues (2006) research (Table 8.1).

In order to compare properly the two studies, although the sample is lower than 100 individuals, the percentage of participants that answered they had moderate or severe problems with respect to that item is reported in Table 8.1. In the different answers for EQ-5D-3L, the situation is quite similar, especially for questions 1, 3 and 5 while for question 2 (self-care) in our research, the sample had a considerably better health status. Only 1 participant out of 45 (2.2%) answered that they had moderate or severe problems with self-care while, in Savoia and colleagues (2006) study, the people who answered with moderate or severe problems with self-care are respectively 2.6% for the younger and 21.8% for the older part of the Savoia sample (et al., 2006). At the same time, the sample of our research was considerably worse for question 4 where 68.9% (31 out 45) answered that they have moderate or severe problems with pain and discomfort while this percentage decreases to 59% for the younger and 67% for the older of the Savoia and colleagues (2006) study (Table 8.1). Regarding SF12, a different pattern for PCS and MCS can be observed. While PCS is always lower than that of the study analysed - 38.9 in our research and 46.1 and 42.4 in the study analysed, MCS is always higher - 50.2 in current study and 47.4 and 45.3 in the study analysed (Table 8.1).

Table 8.1 Comparison of the results for an Italian sample (Savoia et al., 2006) and the current study

Item	Current study baseline (n=45)	Savoia et al., 2006 65-74 (n=205)	Savoia et al., 2006 >75 (n=173)
EQ5-3D tariff	0.71	0.80	0.70
EQ5-3D thermometer	72.6	74	68
EQ5-3D Mobility	31.1%	21.2%	40.0%
EQ5-3D Self-Care	2.2%	2.6%	21.8%
EQ5-3D Usual Activities	22.2%	18.2%	37.3%
EQ5-3D Pain/Discomfort	68.9%	59.6%	67.3%
EQ5-3D Anxiety/Depression	46.7%	44.7%	53.3%
York SF-12 PCS	38.9	46.1	42.4
York SF-12 MCS	50.2	47.4	45.3

The results of the study presented here are also consistent with those of De Belvis and colleagues (2008) where the variables, among other things, are measured as the level of education, living conditions and age using the SF-12 questionnaire in its original version. De Belvis and colleagues (2008) show that both PCS and MCS decrease as age increases in a

larger sample. The same patterns are also shown for the educational level, which is consistent with the results in the study presented here (Appendix 15). The Italian study (De Belvis, 2008) shows how there is a linear increase, especially in MCS, with the increase in the level of education of the participants.

In Appendix 15, a data elaboration of Table 7.22 can be found where the results of the questionnaire data are divided into the 3 groups and in accordance with the 3 main socio-demographic categories: age (before and after 75 years old), living conditions (alone or with somebody) and education (up to fourteen years old and over). The younger part of the sample shows it is generally healthier than the older part; similar values are observed for EQ-5D -3L tariff while there are lower values for general health rating.

Considering the division according to the different groups, the one in the wealthier area shows higher values for the thermometer than those of the entire sample. General health rating values are similar in both the whole sample and the other two groups considered. Further, for the values of EQ-5D-3L in the whole sample, groups S and T have similar values while the less advantaged group (F) has lower values (even if there is a marked improvement which leads to the highest average at the end of the experience).

The Italian study (De Belvis et al., 2008) shows how there is a linear increase, especially in MCS, with the increase in the years of study. This is also reflected by the data collected here where participants who have a low level of education also have a lower level of health in comparison to the more educated, having better scores only in the general health rating.
Considering the living conditions of two samples, there is a small difference between the results because in De Belvis and colleagues (2008), people who live alone have lower PCS and MCS values than those who live with someone. In our study, the pattern is the opposite. This could be explained by the fact that, although living alone, all participants have the chance to/are able to meet up with friends at the Centro Anziani where they go nearly every day, as seen by the interviews.

One of the aim of the study was to have an improvement in self-perceived health from the sample and it can be said that, that considering the data (Table 7.22), there is a general improvement in almost all the variables considered. In particular, there was an improvement in the thermometer and the EQ-5D-3L tariff while the PCS and MCS were equal. Furthermore, the minimum values all increased over time. As indicated in the literature individuals engaging in group singing show that they have a decrease in anxiety and depression both among people of all ages (Giaquinto et al., 2006; Gale et al., 2012, Sun and

Buys (2012) and in older people (Cohen et al., 2006). The results of our study are thus aligned with those of the literature. The reduction in anxiety and depression is very significant because depression has negative effects on health and the decrease in depression is one of the major objectives of the WHO (2010). There are currently 151 million people suffering from depression and, in the projections, it is considered as a major cause of disability in the future. Furthermore, the fact that these two results come from both questionnaires reinforces the validity even more.

Depression in older people increases as reported by (Halvorsrud and Kalfoss, 2007) in connection with retirement and, as stated in the 'aging well' section of the White Paper "Healthy lives, healthy people: update and way forward" (2010), outlines the situation for older people, emphasizing the increasing number of older people, the growing rates of depression, and the increased prevalence of mental decline and memory loss problems. According to the data collected during the period of singing, and so during the intervention, there is an improvement in the self-perceived level of anxiety and depression (i.e. they are less depressed and anxious) which was not found by the questionnaire in the period from baseline to 6 months, i.e. in the follow up. This data reinforces the idea that the intervention of health promotion has a strong effect throughout the activity that probably declines after 12 weeks, but that does not weaken the validity; it can, therefore, be said that a longer intervention would probably have a more lasting effect.

The significant improvement during the period baseline/follow-up in the performance of 'usual activities' is equally interesting. Data suggests that the sample perceived a sense of general wellbeing, which is highlighted by the improvement in dealing with 'usual activities'. The ability to carry out usual activities, which effectively means independence, has greater significance in the older population compared to younger individuals. The literature (Halvorsud and Kalfoss, 2007) indicates that the quality of life of the older population is also influenced by the possibility of living a 'normal' life as nearly as possible. Furthermore, Ryff (1989) advocated environmental mastery (the ability to effectively manage one's life and the surrounding environment) and autonomy as two of the six components of psychological wellbeing.

The above-mentioned York SF-12 and EQ-5D-3L scores discussed were calculated, using the same algorithms as employed in the English Silver Song Club trial to ensure comparability. For the whole English sample, the mean physical component was 39.4 and the mean mental component 49.4. The Italian sample was slightly lower in terms of physical wellbeing, and reported slightly higher mental wellbeing. For the total English sample, the

EQ5-3D score was 0.74 and the value for the Italian sample is 0.71, so very comparable. The most interesting finding in comparing the two studies is that the English study showed a significant difference between the singing and non-singing groups at three and six months on mental health, and after three months also on specific anxiety and depression measures. The findings from the current study are similar, therefore, in showing a significant difference in anxiety and depression items. Beyond the fact that the results of the questionnaires agree completely with those of the literature reviewed, it is of particular importance to monitor the results of the English and Italian ones. It is interesting to note that the model evaluated here in Italy had similar results, with a few corrections, with respect to the English one and it is comparable.

8.3.4. Focus group

The results of the focus group are consistent with results highlighted by the two questionnaires, observation and with literature. Moreover, the data collected during the focus group strengthened the positive opinion from the participants highlighting some aspects that are not easily predictable such as the sense of freedom felt strongly and underlined by the sample.

Mental and physical health

Participants highlighted a general improvement in their mental wellbeing declaring that, overall, they felt more relaxed or happier, a showing that is very close to results reported by the literature (Clift and Hancox, 2001, Tonneijck et al., 2008, Lally, 2009, Livesey et al., 2012).

Interestingly, according to the data collected, singing was an incentive to developing some activity at home which goes beyond doing house-related work, as expressed in the interview - for instance searching for lyrics of a song on internet both to enjoy the singing more and also to rehearse the songs at home. This, again, is connected with what Lally (2009) claimed, that being part of a singing group "has spin-off effects for people in other areas of their lives" (p. 34). In other words, some participants develop a curiosity driven by the experience that they would probably never have developed if they had not taken part in this kind of experience. This was an important achievement of this model of health promotion in the light of the data collected during interviews where older people declared that they did not have any hobbies and divided their life between staying at home and going to the Centri Anziani. This experience of singing therefore had a number of additional effects that were not planned or anticipated (neither the author nor the directors pushed the participants in any way to do

anything else outside the singing sessions). This finding also indicates a further important result which this simple activity had on so many of the older people involved.

Social relationship and camaraderie

During the focus group, older people highlighted the importance of building (or reinforcing) relationships with peers and the sense of camaraderie; these aspects are both consistent with literature findings (Clift and Hancox 2001; Silbert 2005; Bailey and Davidson, 2005; Tonneijck et al., 2008; Skingley and Bungay, 2010). This is also connected with social capital - the model of health promotion analysed here can certainly be labelled as bonding social capital, i.e. it involves people with similar characteristics in social networks, in this case, the connection is age.

The sense of camaraderie and the relationship with other people is an important finding especially if connected to the fact that participants are already individuals who take part in the life of the Centri Anziani. Of course, not all were strictly connected with the Centri Anziani as there are some who were only interested in dancing, for instance; nevertheless, they were people who, apparently, did not suffer deeply from social isolation. Therefore, the fact that they underlined this aspect so strongly means that the effect on socially isolated individuals may probably be stronger and deeper.

Self expression and fulfilment

The data shows that participants felt a strong sense of freedom in expressing themselves through singing. The main consideration that can be drawn from this is that singing gives a sense of freedom. This is connected with Tonneijck (et al. 2008), who pointed out that singing groups are "a platform where participants felt safe" (p.175); this safety is probably seen by participants in the study as the chance to express themselves in a safe and free environment, being connected with peers and not being worried about singing. This is consistent with the study carried out by Chong (2010) who found that " 'self-expression' was the most frequently identified source of [...] satisfaction" (p. 122) among those who enjoys singing. In addition, participants communicated happily that they were surprised at their ability to sing properly and make a good sound, which aligns with what Bailey and Davidson (2005) and also Silbert (2005) found. As seen previously in the interview, only a very small number of the interviewees claimed that they sing, and the majority preferred listening to singing. As mentioned before, they were probably ashamed, so the data confirms that individuals probably only need an opportunity, a reason or an occasion to try out the unexplored; after the experience, they were amazed by their desire to express themselves freely as well as their potential.

The improvement in self-esteem arising from this is important. It is strongly connected with eudamonic wellbeing as developed by Deci and Ryan (2008). All the emotions reported above are closely connected with the model of subjective wellbeing developed by Diener in 2000; in his opinion, subjective wellbeing consists of a number of different components such as "positive affect (experiencing many pleasant emotions and moods)" (p. 34). Sarvimaki and Stenbeck-Hult (2000) also point out that social relationships also contribute to wellbeing, and Bauer and colleagues (2008) underlined that personal growth (strongly connected to the desire to learn lyrics better, or curiosity about the meaning of songs) has an important connection with wellbeing.

In the light of the transferability of the model, an, important finding is that connected with comments of the participants in the focus group who commented on the general organization of the experience and their impact as users. A clear indication of the success of the experience was certainly the almost unanimous desire to have more, or longer, sessions during the week. This is all related to the fact that the wellbeing felt from the experience was strong and, as one participant said, "I realised how important it was for me psychologically when it finished, I felt better". The repertoire was appreciated because, as seen, it was closely connected with the local area and selected on the basis of the information gathered during Part A of the research. One of the most interesting aspects of the repertoire is that there were people who joined the singing group, although they had not taken part in the earlier phase of the research, just because they were interested in the repertoire or friends had indicated that, at that time, they could sing those kind of songs. This will be discussed more extensively later where the main aspects of the transfer are considered.

Enjoyment of experience questionnaire

In the second questionnaire (end of singing), a short questionnaire was added that aimed at assessing what kind of impact the experience had on participants beyond the health measures; the questions mirrored those asked during the pilot sessions. The data collected with this brief questionnaire reinforced the idea that the experience was very positive for the sample in terms of joy, pleasure and fun. The majority of the sample liked the experience very much, showing that they particularly enjoyed the experience of singing and would be happy to repeat that regularly. This is re-emphasized when the questionnaire directly asked if singing is an enjoyable activity. The results tell us that 40 people out of 45 said it was very pleasant. The aspect that they found most enjoyable was not what one might have thought, i.e. the opportunity to share moments with other people, but singing in itself. Happiness and serenity are again the feelings most showed by the sample, a finding that aligns perfectly with the literature (Clift and Hancox 2001; Lally, 2009) and was highlighted during both

sessions on the observations data as well as explicitly stated during the focus group. Results similar to those of the focus group were found again with regard to the feelings of participants on completion of the project. They felt a sense of regret because the experience had come to an end as well as that of the achievement of objectives (Hillman, 2002; Lally, 2009).

The data collected through open-ended questions, in which participants could express things other than those suggested by the questionnaire, show that the model was successfully transferred, for example: "I would not change anything in the experience". The most interesting sentence was the one that explicitly connected health and the experience: "my mood and my abilities have improved with this project and it is good for my health". The activity of singing produced wellbeing in terms of personal growth and self esteem which are part of psychological wellbeing (Ryff 1989). There was also happiness and a positive mood, which are important aspects of wellbeing as underlined by Diener (2000).

8.3.5. Triangulation of data Part B

As declared, a brief triangulation of the data should be carried out to raise the credibility and validity of the results, starting from the fact that the standardized questionnaires, observations and focus group had, as has been said, objective (c) i.e. to assess participants' reactions and their perceived wellbeing before and after the experience, in common. The observation shows a sample who had an increasing trend of attention and enjoyment with a development of interest about music and the songs sung during the experience. A great number of positive comments during the session show a positive mood during the experience and a growth of self esteem.

The questionnaire on the experience shows that the it was very welcome by the participants who expressed their interest and enjoyment on several levels. According to the data, 'Singing' and 'having the chance to share time moments with people' were the two major aspects of interest and enjoyment in the entire experience. Standardized questionnaires show a significant improvement in the level of anxiety, depression and usual activities. While the focus group shows an increase in self-perceived physical and mental wellbeing, contentment and happiness, self-worth and self-expression are associated with a sense of group belonging.

According to the above themes emerged in all the collection of data, during Part B, it can be said that there are consistent. Of course, there are some results which are much more focused on health related issues rather than on mood or self-esteem or enjoyment; nevertheless, this

is related to the themes covered by the questionnaire and not the results. Furthermore, all insights are strongly correlated to wellbeing. Starting from the fact that the primary objective of the triangulation is to strengthen the results of a study, in this case, it can be said to that triangulating data from this research will be more complementary rather than a reinforcement. The data suggests some common themes, such as joy, lowering stress and improved mood recorded by both the quantitative and the qualitative data, and there are others that enrich the data rather than confirm it or that show the same data from a different facet. The quantitative data is the one that has more strength in the scientific arena. At the same time, quantitative data are those which explain less so the qualitative data thus enriched the quantitative data by giving an explanation of the reason (or at least giving the opportunity to give a possible explanation) that may have created some result.

In conclusion the triangulation carried out shows that all data reveals that the singing experience was well received by participants who improved their wellbeing to a different extent and with different points of view.

8.4. Overall discussion

Discussing the results of Parts A and B together is important because the research is unique and was divided for methodological and practical reasons. It is now important to have a discussion that connects all the results in order to give a general overview of the study. The aim of this research was to explore the effectiveness and transferability of the Silver Song Clubs model, a project which is running very successfully in the south of England, for older people in a different social and cultural context, i.e. in the capital city of Italy, Rome. The specific objectives were:

a) To gather information on and assess the situation of the older population in Italy, and particularly Rome, both from the point of view of the older population and the professionals involved in the care of older people,
b) To explore the meaning and role of music across the lifespan and currently of older Italian people,
c) To assess participants' reactions and their perceived wellbeing before and after the experience of regular group singing and after a 3 months follow-up period,
d) To assess issues of organization, repertoire and delivery in terms of effectiveness and transferability and their differences with the English experience.

Transferring a good practice is neither easy nor obvious and, in any case, the socio-cultural dimensions cannot be forgotten in the process. Health promotion is a phenomenon that should be thought of as global (WHO, 1986), therefore health promotion tools developed in one context must be adapted to meet the circumstances of another context, especially if an

attempt is made to translate good ideas from one culture to another. Economic and social policy and practical issues should be taken into account (Azarmina et al., 2008) in transferring a model of health promotion. According to Huff and Cline (2008), there are difficulties in using health promotion tools in the same country with different ethnic groups so the difficulties in transferring from one nation to another will be even more marked. Two main aspects should be taken into account - the situation of the two countries and the main features of the model. In developing the study and assessing the results, the maxim has been "The key is to be clear about how much change or adaptation is permissible and to record variations in implementation" (Craig et al., 2008 p. 982).

The important element to recall in the development of the initiative was not so much how Silver Song Clubs are organized because this was highlighted above, but who is a typical participant in these song clubs in England. Participants in England are mainly older people over 60 with a good health status, with socio-economic conditions which vary amongst the different locations (i.e. small town such Dover, Folkestone or Deal in the South East of England). In some of the venues there are also participants with mental decline and memory loss problems . The recruitment of the group of older people in Italy who took part in the experience and the research was mainly driven by the above features, except for participants with mental decline and memory loss problems who were excluded from the research.

Although the two nations belong to Europe they are very different in culture, social and family structure and traditions. There are, however, some fundamental points in common that justified the idea of transferring and made it possible. As a preliminary point, the two worlds, England and Italy, had one important aspect in common - an exponential growth in the older population group, therefore, the transfer would have had a solid background in common from this point of view. Further, older people in the English and Italian context have a number of characteristics in common, such as poor health, loss of relatives and partners and retirement issues. The main difference is probably in how older people conduct their lives in the two countries, the kind of daily life they lead, including the social and historical background. What do these people expect from older age? Other elements that should be analysed are asking whether older age is as they imagined it would be. Furthermore, while both groups are different, they certainly share the desire to be included in society.

An experiment of this kind in a country that is not experiencing the same problems with older people would not make sense. As we have seen, many problems in Italy are aggravated

by social change (loss of the meaning of the Mediterranean family model) and not sufficiently digested by policy which still recognises the family as the first 'health care stakeholder', as has been seen in the policies analysed. In the light of data gathered during the interviews with politicians and social workers, the picture of the situation drawn by them is consistent with that reported in the literature with respect to the needs of older people. Poverty, family fragmentation, social isolation, loss of housing and landmarks are situations and concepts recalled in the above mentioned literature as problems that affect the population of older people worldwide and certainly in Italy.

As has been indicated, there are a number of common denominators between England and Italy in terms of the older population. These were significant in terms of the fundamental idea underlying the model of health promotion and were the most important starting point. However, the number and type of differences could have been a problem for the development of the model in Italy or dictated the requirement to make some adjustments.

The main problems in the development of the Silver Song Club model in Rome related to:

1) Lack of choir culture,
2) Difference between small towns and Rome,
3) Repertoire,
4) Organizational issues, mainly focused on the timetable.

1) One aspect that could have been a significant obstacle was the fact that the "choir culture" is less developed in Italy in comparison with England. As noted, Italy has a greater tradition of solo singing but that of singing in a choir is much less developed. This does not mean that there are no professional choirs but, more specifically, that the establishment of choirs is not as widespread at amateur level. This leads to two problems - firstly, suggesting this type of initiative was risky and, secondly, the diffusion of the culture of solo singing has lead to the development of the idea of "I can't sing, I'm tone-deaf". Therefore, finding out whether older Italians were interested in the possibility of developing this health promotion model had to be thoroughly investigated. Would the institutions react with enthusiasm? And what about the older people?

   The data of Part A suggests that the idea of getting together to sing was certainly immediately attractive both among the professionals surveyed and the older people. The all-round wellbeing of the older people is not recognized by policy at central level but is, however, strongly felt at the peripheral level. The assessment of the condition of the older outside a purely statistical view or in large numbers is clearly

an important aspect, as mentioned, even by politicians of the Municipi. Although they do not have daily contact with older people, they recognized a great need for health promotion activities that go beyond medicine and which have a valid and sound scientific basis.

2) Another important difference that had to be taken into account was the place where the model would be developed. In England, the development was in some small towns in the South East while, in Italy, the transfer attempt would take place in a city like Rome, the largest city in Italy. The author was well aware that Rome is certainly a very different context from small towns like Deal, Dover or Folkestone in South East England. In reality, this proved to be a non-issue as the division of Rome into 19 Municipi, each with its own small 'government', as explained above, attenuated this aspect. It could not be entirely deleted as the Municipi are an internal division and Rome is a city in its own right. Nevertheless, the mere fact that there are some, albeit slight, differences among the Municipi in terms of the offer of health promotion activities for older people was sufficient to make a distinction. The interviews with politicians revealed that there were a number of initiatives created by the individual Municipio directed towards their residents which are not spread to all Municipi. During the interview, politicians stressed that, in many cases, the decision to promote one activity rather than another was related to the socio-cultural level of the inhabitants.

   The division into Municipi and the fact of having specific socio-demographic data on each Municipio was important in facilitating the development of the project. Another assessment that would be interesting is to transfer the model to a small Italian town, socio-demographically similar to those where SSCs were started in England and measuring whether the results are even more similar to those of the English study.

3) With regard to the repertoire, Part A of the research also focused on discovering what could be a viable repertoire for the participants because a boring repertoire would clearly lead to failure of the study. Despite this, the older people say that they accept what the radio offered them musically during interviews. Starting from that, it is interesting to note that when they were asked to express a preference, they were happy and able to do this, once again, the need by older people to feel that their voice is heard can be seen in this. The decision to ask for a list of favourite songs during the interviews and the repetition of the same question during the pilot sessions (as well as during the experience) was essential. During the focus groups, the participants stressed that the repertoire was appropriate and how much they had enjoyed it. It was also the driving force to widen participation in the singing group,

even though these people were not included in the research because they joined the singing groups in a subsequent phase, the result is that the group would be widened by giving more people the chance to improve their health status and perception of the quality of life.

4) The model was adapted with respect to the timetable. The interviews with the older people in Part A clearly showed what was probably the most feasible period of the day. Asking the interviewees to talk about their day had a dual purpose - firstly to assess what kind of life the older people interviewed had (active vs. inactive/isolated) and, secondly, to clarify what would be the best time of the day for developing this experience. On this point, the Italian experience detached sharply from the model. In Italy, the sessions were held in the late afternoon and only group F sang in the morning. This group was the least successful in terms of number of participants.

Part A was therefore essential in the development of Part B where the model was actually tested. The results of Part B show that the transfer of the model was successful mainly for two reasons:

- The results of the questionnaires showed, especially in comparison with the English one, that the model works because singing is a tool to improve health which has no boundaries;
- The participation of those taking part (and even those not included in the research) was enthusiastic, with very few losses, most of which were due to force majeure.

As discussed above, the results are encouraging because they demonstrate firstly that there are indications of a statistically significant improvement in some items (anxiety and depression/usual activities) and, secondly, that these results are similar to those in England. In other words, according to the data, the significance is two-fold and the most important consequence is that the model based on singing is effective and 'works', 'although translated in Italian' in very different contexts. Singing thus has a positive effect on individuals beyond the chosen repertoire and socio-cultural conditions of departure. The participation of the sample showed clearly during the observation, where participation was generally very positive and enthusiastic. It suggests that, in accordance with the interviews of Part A, although they had not had the opportunity, or time, to explore singing in depth in their lives, it had a strong positive impact. They said they felt better, free to express themselves and also that they had felt the pleasure of the experience fully once finished.

During Part B, the participants involved in the research carried out a number of activities. They went to the place where the sessions were held (physical activity), had contact with peers and did something enjoyable (social life) before, during and at the end of the session and, lastly, their cognitive ability was stimulated in reading, singing and following the director's indications. It is known that all these activities have an effect on human health and, in particular, that of older people (Bygren et al., 1996; Akbaraly, et al. 2009; Buchman et al. 2009). Specifically, and in agreement with what was said by Glass and colleagues (2006), social engagement has an effect on depression, an aspect which is confirmed by the results obtained in the Italian study as well as by those in the English one. The proposed activity is not only connected to singing in itself but to a corollary of assets resulting and arising from singing. In addition, the results of the focus groups show that that this model led to the development of activities, also outside the session. All the data suggests that the wellbeing acquired was not only extended but interests and hobbies unknown before were also developed.

The experience thus affected hedonic wellbeing, stimulating pleasure and positive mood (Ryan and Deci, 2001) as well as the eudaimonic wellbeing, that focuses on the development and growth of human potential (Ryff, Singer and Love, 2004) in terms of personal growth and positive relations with others (Ryan and Deci, 2001). In literature, there is general agreement that both hedonic and eudaimonic wellbeing have positive, although maybe not particularly strong, connections with physical health (Ryff, Singer and Love, 2004; Pressman and Cohen, 2005; Howell, Kern and Lyubomirsky, 2007; Chida and Steptoe, 2008, and Krijthe et al., 2011). In the light of this, improvement in wellbeing at both questionnaire level and the focus group level is important.

In discussing these results, it should be taken into account that even though the study was conducted over more than nine months, the singing experience was weekly over a three month period. The improvement in some items of the questionnaires is already very encouraging from this point of view, and is closely associated with what participants repeatedly stressed, i.e. the 'need' for a greater number of sessions or alternatively, an additional and longer experience.

Clearly, the results obtained should be considered with caution, the sample is small and it is difficult to generalize. The goal of this study, however, was not so much to generalize a result as to explore the effectiveness and transferability of this model in Italy. For the assessment of the necessary corrective measures for an appropriate adaptation to compare the results with the English ones, the next step could be to develop the model with a larger

number of participants. As has been seen, the corrections introduced in the study were minimal. The intention was to take the model trying to change it as little as possible. This is because there must be a useful balance between necessary corrections to the evaluation of the model and distortion of the model itself. Further, the real strength of the model lies in its linearity and simplicity; there is an intrinsic transferability due to the main tool which is singing, an act involving the whole of mankind, together with the simplicity of the intervention and its low cost.

8.4.1. Discussion summary

Recalling the aim of the study, i.e. to explore the effects of the Silver Song Club model for older people in a different social and cultural context, and the specific objectives of the research, a critical appraisal of the results can then be made.

With respect to Objective a) the exploration into the status of the older people in Rome was not exhaustive because 20 politicians and 40 elderly people can give an idea but obviously cannot give results on which to base serious suppositions. At the same time, the consistency in the data is a sign that topics that are certainly among the most important were probably touched. The conditions described and the information drawn from the interviews is consistent with both the results reported by scientific studies and that of international bodies.

As regards Objective b), this was one of the most interesting parts of the whole research, both for the initial reactions of the participants and in evaluating how important the family is in the life of each of us. The data gathered suggests that the differences reported are substantially attributable to the influence of the family in the first approach to music. In general, those people who had had the chance to appreciate music from their childhood lived a 'life in music'. Those who, conversely, had not had this experience during early childhood discovered music later in life, or even, in the final part of life. The differences seen during the life of the people tend to flatten out and there is an increasing use of music as company.

With reference to Objective c), the reactions of participants and their wellbeing was assessed using a mixed methodological approach. There was an improvement, in the wellbeing indicated by both questionnaires, as recorded by the observations and the focus group. The experience beyond the statistically significant improvement was very important in the lives of participants and helped to create a growing expectation in the weeks in which there were singing groups and giving a meaning to the days when there was a session, which continued into the following days.

Lastly, Objective d) is the model of health promotion very well known in its English version. Research certainly had to be carried out by those who knew the starting model and its intrinsic meaning and also, at the same time, by a person who was familiar with the receiving population. From this point of view, the author had a significant advantage. Therefore, it can be said that the model, as presented in Italian, requires no further corrective additions to those already included. The results are indicative and encouraging.

8.5. Implications

There are several implications for public health, health promotion and social care that can be drawn from this research; an improvement in the health status of older people on so many levels (health, wellbeing, quality of life and social connections) certainly has strong implications in society where older people are so numerous. In the light of this, and starting from the fact that it is quite impossible to crystallize this kind of output, there are two major implications and feedback that are of particular interest:

1) Dissemination of good practices

First it was demonstrated that a model of health promotion based on singing works in a different European context. This should lead to the widest possible dissemination of the model evaluating the effectiveness in other European and non-European Countries. This is not only desirable from the point of view of national health promotion (the author would say of each nation), but even more to reach out what WHO Europe has stressed in several documents and reports as the need to share and spread good practice;

2) Cost-effectiveness

The model works and is cost effective. The investment for each group is not particularly expensive while the effect is potentially very significant in terms of health gained by older people which as has been said are the biggest users of the health system.

In conclusion, starting from the fact as said above that simple arts activities such as singing have a major impact on health and wellbeing of older people and that, according to Hyyppa (2010), social activities carried out by older people have more effect on their health in comparison to physical activities, due to the fact that older people are less likely to develop better physical health, it seems crucial that policy makers take into account social activities to promote the health and wellbeing of older adults.

8.6. Recommendations and Future Research

Further research should be done in two main directions. The first is methodological and the other concerns recruiting a wider range of participants. With respect to the former, it would be interesting to repeat the study with a control group having a larger number of participants as already done in England. With respect to the kind of participants, in the current study participants were drawn mainly from Centri Anziani; therefore, they are individuals who probably have little experience of social isolation. For this reason, beyond the encouraging results achieved, it would be even more interesting to have individuals who do not have the benefit of involvement in support organisations (such as the Centri Anziani) so that a comparative view can be gained of the effect on people who experience more loneliness and social isolation. Beyond the research closely related to the work presented here, it would be extremely relevant, especially in the light of memories raised during interviews in Part A, to develop research to investigate the musical experience, both in terms of listening and singing. This is especially true for individuals who are experiencing mental decline and memory loss problems; these people have a strong memory of the past but, conversely, have problems with recent memory, therefore work on reminiscence, through music and singing could be very important for their self esteem and their quality of life. All tools to improve wellbeing of the people should be explored as much as possible in order to strengthen the evidence in this field.

8.7. Limitations

As underlined above, it is difficult use the same hierarchical evidence which is used for more medical based health promotion tools. In 2001, Black challenged the concept of evidence-based policy stressing that "there are many sorts of evidence, that sensible decisions may not reflect scientific rationality, and that context is all important, particularly with policies related to services" (p. 277).

The study has some obvious limitations which substantially relate to the sample, the tools to detect improvement in quality of life and wellbeing and the lack of a control group. As far the former is concerned, the participants recruited through the support of the Centro Anziani were, for the most part, older individuals already involved in them as a place where they could spend the day safely. The number of participants who took part in the sessions of group singing and who then successfully completed the 3 questionnaires was limited. Singing groups made up of very old people such as those in the present study may generally be quite small and are also likely to be affected by variable attendance and people leaving due to health and other problems. Nevertheless, the small sample size should be set against

the exploratory nature of the current study and its concern with effectiveness and transferability.

The sample is a convenience sample, in other words this does not reflect any statistical proportion of the older population, however considering the fact that the Centri Anziani are some of the most attended venues, along with religious facilities and the University of the Third Age a kind of 'University' which gives older adults the chance to access a number of lectures on subjects ranging from arts and crafts to psychology, sciences, sociology and so on but this is used only by older rather educated people. In the light of the above it can be accepted as a sample that reflects older people's attitudes.
As far as the subjectivity above mentioned is concerned results are based on self–reported questionnaires and qualitative data therefore they suffer to a grade of non-objectivity which should also be taken into account.
Despite the limitations mentioned above, the study had a number of strengths, including the fact that it has shown that the model of group singing devised initially in England, can be a useful tool for health promotion when used with older people in Italy.

8.8. Reflections on method

The title of this study contains two key elements - exploration of effectiveness and transferability. These two aspects must be kept in consideration when the methodology is considered critically. A mixed methods approach was chosen with Part A exploring some fundamental aspects in order to develop Part B of the research, which focused on effectiveness and transferability. Research conducted by Chong (2010) was taken into account during the development of Part A; in his research, the author suggests that there are a number of obstacles to singing and that not everyone has the desire to sing. As discussed previously, singing has a very intimate dimension. During Part A of the research, mainly qualitative methods, such as semi-structured interviews were used with professionals (social workers and politicians) and older people. The semi-structured interviews allowed a valid and thorough response by the professionals who had the opportunity to express their opinions on the social and health status of the older population in Rome.

The approach to older people was handled very sensitively. On one hand, older people may be vulnerable and this should be taken into account; on the other, if older people are unfamiliar with the concept of research, it can be difficult to convey to them why the researcher is interested in a certain topic, and why a lot of questions are being asked. Unfortunately, the initial choice of a focus group with older people was mis-judged as the group discussion was not very productive. On the other hand, during the interviews, a good

understanding was created with a large number of participants and this allowed sharing of the memories relating to music even though at times the older people departed from the intended focus and wanted to talk about other issues.

The three pilot sessions were invaluable, especially in clarifying some organizational issues which were important in relation to the effectiveness and transferability of the study. The tasters helped to determine the repertoire, and the duration of the sessions, and allowed an assessment of the effects that a questionnaire would have on participants. The taster session also allowed for suitable modifications to the devised questionnaire and additional items were added/substituted. Also it is also clear that listing other possible options in responding to questions could be more appropriate since participants did not add personal reflections where these were asked for.

Despite some corrections, the methodology used in Part A of the research was useful for the purpose for which it was designed and built, and it actually highlighted the relevant aspects required for Part B.

With regard to Part B, a mixed methods approach was also used i.e. qualitative tools such as focus groups and observations and quantitative tools in the form of previously validated questionnaires. The choice of questionnaires was based on the earlier English Randomised Controlled Trial of Silver Song Clubs. The author found a number of difficulties in using the standardized questionnaires. First of all, the questionnaires seemed very long to complete to participants, although there were only 22 items. Moreover, although the questionnaires were easy to understand, participants had many difficulties, probably due to their age and level of education. The author had to find a balance between the need to explain items to participants and the danger of suggesting answers

There was considerable difficulty in convincing participants of the need to complete the questionnaires properly and explaining that an inappropriately completed questionnaire is ultimately useless. Another difficult aspect of the procedure was setting up the code for the questionnaire. Many participants wrote their name and surname directly, while others tried, with many difficulties, to set up the code. Here again, the author helped them to set up the code, although this was quite challenging, especially in the second and third questionnaires. Obviously, if they had made a mistake in setting up the first code, this had to be repeated in the second and the third, otherwise the author would have had difficulty in coupling the questionnaires. This was another extremely challenging moment.

As far as the observation was concerned, the idea was to have a stronger comparison between sessions; therefore, it was decided to do it in an alternative way, but this was

probably a wrong choice. In other words, the observation would have been more interesting looking at the evolution of the sample over all sessions, observing each session and gathering information for every moment experienced by participants.

For the focus groups, the choice of this method was guided by the fact that there was a relationship between the author and participants and that this could encourage the older people to be honest in giving their opinions. After the singing programme, the focus group gave some very interesting and unexpected insights, such as the repeatedly stressed sense of freedom felt by participants during singing.

With respect to audio-video recording, it would have been very interesting to use this approach during sessions to really document the behaviour of the sample. Each session would have given a great amount of data which would highlight a number of features of the process in a more effective way, for example, the quality of interaction with the directors, and interactions amongst participants themselves such as the extent of their comments, smiles, chatting and so on. However, given that that this was the first time that most participants had been involved in a singing group, and it was also the first time that they were involved in research, it was preferable to avoid subjecting participants to constant recording sessions.

The whole process of this study was demanding. The study was a real wager. A number of cultural issues already mentioned in the above chapters and practical problems connected with the transferability made this journey interesting and challenging. As said above, few (but substantial) corrections were made to the model in order to have a better fit to the Italian context; what was quite difficult was to approach the target Italians and this even by an Italian researcher. Certainly, the author strongly believed in what she was doing (which is essential in carrying out a research) and constructed a number of skills during the whole process such as having the right approach with older people. These were essential in handling it and, furthermore, involving them in the research not only as participants but as ‘builders’ in it.

An important aspect in conducting research (even more so with qualitative research) with older adults, is that the researcher should be socially skilled. This is highlighted by Kim (2011) and is a one aspect which should be emphasized. Establishing a contact with both the professionals and, even more, with the older people was crucial, and being able to gain their trust and respect was essential. Probably, the main thing to bear in mind during this kind of research is that participants are giving their time, attention and consideration to the study

while, in most cases, the researcher gives them nothing in return. For the author, it was also important that they did not feel that they were 'guinea pigs' but individuals, participants who could help in the development of health promotion tools for other older people. In this case, there was an exchange to some extent; participants had the opportunity through the research of taking part in a new experience and at the same time, their co-operation and attention was really important to the author beyond what the research was giving them.

Another challenge for the author was the difficulty in being an Italian student who 'represented' an UK University and an English research centre. Participants were quite often confused by this, and asked why a British university was interested in them. Although the Sapienza University was named and it was explained that the local university was a partner in the research. One aspect that had the most effect on people, and which the author had to address, was the name of English university, which both fascinated and scared them at the same time.

8.9. Overall conclusion

Three main conclusion can be made in the light of the above:

1) Silver Song Clubs is a health promotion model which can be successfully transferred to other countries,
2) Singing is a health promotion tool which can be widely used because it is grounded in a fundamental human capacity to engage with music,
3) Findings from the evaluation show that involvement in singing has a positive effect on levels of anxiety and depression (baseline/end of singing) and on dealing with usual activities (baseline/follow up) among older Italians.

The data allows us to conclude that health policy, care and promotion should be focused on how an individual lives more than on the number of years they live. The ageing society is a triumph and a challenge, and it is worth reflecting on whether the improvements in health made before the 1980s took the quality of life into account or were only focused on improving life in quantitative terms. Older people can be and are an asset to the community, but it is equally true that disability in general and that of the older people in particular is a huge burden on the family and wider society and more attention needs to be given to developing innovative approaches to meeting these challenges.

The success of the transfer of the Silver Song Club model to Rome was shown, not simply by the quantitative measures, but most directly by the desire of participants to attend

regularly week by week. The Focus Group and qualitative data allow us to conclude that the model is well structured, simple and straightforward, and tailored to meet the needs and condition of the users. It is an activity open to all older people, whether they are experiencing difficult challenges to their physical and/or mental wellbeing as well as for those who are healthy; therefore, it can be very extensively used in many settings. The sense of social inclusion that the intervention produced was very strong, according to the data collected, and singing groups could be especially helpful for couples in which one of the two has developed the early stages of mental decline and memory loss problems while the other is still healthy. This is an aspect to be considered in the light of the stories of exclusion and social isolation that were collected during the interviews (both from the older people and the professionals) where one of the causes of social exclusion and isolation is disease of a partner, with all the negative consequences that have been highlighted above.

All the data gathered during the research allows us to conclude that singing is an activity that goes beyond any setting or boundaries, when the repertoire is developed properly adapted to the age and culture of the participants.

This PhD study, even with a small sample, shows the effectiveness and transferability of the model of health promotion from a number of towns in the south-east of England to the great city of Rome. It showed that singing, and this model in particular, is a very effective tool of health promotion because it allowed older people to have a number of important insights for their health.

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Appendix 1

Ethic Committee U.K.

22 November 2010 Ref: 10/H&SC/CL24

Ms Elisabetta Corvo
Sidney De Haan Research Centre for Arts and Health
University Centre, Mill Bay
Folkestone CT20 1JG

Dear Elisabetta

Confirmation of compliance for your study *"Exploration of the implementation of an English model of health promotion based on participant in singing groups for older adults (Silver Song Clubs) in Italy."*

I have received a completed and countersigned Ethics Review Checklist dated 20 November 2010 for the above project. Because you have answered "No" to all of the questions in Section B of the form, no further ethical review will be required under the terms of this University's Research Ethics and Governance Procedures.

In confirming compliance for your study, I must remind you that it is your responsibility to follow, as appropriate, the policies and procedures set out in the *Research Governance Handbook* (http://www.canterbury.ac.uk/research/governance/index.asp) and any relevant academic or professional guidelines. This includes providing, if appropriate, information sheets and consent forms, and ensuring confidentiality in the storage and use of data. Any significant change in the question, design or conduct of the study over its course should be notified to the **Research Office**, and may require a new application for ethics approval. You are also required to inform me once your research has been completed.

Wishing you every success with your research.

Yours sincerely

Roger Bone
Research Governance Manager
Tel: +44 (0)1227 782940 ext 3272 (enter at prompt)
Email: roger.bone@canterbury.ac.uk

cc: Professor Stephen Clift

The Graduate School and Research Office

Canterbury Christ Church University
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Professor Robin Baker CMG, Vice Chancellor

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Registered Charity No: 1098136

Canterbury Christ Church University

Declaration of adherence to appropriate ethical procedures for research undertaken with human participants in countries outside the United Kingdom

☑ I declare that I, Elisabetta Corvo

have followed all the necessary procedures to ensure that the research involving human participants I have carried out, or intend to carry out, entitled

"Exploration of the implementation of an English model of health promotion based on participant in singing groups for older adults (Silver Song Clubs) in Italy"

in Italy

between November 2010 and March 2012

as part of my research degree, conforms in full to the ethical requirements of that country.

☑ I have acquired all the necessary permission from all the necessary parties with

regard to access, use of research instruments or any other invasive procedures, and confidentiality.

☑ I have made the purpose of my research appropriately clear to all the parties that

I am required to, and have behaved appropriately in response to the outcomes of this communication.

☐ I attach a copy of any regulatory or ethical documentation/certificates that I have had to sign or have been awarded by the jurisdiction within which I am operating.

Signed: Elizabeth Court

Date: 4.12.2010

Completed declaration should be returned to the Research Governance Manager, Graduate School and Research Office. Researchers should retain a copy for inclusion in their thesis/dissertation.

Appendix 2

Ethic Committee Italy

PRIMA FACOLTÀ
DI MEDICINA E CHIRURGIA

SAPIENZA
UNIVERSITÀ DI ROMA

Dipartimento Sanità Pubblica e Malattie Infettive
Area Nursing
Prof. Julita Sansoni
Tel.06.4959255 w3.uniroma1.it/nursing

Roma 04.12.2010

Oggetto: Esplorazione sulla fattibilità applicativa di un modello di promozione della salute inglese basato sulla partecipazione a gruppi di canto per persone ultrasessantenni in Italia

Gentile Dott.ssa Elisabetta Corvo

La presente per attestare che dopo attenta valutazione del ricerca in oggetto, sentito anche il Preside della Facoltà di Farmacia e Medicina, non si è ravvisata la necessità di sottoporre la ricerca al vaglio del giudizio del Comitato etico di questa Università .

Cordialità

Prof. Julita Sansoni

DIPARTIMENTO DI SANITA' PUBBLICA E MALATTIE INFETTIVE

Rome, 4th December 2010

Re:Exploration of the implementation of an English model of singing group for older adults (SSC) in Italy

Ms Elisabetta Corvo,

This is to certify that after careful assessment of the above research, and after speaking to the Dean of the Faculty of Pharmacology and Medicine, it has been decided that the research need not be submitted to the Ethics Committee of this University.

Kind Regard

Prof. Julita Sansoni

DIPARTIMENTO DI SANITA' PUBBLICA E MALATTIE INFETTIVE

Appendix 3

Informed Consents

Esplorazione sulla fattibilità applicativa di un modello di promozione della salute inglese basato sulla partecipazione a gruppi di canto per persone ultrasessantenni in Italia.

Informazioni per i partecipanti – *FASE A Ultrasessantenni*

La dottoressa Elisabetta Corvo sta conducendo una ricerca: La ringraziamo per la sua disponibilità a partecipare alla stessa. Per favore legga con attenzione questo foglio informativo che Le darà le informazioni necessarie per la comprensione della ricerca e per la Sua partecipazione. Non esiti a chiedere ulteriori informazioni e/o specificazioni nel caso avesse ulteriori dubbi o perplessità.

Premessa

L'obiettivo di questo studio è quello di valutare la fattibilità, l'applicabilità nel contesto italiano di un modello inglese di promozione della salute, basato su gruppo di canto per le persone ultrasessantenni.

Cosa dovrò fare?

Le sarà chiesto di condividere le sue opinioni su argomenti come l'assistenza socio – sanitaria agli anziani, la musica e la salute, la qualità della vita ed il benessere. Se lei decide di partecipare non sarà sottoposto ad alcun rischio.

Per partecipare alla ricerca lei deve essere

Una persona ultrasessantacinquenne.

Procedure

Le verrà chiesto di partecipare a questo studio. Condividendo le sue opinioni sulla musica sulla qualità della vita e sul benessere.

Feedback

Lei avrà la possibilità di accedere a tutto il lavoro una volta conclusa la stesura.

Riservatezza

Tutti i dati e le informazioni personali verranno conservate con cura in accordo con il British Data Protection Act 1998, e con il decreto legislativo 196/2003 (ss.mm.) e con le regole dell'università riguardo alla conservazione dei dati. Solo la Dottoressa Elisabetta Corvo avrà accesso ai dati. Al completamento dello studio i dati verranno, comunque resi anonimi rimuovendo ogni eventuale traccia.

Divulgazione dei risultati

Tutti i dati raccolti durante lo studio verranno utilizzati solo ed esclusivamente con obiettivi scientifici. Nessun risultato potrà essere ricondotto ai partecipanti. A completamento della ricerca vi potrà essere la pubblicazione in rilevanti riviste scientifiche. Allo stesso modo vi sarà la possibilità che lo studio venga discusso in conferenze.

Decisione sulla partecipazione

Se Lei ha qualsiasi dubbio o preoccupazione riguardo ad una qualsiasi delle procedure della ricerca non esiti a chiedermi informazioni. Qualora Lei decida di partecipare, lei sarà libero/a di lasciare lo studio in ogni momento senza dare alcuna spiegazione.

Atre domande?

Contatti la dottoressa Elisabetta Corvo all'indirizzo email canzonidargento@libero.it o al numero telefonico 3408717709

Esplorazione sulla fattibilità applicativa di un modello di promozione della salute inglese basato sulla partecipazione a gruppi di canto per persone ultrasessantenni in Italia.

Informazioni per i partecipanti – *FASE A Professionisti*

La dottoressa Elisabetta Corvo sta conducendo una ricerca: La ringraziamo per la sua disponibilità a partecipare alla stessa. Per favore legga con attenzione questo foglio informativo che Le darà le informazioni necessarie per la comprensione della ricerca e per la Sua partecipazione. Non esiti a chiedere ulteriori informazioni e/o specificazioni nel caso avesse ulteriori dubbi o perplessità.

Premessa

L'obiettivo di questo studio è di valutare la fattibilità, l'applicabilità nel contesto italiano di un modello inglese di promozione della salute, basato su gruppo di canto per le persone ultrasessantenni.

Cosa deve fare?

Nell'intervista Le sarà chiesto di condividere le sue opinioni su argomenti come l'assistenza socio-sanitaria agli anziani, la musica e la salute, la qualità della vita ed il benessere. Se Lei deciderà di partecipare non sarà sottoposto ad alcun rischio né fisico né di altro tipo.

Per partecipare alla ricerca, Lei deve essere

Un professionista che si occupi a vario livello della popolazione anziana.

Procedure

Lei verrà intervistato anonimamente.

Feedback

Lei avrà la possibilità di accedere ai risultati emersi dal lavoro una volta conclusa la sua stesura.

Riservatezza

Tutti i dati e le informazioni personali verranno conservate con cura in accordo con il British Data Protection Act 1998, e con il decreto legislativo 196/2003(ss.mm.) e con le regole dell'università riguardo alla conservazione dei dati. Solo la Dottoressa Elisabetta Corvo avrà accesso ai dati. Al completamento dello studio i dati verranno comunque resi anonimi rimuovendo ogni eventuale traccia.

Divulgazione dei risultati

Tutti i dati raccolti durante la ricerca verranno utilizzati solo ed esclusivamente con obiettivi scientifici. Nessun risultato potrà essere ricondotto ai singoli partecipanti. A completamento della ricerca vi potrà essere la pubblicazione dei dati in forma aggregata su riviste scientifiche. Allo stesso modo vi sarà la possibilità che lo studio possa venire presentato in conferenze.

Decisione sulla partecipazione

Se Lei ha qualsiasi dubbio o preoccupazione riguardo la procedura della ricerca non esiti a chiedermi informazioni. Qualora Lei decida di partecipare, lei sarà libero/a di lasciare lo studio in ogni momento senza dover fornire alcuna spiegazione

Atre domande?

Contatti la dottoressa Elisabetta Corvo all'indirizzo email canzonidargento@libero.it o al numero telefonico 3408717709

MODULO DI CONSENSO

Esplorazione sulla fattibilità applicativa di un modello di promozione della salute inglese basato sulla partecipazione a gruppi di canto per persone ultrasessantenni in Italia

Nome del ricercatore Dottoressa ELISABETTA CORVO

Contact details:

Address:

Sidney De Haan Research Centre for Arts and Health
University Centre, Mill Bay Folkestone,
CT20 1JG, Kent

Sapienza Università di Roma
Area Nursing – Professoressa Julita Sansoni
Piazza Aldo Moro, 1
00100 ROMA

Tel: 3408717709

Email: ec210@canterbury.ac.uk – canzonidargento@libero.it

1. Confermo di aver letto e capito il foglio informativo sulla ricerca "Esplorazione sulla fattibilità applicativa di un modello di promozione della salute inglese basato sulla partecipazione a gruppi di canto per persone ultrasessantenni in Italia" e di aver avuto l'opportunità di avere chiarimenti.	
2. Ho capito che la mia partecipazione è del tutto volontaria e posso decidere di ritirarmi dall'ricerca in un qualsiasi momento senza dare spiegazioni.	
3. Ho capito che le informazioni che darò sulla mia persona saranno confidenziali e riservate.	
4. Accetto di partecipare alla ricerca.	

_____	_____	_____
Nome del partecipante	Data	Firma
_____	_____	_____
Nome della persona che prende il consenso(se differente dal ricercatore)	Data	Firma

Esplorazione sulla fattibilità applicativa di un modello di promozione della salute inglese basato sulla partecipazione a gruppi di canto per persone ultrasessantenni in Italia.

Informazioni per i partecipanti – *FASE B*

La dottoressa Elisabetta Corvo sta conducendo una ricerca: La ringraziamo per la sua disponibilità a partecipare alla stessa. Per favore legga con attenzione questo foglio informativo che Le darà le informazioni necessarie per la comprensione della ricerca e per la Sua partecipazione. Non esiti a chiedere ulteriori informazioni e/o specificazioni nel caso avesse ulteriori dubbi o perplessità.

Premessa

L'obiettivo di questo studio è quello di valutare la fattibilità, l'applicabilità nel contesto italiano di un modello inglese di promozione della salute, basato su gruppo di canto per le persone ultrasessantenni.

Cosa dovrò fare?

Le sarà chiesto di condividere le sue opinioni su argomenti come l'assistenza socio-sanitaria agli anziani, la musica e la salute, la qualità della vita ed il benessere, la sua salute. Se lei decide di partecipare non sarà sottoposto ad alcun rischio.

Per partecipare alla ricerca lei deve essere

Una persona ultrasessantenne.

Procedure

Partecipare a gruppi di canto d'insieme e condividere le sue opinioni sull'esperienza e sulla sua salute.

Feedback

Lei avrà la possibilità di accedere a tutto il lavoro una volta conclusa la stesura.

Riservatezza

Tutti i dati e le informazioni personali verranno conservate con cura in accord con il British Data Protection Act 1998, e con il decreto legislativo 196/2003 (ss.mm.) e con le regole dell'università riguardo alla conservazione dei dati. Solo la Dottoressa Elisabetta Corvo avrà accesso ai dati. Al completamento dello studio i dati verranno, comunque resi anonimi rimuovendo ogni eventuale traccia.

Divulgazione dei risultati

Tutti i dati raccolti durante lo studio verranno utilizzati solo ed esclusivamente con obiettivi scientifici. Nessun risultato potrà essere ricondotto ai partecipanti. A completamento della ricerca vi potrà essere la pubblicazione in rilevanti riviste scientifiche. Allo stesso modo vi sarà la possibilità che lo studio venga discusso in conferenze.

Decisione sulla partecipazione

Se Lei ha qualsiasi dubbio o preoccupazione riguardo ad una qualsiasi delle procedure della ricerca non esiti a chiedermi informazioni. Qualora Lei decida di partecipare, lei sarà libero/a di lasciare lo studio in ogni momento senza dare alcuna spiegazione.

Atre domande?

Contatti la dottoressa Elisabetta Corvo all'indirizzo email canzonidargento@libero.it o al numero telefonico 3408717709.

Appendix 4

Professional's interview

- Introduction of myself
- Universities involved
- Brief description of the research
- Main purpose of the interview
- Any questions?

Part A – Professionals' Interview

1. Could you please describe what your professional position is?
2. How many years have you been in this field?
3. Could you please describe the area where you work in terms of demography, economic and social condition?
4. Have you ever worked in the same field in another geographical area? If so, how long ago?
5. What is your professional view about the dichotomy between biologically old life and social old age?
6. What is the role of the family in the everyday day life of older people in your professional opinion/experience?
7. What is the role of the GP in the everyday day life of older people in your professional opinion/experience?
8. What kind of relationships do elderly people normally have (friends, partner, relatives and so on), or are they isolated?
9. In your experience, what kinds of requirements do elderly people normally ask for?
10. What kind of activities do older people carry out out in everyday life (gardening, dancing, playing cards, chatting with friends, watching TV...)?
11. In your experience, are elderly people interested in extending their knowledge?
12. Do you think they will be interested in participating in this kind of singing group? (Explain why.)
13. If you answered yes to Question 4, are there any significant differences between the areas in relation to the answers to Questions 10, 11, 12 and 13?

Part A Professionals' interview – Canzoni d'argento

Appendix 5

Older people interview

Part A – Interview of Older People

Introduction of myself

Universities involved

Brief description of the research

Main purpose of the interview

Any questions?

Part A – Interview of Older People

Age	Sex	Local Conditions	Living Conditions	Education
60-64	M – F	Ad –Disadv.	Alone	Until 10
65-69			With Partner	Until 14
70-74			With children	Until 18
75-79			Other	Until 25
80-84				
85-90				
90-95				
95+				

- Today we'll take a walk down the memory lane of your life and we'll touch four different periods:
    - Childhood (0-12)
    - Adolescence (13-29)
    - Adulthood (30-59)
    - Old age (60+)

  and the role of music in your past and present life.

CHILDHOOD

Looking back at your childhood, did you listen to music?

YES

- When? (special occasions, everyday life, in the morning, in the evening, or…)
- Where? (at home, school, in church, theatre, concert, or….)
- Who with? (mother, father, siblings, friends, or…)
- How did you listen to music? (on the radio, or….)

Looking back to your childhood, did you sing?

YES

- When? (special occasions, everyday life, in the morning, in the evening, or…)
- Where? (at home, school, in church, or….)
- Who with? (mother, father, siblings, friends, or…)
- Did anybody sing for/to you?
- Do you remember a particular song which reminds you of the past?
    - What kind of memories does it bring?
    - Are you able (do you mind) to sing this song for me?

NO

- In your opinion, why?
- Do you think this depended on circumstances, family tastes, family way of life, the particular time?

ADOLESCENCE

Looking back to your childhood, did you listen to music?

YES

- When? (special occasions, everyday life, in the morning, in the evening, or…)
- Where? (at home, school, in church, theatre, concerts, or….)
- Who with? (mother, father, siblings, friends, girlfriend/boyfriend…..)
- How did you listen to music? (on the radio, or…..)
- With the coming of television, did you listen to more music?
- Do you remember a particular melody which reminds you of the past?

Looking back to your childhood, did you sing?

YES

- When? (special occasions, everyday life, in the morning, in the evening, or…)
- Where? (at home, school, in church, or….)
- Who with? (mother, father, siblings, friends, or…)
- Do you remember a particular song, which reminds you of the past?
    - Which kind of memories does it bring?
    - Are you able (do you mind) to sing this song for me?

NO

- In your opinion, why?
- Do you think this depended on circumstances, family tastes, family way of life, the particular time?

ADULTHOOD

Looking back to your adulthood, did you listen to music?

YES

- When? (special occasions, everyday life, in the morning, in the evening, or…)
- Where? (at home, school, in church, or….)
- Who with? (relatives, sons, daughters, wife/husband, friends…)
- How did you listen to music - on the radio, music cassettes, CDs, record player or…?
- With the coming of television, did you listen to more music?
- Do you remember a particular melody which reminds you of the past?

Looking back to your childhood, did you sing?

YES

- When? (special occasions, everyday life, in the morning, in the evening, or…)
- Where? (at home, school, in church, or….)
- Who with? (relatives, sons, daughters, wife/husband, friends, or…)
- Do you remember a particular song, which reminds you of the past?
    - What kind of memories does it bring?
    - Are you able (do you mind) to sing this song for me?

- At that time, did you have time to spend on listening to music or singing?

NO

- In your opinion, why?
- Do you think this depended on circumstances, family tastes, family way of life, the particular time?

- OLD AGE 1-

Looking at the present, do you listen to music?

YES

- When? (special occasions, everyday life, in the morning, in the evening, or…)
- Where? (at home, school, in church, or….)
- Who with? (relatives, sons, daughters, wife/husband…)
- How do you listen to music - on the radio, music cassettes, CDs, record player or…?

Looking at the present, do you sing?

YES

- When? (special occasions, everyday life, in the morning, in the evening, or…)
- Where? (at home, school, in church, or….)
- Who with? (relatives, sons, daughters, wife/husband…)
- Do you sing songs of the past or the present?
    - What kind of memories does they bring?
    - Are you able (do you mind) to sing one of these songs for me?

NO

- In your opinion, why?
- Do you think this depended on circumstances, family tastes, family way of life, the particular time?

- OLD AGE 2 -

1. How do you spend your days?
2. Do you have any particular hobbies?
3. What kind of music do you listen to?
4. Do you listen to music occasionally or every day?
5. Compared with the past, is music more or less important in your personal life now?
6. When do you listen to music during the day?
7. Do you have a collection of records/cassettes/CDs? If yes, do you still buy music?
8. How do you choose the kind of music you listen to? Does it depend on your mood, the time of day, or other reasons?
9. There is often music in the supermarket or shops nowadays. Do you like this or do you honestly prefer silence?
10. Do you listen to music alone or with other people?
11. If with another person, who decides what kind of music to listen to - you or the other person?
12. Do you prefer singing or listening, or do you like to do both? Why?
13. What are your favourite songs?
14. If you were on a desert island, what songs would you take (you can only choose a few to take with you)?

Appendix 6

Introduction Letter

PRIMA FACOLTÀ
DI MEDICINA E CHIRURGIA

SAPIENZA
UNIVERSITÀ DI ROMA

Dipartimento Sanità Pubblica e Malattie Infettive
Area Nursing
Prof. Julita Sansoni
Tel.06.4959255 w3.uniroma1.it/nursing

Roma 12.09.2010

A CHI DI INTERESSE

L'Area Nursing del Dipartimento di Sanità Pubblica e Malattie Infettive di questa Sapienza Università di Roma nella persona della prof. Julita Sansoni, supervisiona/è partner e facilita, per la parte italiana, la ricerca della dott.ssa Elisabetta Corvo, dottoranda presso la Canterbury Christ Church University nel Regno Unito (Sidney de Haan Research Centre for Arts and Health - (http://www.canterbury.ac.uk/centres/sidney-de-haan-research/) che finanzia il progetto.

Direttore scientifico del Centro di Ricerca è il Prof. Stephen Clift, supervisore inglese del progetto su menzionato, focalizzato sulla valutazione ed applicazione di un modello di promozione della salute inglese, proposto ora, nel contesto sociale e culturale italiano, romano in particolare.

Il modello, che usa la musica - gruppo di canto di insieme - è già stato validato ed usato oltre che in Inghilterra, in altre nazioni europee ed extraeuropee ed è stato costruito tenendo presente i principi promossi dall'Organizzazione Mondiale della Sanità.

La ricerca rivolta alla popolazione anziana, è divisa in due parti, la prima consta in una serie di interviste focalizzate sullo status della popolazione anziana romana a persone coinvolte a vario titolo nella gestione dei Servizi socio-sanitari (ad esempio consiglieri municipali, assistenti sociali etc) e in un ciclo di interviste alla popolazione anziana, condotte in differenti contesti territoriali romani, al fine di valutarne l'interesse alla partecipazione all'esperienza ed il ruolo della musica nella vita delle persone anziane.

In una seconda fase, in base ai risultati della prima, verranno organizzati gruppi di canto costituiti da persone anziane, e verrà condotta una valutazione attraverso strumenti metodologici qualitativi e quantitativi (questionari pre e post esperienza) al fine di evincere se vi sia stato o meno un miglioramento della qualità della vita e del benessere delle persone coinvolte nella ricerca alla conclusione delle 12 settimane di durata dell'esperienza. I risultati, anonimi, faranno parte della tesi di dottorato della Dott.ssa Corvo e saranno la base per articoli scientifici in riviste di settore.

Con la presente siamo a chiedere di facilitare i colloqui e l'accesso alle Strutture dedicate.

Cordialmente

Julita Sansoni

DIPARTIMENTO DI SANITÀ PUBBLICA E MALATTIE INFETTIVE

Appendix 7

Flyer of the research

Cantare insieme può migliorare il senso di benessere e lo stato di salute delle persone anziane?

Progetto di ricerca

Gruppo di canto d'argento

Prima Facoltà di Medicina e Chirurgia
Sapienza Università di Roma

Sing for your life

Sidney De Haan Research Centre for Arts an

Canterbury Christ Church University

Silver Song Clubs in Italy

L'obiettivo del progetto è costituire dei gruppi di canto d'insieme simili all'esperienza dei Silver Song Clubs concepiti e sviluppati con grande successo nel Sud-Est dell'Inghilterra.

I Silver Song Club, "gruppi di canto d'argento" sono costituiti da gruppi di anziani dai 60 anni in su che si riuniscono per cantare insieme. Allo stesso modo nel contesto italiano e più precisamente romano, verranno costituiti dei gruppi simili a quelli dei Silver Song Club inglesi. I gruppi così costituiti verranno poi valutati al fine di evincere se vi sia stato un miglioramento dello stato di benessere e della qualità della vita percepita dei partecipanti dopo l'esperienza.

Il progetto verrà portato avanti dalla Dottoressa Elisabetta Corvo. Elisabetta Corvo è attualmente dottoranda presso il Sidney De Haan Research Centre nel Regno Unito. Sarà supportata dalla Prof. Julita Sansoni responsabile dell'Area Nursing del Dipartimento di Scienze di Sanità Pubblica della "Sapienza" Università di Roma.
Principali quesiti cui la ricerca vorrebbe rispondere

- In quale misura gli anziani in Italia sono interessati a partecipare a gruppi di canto?
- Il modello "Silver Song Club" di grande successo e sviluppo nel Regno Unito potrebbe avere successo anche in un contesto italiano?
- Quale impatto ha l'esperienza del canto nel benessere e nella qualità della vita dei partecipanti all'esperienza?
- L'esperienza del canto in gruppo può ridurre il bisogno di assistenza medica o sociale di base?

Nel progetto verranno coinvolti sia i centri anziani che i municipi e tutte le associazioni che svolgono attività ludiche nell'interesse della popolazione anziana. I gruppi verranno seguiti da musicisti esperti.
Il progetto necessiterà di un'approvazione da parte dei comitati etici delle Università coinvolte e il permesso dei centri anziani o delle associazioni. I partecipanti verranno invitati a rispondere ad un questionario anonimo e prendere parte a delle interviste di gruppo.

Ricercatori italiani ed inglesi si sono uniti per rispondere a questa domanda con l'aiuto della popolazione anziana di Roma.

Nei prossimi due anni verranno creati gruppi di canto composti da persone anziane per valutarne gli effetti sulla qualità della vita percepita.

Il progetto è ispirato al lavoro dell'associazione inglese 'Sing For Your Life', la quale organizza e gestisce i c.d. 'Silver Song Clubs' (gruppi di canto d'argento).

Partners nel progetto

THE SIDNEY DE HAAN RESEARCH CENTRE FOR ARTS AND HEALTH (SIDNEY DE HAAN CENTRO DI RICERCA PER L'ARTE E LA SALUTE)

Il centro fa parte della Canterbury Christ Church University nel Regno Unito. Il Centro ha valutato l'impatto che l'esperienza dei Silver Song Club ha sui partecipanti, i risultati prodotti fin'ora da queste ricerche dimostrano che la partecipazione a gruppi di canto ha sostanziali benefici sul benessere e sulla qualità della vita degli anziani. In questo momento il Centro di ricerca è impegnato in uno studio randomizzato (randomised trial) sui partecipanti ai Silver Song Club finanziato dal Centro Nazionale delle ricerche del Regno Unito. Per dettagli vedere:
http://www.canterbury.ac.uk/centres/sidney-de-haan-research/index.asp

AREA INFERMIERISTICA - DIPARTIMENTO DI SCIENZE DI SANITÀ PUBBLICA

L'area nursing del Dipartimento di Scienze di Sanità pubblica della "Sapienza" Università di Roma è il partner scientifico italiano del progetto finanziato dall'Unione Europea "Health pro elderly". Il progetto identifica le linee guida per "best practice in health promotion" per la popolazione anziana in tutta Europa. Per dettagli vedere:
http://www.healthproelderly.com/hpe_partner_university_rome.php

SING FOR YOUR LIFE

E' un'associazione inglese che gestisce un network di più di 40 'Silver Song Clubs' su tutto il territorio del Sud est dell'Inghilterra. Questi gruppi coinvolgono persone dai 60 anni in su, alcuni partecipanti hanno problemi di salute correlati alla loro età, come ad esempio la demenza. I gruppi sono diretti da musicisti esperti. Per dettagli vedere:
http://www.singforyourlife.org.uk

Il gruppo di ricerca

DOTTORESSA ELISABETTA CORVO

Elisabetta Corvo è laureata in giurisprudenza, presso l'università di Milano - Bicocca con una tesi in sociologia del diritto, ha inoltre conseguito un Masters Degree in Health Promotion and Public Health presso la Canterbury Christ Church University. Ha svolto per molti anni l'attività di volontaria sia per una pubblica assistenza milanese (Croce Verde) che aiutando ragazzi ed adulti affetti dalla sindrome di Down. Impegnata professionalmente in differenti contesti, recentemente ha lavorato per una cooperativa sociale romana come progettista.

PROFESSORESSA JULITA SANSONI

Julita Sansoni è professoressa della "Sapienza" Università di Roma e lavora presso l'area infermieristica del Dipartimento di Scienze di Sanità Pubblica della stessa Università. Ha un background infermieristico ed è laureata in Pedagogia oltre che aver seguito una formazione in counseling. La professoressa Sansoni è coordinatrice italiana del progetto "Health pro elderly" dell'Unione Europea, rappresenta gli infermieri italiani nella Federazione europea degli Infermieri (EFN) ed è componente del Board del Consiglio Internazionale degli Infermieri (ICN).

PROFESSOR STEPHEN CLIFT

Stephen Clift è professore di Educazione alla salute nella facoltà di Sanità Pubblica e Assistenza sociale della Canterbury Christ Church University, egli è inoltre Direttore della ricerca scientifica presso il Sidney De Haan Research Centre for Arts and Health (Sidney de Haan centro di ricerche per l'arte e la salute). Il professor Clift è impegnato e lavora nel settore della promozione della salute e della sanità pubblica da più di 25 anni

Per maggiori dettagli

Dottoressa Elisabetta Corvo
canzonidargento@libero.it

Appendix 8

Part A Post Pilot Session Questionnaire

Parte A – Questionario post sessione

Età	Sesso	Con chi vive?	Fino a che età ha studiato
60-64	M – F	Da solo/a	Fino 10 aa
65-69		Con il partner	Fino 14 aa
70-74		Con i figli	Fino 18 aa
75-79		Altro	Fino 25 aa
80-84			
85-90			
90-95			
95+			

1) Si è divertito oggi? **(da 1=no a 5=molto)**

   1------2------3------4------5

2) Quale aspetto le è piaciuto di più?

   Cantare

   Ascoltare la musica

   Stare con gli altri

   Tutti

   Altro

   .....

3) Come si è sentito durante la sessione? (può aggiungere altri stati d'animo se lo desidera)

   Ero Contento

   Ero Sereno

   Ero Malinconico

Ero Coinvolto

Ero Annoiato

Ero Felice

Ero Stressato

.....

4) Come si è sentito alla fine della sessione?

Ero contento

Ero dispiaciuto perché la sessione era finita

Di aver fatto qualcosa di bello e importante

Altro

.....

5) Pensa che cantare sia piacevole? **(da 1=no a 5=molto)**

1------2------3------4------5

6) Le canzoni scelte andavano bene? **(da 1=no a 5=molto)**

1------2------3------4------5

7) Che canzoni le piacerebbe cantare?

Canzoni italiane

Canzoni romanesche

Opera

Canzoni internazionali

Altro……

8) Scriva una canzone che le piacerebbe cantare

……

9) Se ci fosse la possibilità lei parteciperebbe ad un'attività come questa?
(da 1=no a 5=molto)

1------2------3------4------5

Appendix 9

Pre-Coded Schedule

Canterbury Christ Church University

Prima Facoltà di Medicina e Chirurgia
Sapienza Università di Roma

Pre-Coded Schedule

Age concern	
Municipio	
Number of Participants	
Programme	
Start of the session	
Break	
Re-start	
End of the session	

- SONG TITLE	
100% PARTICIPATION	
75% PARTICIPATION	
50% PARTICIPATION	
LESS THAN 50% PARTICIPATION	
ATTENTION	
NO ATTENTION	
SMILES	
COMMENTS - CHATTING	
NO SMILES OR LAUGHTER	
- SONG TITLE	
100% PARTICIPATION	
75% PARTICIPATION	
50% PARTICIPATION	
LESS THAN 50% PARTICIPATION	
ATTENTION	
NO ATTENTION	
SMILES	
COMMENTS - CHATTING	
NO SMILES OR LAUGHTER	

Appendix 10

Baseline Questionnaire

Canterbury Christ Church University

Prima Facoltà di Medicina e Chirurgia
Sapienza Università di Roma

QUESTIONARIO
"CANZONI D'ARGENTO"

CODICE

Iniziale del proprio nome di battesimo	Iniziale del cognome della mamma prima di sposarsi	Giorno del compleanno

Oppure

Nome e Cognome

I dati personali verranno cancellati

SEGNARE CON UNA CROCETTA (☒ COSÌ) UNA SOLA CASELLA DI CIASCUN GRUPPO.

ETÀ

60-65	❑
65-69	❑
75-79	❑
70-74	❑
80-84	❑
85-90	❑
90-95	❑
95+	❑

Sesso

M	❑	F	❑

Con chi vive?

Da solo/a	❑	Con i figli	❑
Altro	❑	Con il partner	❑

Fino a quale età ha studiato?

Fino a 10 aa	❑
Fino a 14 aa	❑
Fino a 18 aa	❑
Fino a 25 aa	❑

Indicare quale delle seguenti affermazioni descrive meglio il suo stato di salute oggi, segnando con una crocetta (☒ così) una sola casella di ciascun gruppo.

Capacità di Movimento

Non ho difficoltà nel camminare ❑
Ho qualche difficoltà nel camminare ❑
Sono costretto/a a letto ❑

Cura della Persona

Non ho difficoltà nel prendermi cura di me stesso ❑
Ho qualche difficoltà nel lavarmi o vestirmi ❑
Non sono in grado di lavarmi o vestirmi ❑

Attività Abituali *(per es. lavoro, studio, lavori domestici, attività familiari o di svago)*

Non ho difficoltà nello svolgimento delle attività abituali ❑
Ho qualche difficoltà nello svolgimento delle attività abituali ❑
Non sono in grado di svolgere le mie attività abituali ❑

Dolore o Fastidio

Non provo alcun dolore o fastidio ❑
Provo dolore o fastidio moderati ❑
Provo estremo dolore o fastidio ❑

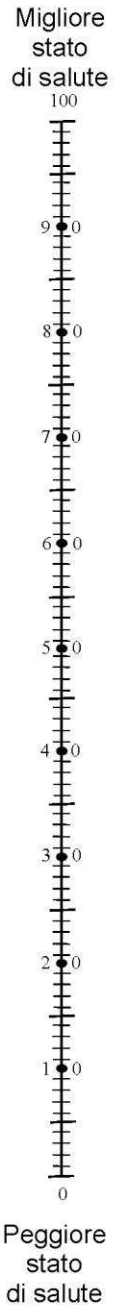
Ansia o Depressione

Non sono ansioso o depresso ❑
Sono moderatamente ansioso o depresso ❑
Sono estremamente ansioso o depresso ❑

Per aiutarla ad esprimere il suo stato di salute attuale, abbiamo disegnato una scala graduata (simile ad un termometro) sulla quale il migliore stato di salute immaginabile è contrassegnato dal numero 100 ed il peggiore dallo 0.

Vorremmo che indicasse su questa scala quale è, secondo lei, il livello del suo stato di salute oggi, tracciando una linea dal riquadro sottostante fino al punto che corrisponde al suo stato attuale di salute.

Il suo stato di salute oggi



Questa sezione intende valutare cosa Lei pensa della sua salute. Le informazioni raccolte permetteranno di essere sempre aggiornati su come si sentea svolgere le sue attività consuete.

Risponda ad ogni domanda del questionario indicando la Sua risposta come mostrato di volta in volta, se non si sente certo, effettui la scelta che comunque le sembra la migliore.

1. **In generale** direbbe che la sua salute è:

Eccellente	Molto Buona	Buona	Passabile	Scadente
☐	☐	☐	☐	☐

2. La sua salute La limita **attualmente** nello svolgimento di attività di moderato impegno fisico (come spostare un tavolo, usare l'aspirapolvere,giocare a bocce, o fare un giro in bicicletta, ecc)?

Si, mi limita Parecchio	Si, mi limita parzialmente	No, non mi limita per nulla
☐	☐	☐

3. La sua salute La limita **attualmente** nel salire qualche piano di scale?

Si, mi limita parecchio	Si, mi limita parzialmente	No, non mi limita per nulla
☐	☐	☐

4. **Nelle ultime 4 settimane** ha reso meno di quanto avrebbe voluto sul suo lavoro o nelle altre attività quotidiane, a causa della sua salute fisica?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
☐	☐	☐	☐	☐

5. **Nelle ultime 4 settimane** ha dovuto limitare alcuni tipi di lavoro o di alter attività a causa della sua salute fisica?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
☐	☐	☐	☐	☐

6. **Nelle ultime 4 settimane** ha reso meno di quanto avrebbe voluto sul suo lavoro o nelle altre attività quotidiane, a causa del suo stato emotivo? (quale sentirsi depresso o ansioso)?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

7. **Nelle ultime 4 settimane**, ha avuto un calo di concentrazione sul lavoro o nelle alter attività quotidiane, a causa del suo stato emotive? (quale sentirsi depresso o ansioso)?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

8. **Nelle ultime 4 settimane,** in che misura il dolore l'ha ostacolata nel lavoro che svolge abitualmente?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

9. Questa domanda si riferisce a come si è sentito nelle ultime 4 settimane. Risponda scegliendo la risposta che più si avvicina al Suo caso. Per quanto tempo **nelle ultime 4 settimane** si è sentito calmo e sereno?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

10. Questa domanda si riferisce a come si è sentito nelle ultime 4 settimane. Risponda scegliendo la risposta che più si avvicina al Suo caso. Per quanto tempo **nelle ultime 4 settimane** si è sentito pieno di energie?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

11. Questa domanda si riferisce a come si è sentito nelle ultime 4 settimane. Risponda scegliendo la risposta che più si avvicina al Suo caso. Per quanto tempo **nelle ultime 4 settimane** si è sentito scoraggiato e triste?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

12. **Nelle ultime 4 settimane**, per quanto tempo la Sua salute fisica o il suo stato emotive hanno interferito nelle sue attività sociali, in famiglia, con gli amici?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

Appendix 11

End of Singing Questionnaire

Canterbury Christ Church University

Prima Facoltà di Medicina e Chirurgia
Sapienza Università di Roma

QUESTIONARIO

"CANZONI D'ARGENTO"

CODICE

Iniziale del proprio nome di battesimo	Iniziale del cognome della mamma prima di sposarsi	Giorno del compleanno

Oppure

Nome e Cognome

I dati personali verranno cancellati

SEGNARE CON UNA CROCETTA (☒ COSÌ) UNA SOLA CASELLA DI CIASCUN GRUPPO.

ETÀ

60-65	❑
65-69	❑
75-79	❑
70-74	❑
80-84	❑
85-90	❑
90-95	❑
95+	❑

Sesso

M	❑	F	❑

Con chi vive?

Da solo/a	❑	Con i figli	❑
Altro	❑	Con il partner	❑

Fino a quale età ha studiato?

Fino a 10 aa	❑
Fino a 14 aa	❑
Fino a 18 aa	❑
Fino a 25 aa	❑

Indicare quale delle seguenti affermazioni descrive meglio il suo stato di salute oggi, segnando con una crocetta (☒ così) una sola casella di ciascun gruppo.

Capacità di Movimento

Non ho difficoltà nel camminare ❑
Ho qualche difficoltà nel camminare ❑
Sono costretto/a a letto ❑

Cura della Persona

Non ho difficoltà nel prendermi cura di me stesso ❑
Ho qualche difficoltà nel lavarmi o vestirmi ❑
Non sono in grado di lavarmi o vestirmi ❑

Attività Abituali *(per es. lavoro, studio, lavori domestici, attività familiari o di svago)*

Non ho difficoltà nello svolgimento delle attività abituali ❑
Ho qualche difficoltà nello svolgimento delle attività abituali ❑
Non sono in grado di svolgere le mie attività abituali ❑

Dolore o Fastidio

Non provo alcun dolore o fastidio ❑
Provo dolore o fastidio moderati ❑
Provo estremo dolore o fastidio ❑

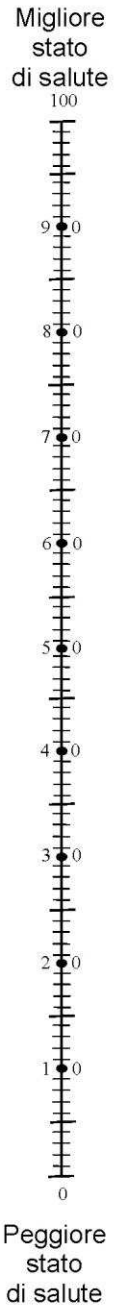
Ansia o Depressione

Non sono ansioso o depresso ❑
Sono moderatamente ansioso o depresso ❑
Sono estremamente ansioso o depresso ❑

Per aiutarla ad esprimere il suo stato di salute attuale, abbiamo disegnato una scala graduata (simile ad un termometro) sulla quale il migliore stato di salute immaginabile è contrassegnato dal numero 100 ed il peggiore dallo 0.

Vorremmo che indicasse su questa scala quale è, secondo lei, il livello del suo stato di salute oggi, tracciando una linea dal riquadro sottostante fino al punto che corrisponde al suo stato attuale di salute.

Il suo stato di salute oggi



Questa sezione intende valutare cosa Lei pensa della sua salute. Le informazioni raccolte permetteranno di essere sempre aggiornati su come si sentea svolgere le sue attività consuete.

Risponda ad ogni domanda del questionario indicando la Sua risposta come mostrato di volta in volta, se non si sente certo, effettui la scelta che comunque le sembra la migliore.

1. **In generale** direbbe che la sua salute è:

Eccellente	Molto Buona	Buona	Passabile	Scadente
☐	☐	☐	☐	☐

2. La sua salute La limita **attualmente** nello svolgimento di attività di moderato impegno fisico (come spostare un tavolo, usare l'aspirapolvere,giocare a bocce, o fare un giro in bicicletta, ecc)?

Si, mi limita parecchio	Si, mi limita parzialmente	No, non mi limita per nulla
☐	☐	☐

3. La sua salute La limita **attualmente** nel salire qualche piano di scale?

Si, mi limita parecchio	Si, mi limita parzialmente	No, non mi limita per nulla
☐	☐	☐

4. **Nelle ultime 4 settimane** ha reso meno di quanto avrebbe voluto sul suo lavoro o nelle altre attività quotidiane, a causa della sua salute fisica?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
☐	☐	☐	☐	☐

5. **Nelle ultime 4 settimane** ha dovuto limitare alcuni tipi di lavoro o di alter attività a causa della sua salute fisica?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
☐	☐	☐	☐	☐

6. **Nelle ultime 4 settimane** ha reso meno di quanto avrebbe voluto sul suo lavoro o nelle altre attività quotidiane, a causa del suo stato emotivo? (quale sentirsi depresso o ansioso)?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

7. **Nelle ultime 4 settimane**, ha avuto un calo di concentrazione sul lavoro o nelle alter attività quotidiane, a causa del suo stato emotive? (quale sentirsi depresso o ansioso)?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

8. **Nelle ultime 4 settimane,** in che misura il dolore l'ha ostacolata nel lavoro che svolge abitualmente?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

9. Questa domanda si riferisce a come si è sentito nelle ultime 4 settimane. Risponda scegliendo la risposta che più si avvicina al Suo caso. Per quanto tempo **nelle ultime 4 settimane** si è sentito calmo e sereno?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

10. Questa domanda si riferisce a come si è sentito nelle ultime 4 settimane. Risponda scegliendo la risposta che più si avvicina al Suo caso. Per quanto tempo **nelle ultime 4 settimane** si è sentito pieno di energie?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

11. Questa domanda si riferisce a come si è sentito nelle ultime 4 settimane. Risponda scegliendo la risposta che più si avvicina al Suo

caso. Per quanto tempo **nelle ultime 4 settimane** si è sentito scoraggiato e triste?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

12. **Nelle ultime 4 settimane**, per quanto tempo la Sua salute fisica o il suo stato emotive hanno interferito nelle sue attività sociali, in famiglia, con gli amici?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

1) Durante questa esperienza si è divertito? (da 1=no a 5=molto)

1------2------3------4------5

2) Quale aspetto le è piaciuto di più?

Cantare ❑

Ascoltare la musica ❑

Stare con gli altri ❑

Tutti i sopra indicati ❑

Altro ❑

.....

.....

3) Come si è sentito durante l'esperienza? (può aggiungere altri stati d'animo se lo desidera)

Ero Contento ❑

Ero Sereno ❑

Ero Malinconico ❑

Ero Coinvolto ❑

Ero Annoiato ❑

Ero Felice ❑

Ero Stressato ❑

.....

.....

4) Come si è sentito alla fine della esperienza?

Ero contento ❑

Ero dispiaciuto perché era finita ❑

Di aver fatto qualcosa di bello e importante ❑

Altro

.....

.....

5) Pensa che cantare sia piacevole? (da 1=no a 5=molto)

1------2------3------4------5

6) Cosa migliorerebbe di questa esperienza?

.....
.....
.....
.....

7) Se ci fosse la possibilità lei parteciperebbe ancora ad un'attività come questa?
(da 1=no a 5=molto)

1------2------3------4------5

Ha qualche altra osservazione da aggiungere rispetto alla sua salute ed alla partecipazione a questo progetto?

.....
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Appendix 12

Follow Up Questionnaire

Canterbury Christ Church University

Prima Facoltà di Medicina e Chirurgia
Sapienza Università di Roma

QUESTIONARIO
"CANZONI D'ARGENTO"

CODICE

Iniziale del proprio nome di battesimo	Iniziale del cognome della mamma prima di sposarsi	Giorno del compleanno

Oppure

Nome e Cognome

I dati personali verranno cancellati

SEGNARE CON UNA CROCETTA (☒ COSÌ) UNA SOLA CASELLA DI CIASCUN GRUPPO.

ETÀ

60-65	❑
65-69	❑
75-79	❑
70-74	❑
80-84	❑
85-90	❑
90-95	❑
95+	❑

Sesso

M	❑	F	❑

Con chi vive?

Da solo/a	❑	Con i figli	❑
Altro	❑	Con il partner	❑

Fino a quale età ha studiato?

Fino a 10 aa	❑
Fino a 14 aa	❑
Fino a 18 aa	❑
Fino a 25 aa	❑

Indicare quale delle seguenti affermazioni descrive meglio il suo stato di salute oggi, segnando con una crocetta (☒ così) una sola casella di ciascun gruppo.

Capacità di Movimento

Non ho difficoltà nel camminare ❑
Ho qualche difficoltà nel camminare ❑
Sono costretto/a a letto ❑

Cura della Persona

Non ho difficoltà nel prendermi cura di me stesso ❑
Ho qualche difficoltà nel lavarmi o vestirmi ❑
Non sono in grado di lavarmi o vestirmi ❑

Attività Abituali *(per es. lavoro, studio, lavori domestici, attività familiari o di svago)*

Non ho difficoltà nello svolgimento delle attività abituali ❑
Ho qualche difficoltà nello svolgimento delle attività abituali ❑
Non sono in grado di svolgere le mie attività abituali ❑

Dolore o Fastidio

Non provo alcun dolore o fastidio ❑
Provo dolore o fastidio moderati ❑
Provo estremo dolore o fastidio ❑

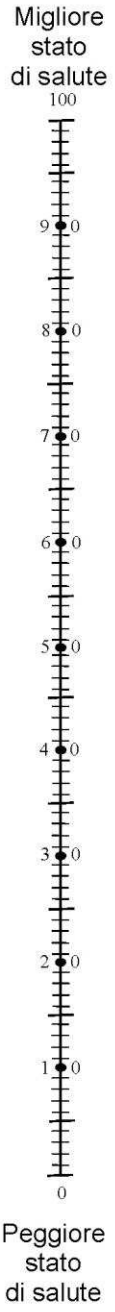
Ansia o Depressione

Non sono ansioso o depresso ❑
Sono moderatamente ansioso o depresso ❑
Sono estremamente ansioso o depresso ❑

Per aiutarla ad esprimere il suo stato di salute attuale, abbiamo disegnato una scala graduata (simile ad un termometro) sulla quale il migliore stato di salute immaginabile è contrassegnato dal numero 100 ed il peggiore dallo 0.

Vorremmo che indicasse su questa scala quale è, secondo lei, il livello del suo stato di salute oggi, tracciando una linea dal riquadro sottostante fino al punto che corrisponde al suo stato attuale di salute.

Il suo stato di salute oggi



Questa sezione intende valutare cosa Lei pensa della sua salute. Le informazioni raccolte permetteranno di essere sempre aggiornati su come si sentea svolgere le sue attività consuete.

Risponda ad ogni domanda del questionario indicando la Sua risposta come mostrato di volta in volta, se non si sente certo, effettui la scelta che comunque le sembra la migliore.

1. **In generale** direbbe che la sua salute è:

Excellente	Molto Buona	Buona	Passabile	Scadente
☐	☐	☐	☐	☐

2. La sua salute La limita **attualmente** nello svolgimento di attività di moderato impegno fisico (come spostare un tavolo, usare l'aspirapolvere,giocare a bocce, o fare un giro in bicicletta, ecc)?

Si, mi limita parecchio	Si, mi limita parzialmente	No, non mi limita per nulla
☐	☐	☐

3. La sua salute La limita **attualmente** nel salire qualche piano di scale?

Si, mi limita parecchio	Si, mi limita parzialmente	No, non mi limita per nulla
☐	☐	☐

4. **Nelle ultime 4 settimane** ha reso meno di quanto avrebbe voluto sul suo lavoro o nelle altre attività quotidiane, a causa della sua salute fisica?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
☐	☐	☐	☐	☐

5. **Nelle ultime 4 settimane** ha dovuto limitare alcuni tipi di lavoro o di alter attività a causa della sua salute fisica?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
☐	☐	☐	☐	☐

6. **Nelle ultime 4 settimane** ha reso meno di quanto avrebbe voluto sul suo lavoro o nelle altre attività quotidiane, a causa del suo stato emotivo? (quale sentirsi depresso o ansioso)?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

7. **Nelle ultime 4 settimane**, ha avuto un calo di concentrazione sul lavoro o nelle alter attività quotidiane, a causa del suo stato emotive? (quale sentirsi depresso o ansioso)?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

8. **Nelle ultime 4 settimane,** in che misura il dolore l'ha ostacolata nel lavoro che svolge abitualmente?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

9. Questa domanda si riferisce a come si è sentito nelle ultime 4 settimane. Risponda scegliendo la risposta che più si avvicina al Suo caso. Per quanto tempo **nelle ultime 4 settimane** si è sentito calmo e sereno?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

10. Questa domanda si riferisce a come si è sentito nelle ultime 4 settimane. Risponda scegliendo la risposta che più si avvicina al Suo caso. Per quanto tempo **nelle ultime 4 settimane** si è sentito pieno di energie?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

11. Questa domanda si riferisce a come si è sentito nelle ultime 4 settimane. Risponda scegliendo la risposta che più si avvicina al Suo caso. Per quanto tempo **nelle ultime 4 settimane** si è sentito scoraggiato e triste?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

12. **Nelle ultime 4 settimane**, per quanto tempo la Sua salute fisica o il suo stato emotive hanno interferito nelle sue attività sociali, in famiglia, con gli amici?

Sempre	Quasi sempre	Una parte del tempo	Quasi mai	Mai
□	□	□	□	□

Appendix 13

Centro Anziani President's Agreement

Roma, 10 Ottobre 2011

Con la presente dichiaro in qualità di **Presidente del Centro Anziani** sito in Via Sabotino 7 in Roma, all'interno del territorio del Municipio XVII, di aver acconsentito allo svolgimento delle 12 sessioni musicali che fanno parte del progetto di ricerca "**"Esplorazione sulla fattibilità applicativa di un modello inglese di promozione della salute basato sulla partecipazione a gruppi di canto per persone ultrasessantenni in Italia"** portato avanti dalla Dottoressa Elisabetta Corvo della Canterbury Christ Church University in *partnership* con la Sapienza Università di Roma.

Le sessioni avranno inizio in data odierna (10 ottobre) e proseguiranno per circa 12 settimane, coinvolgeranno parte degli iscritti a questo Centro Anziani. La dottoressa Elisabetta Corvo ha spiegato a me personalmente, esaustivamente, tutti gli aspetti della ricerca ed in particolare l' utilizzo di questionari, all'inizio, alla fine e a tre mesi dell'esperienza.

In fede

Teresa Maccari

Roma, 11 Ottobre 2011

Con la presente dichiaro in qualità di **Presidente del Centro Anziani** "Teresa Frassinelli" in Roma, all'interno del territorio del Municipio VI, di aver acconsentito allo svolgimento delle 12 sessioni musicali che fanno parte del progetto di ricerca **"Esplorazione sulla fattibilità applicativa di un modello inglese di promozione della salute basato sulla partecipazione a gruppi di canto per persone ultrasessantenni in Italia"** portato avanti dalla Dottoressa Elisabetta Corvo della Canterbury Christ Church University in *partnership* con la Sapienza Università di Roma.

Le sessioni avranno inizio in data odierna (11 ottobre) e proseguiranno per circa 12 settimane, coinvolgeranno parte degli iscritti a questo Centro Anziani. La dottoressa Elisabetta Corvo ha spiegato a me personalmente, esaustivamente, tutti gli aspetti della ricerca ed in particolare l'utilizzo di questionari, all'inizio, alla fine e a tre mesi dell'esperienza.

In fede

Remo Ponzo

.viaTerninove.
Centro Servizi
per l'orientamento
e il benessere del
Cittadino Anziano

Roma, 25 Gennaio 2012

Con la presente dichiaro in qualità di responsabile del Centro Servizi *viaTerni9* sito in Via Terni 9 in Roma, gestito in convenzione con il Municipio 9 di Roma Capitale dalla Cooperativa Sociale META onlus, di aver acconsentito allo svolgimento delle 12 sessioni musicali che fanno parte del progetto di ricerca **"Esplorazione sulla fattibilità applicativa di un modello inglese di promozione della salute basato sulla partecipazione a gruppi di canto per persone ultrasessantenni in Italia"** portato avanti dalla Dottoressa Elisabetta Corvo della Canterbury Christ Church University in *partnership* con la Sapienza Università di Roma.

Le sessioni avranno inizio in data odierna e proseguiranno per circa 12 settimane, vedranno la partecipazione degli anziani coinvolti nel progetto "Centro dei servizi per l'orientamento e il benessere del cittadino anziano *viaTerninove*". La dottoressa Elisabetta Corvo ha illustrato a me personalmente, esaustivamente, tutti gli aspetti della ricerca ed in particolare l'utilizzo di questionari, all'inizio, alla fine e a tre mesi dell'esperienza.

In fede

Dottoressa Carla Malatesta

Appendix 14

Songs book

Canzoni d'argento

-Testi -

ARRIVEDERCI ROMA

T'invidio, turista
che arrivi, t'imbevi
de Fori e de scavi,
poi tutto d'un colpo
te trovi Fontana de
Trevi tutta per te!
Ce sta 'na leggenda
romana legata a
'ata vecchia fontana
per cui se ce butti un
soldino costringi il
destino a fatte torna'.
E mentre er . soldo bacia er
fontanone la tua
canzone in fondo e'
questa qua!
Arrivederci, Roma...
good bye...
au revoir...
Si ritrova a pranzo a
Squarciarelli
fettuccine e vino dei
Castelli come ai tempi
belli che
Pinelli immortalo'!
Arrivederci Roma...
good bye...
au revoir...
Si rivede a spasso in
carrozzella e ripensa a
quella "ciumachella"
ch'era tanto bella e
che gli ha detto
sempre "no!"
Stasera la vecchia
fontana racconta alla
solita luna la storia
vicina e lontana di
quella inglesina col
naso all'insu'.
Io proprio qui
l'ho incontrata e qui,
proprio qui l'ho
baciata. Lei qui con la
voce smarrita m'ha
detto: "E' finita,
ritorno lassu'!"
Ma prima di partire
l'inglesina butto' la
monetina e sussurro':
Arrivederci Roma...
good bye...
au revoir...
Voglio ritornar a via
Margutta, voglio
rivedere la soffitta
dove m'hai tenuta
stretta stretta in
braccio a te!
Arrivederci Roma...
Non so scordarti piu'...
Porto in Inghilterra i
tuoi tramonti, porto a
Londra Trinita' dei Monti
porto nel mio cuore i
giuramenti e
gli "I love you!"
Arrivederci Roma!

CHITARRA ROMANA

Sotto un manto di stelle
Roma bella mi appare,
solitario il mio cuor disilluso
d'amor.
vuol nell'ombra cantar

Una muta fontana
e un balcone lassù,
o chitarra romana
accompagnami tu.

Suona suona mia chitarra
lascia piangere il mio cuore,
senza casa e senza amore
mi rimani solo tu.

Se la voce è un po' velata
accompagnami in sordina,
la mia bella fornarina
al balcone non c'è più.
Lungotevere dorme
mentre il fiume cammina,
io lo seguo perchè mi
trascina con sè
e travolge il mio cuor.

Vedo un ombra lontana
e una stella lassù,
o chitarra romana
accompagnami tu.

Se la voce è un pò velata
accompagnami in sordina,
la mia bella fornarina
al balcone non c'è più.

O chitarra romana
accompagnami tu

FUNICOLI' FUNICOLA'

Aieressera, Nanninè, me ne sagliette,
tu saie addó? Addó 'stu core 'ngrato cchiù dispiette farme nun pò! Addó lo fuoco coce, ma si fuje te lassa stà! E nun te corre appriesso, nun te struje, 'ncielo a guardà!...Jammo, jammo,
'ncoppa, jammo ja', funiculì, funiculà!

Ne'... jammo da la terra a la montagna!
no passo nc'e'! Se vede Francia, Proceta e la Spagna... Io veco a tte!
Tirate co la fune, ditto 'nfatto, 'ncielo se va.
Se va comm' a lu viento a l'intrasatto, gue', saglie sa'! Jammo, jammo 'ncoppa, jammo ja',
funiculì, funiculà!

Se n'è sagliuta, oi Nè, se n'è sagliuta
la capa già! È gghiuta, po' è turnata, po' è venuta... sta sempe 'ccà!
La capa vota, vota, attuorno, attuorno,
attuorno a tte! Sto core canta sempe nu taluorno
Sposammo, oi Nè! Jammo 'ncoppa, jammo ja',
funiculì, funiculà

MA L'AMORE NO

Guardando le rose
sfiorite stamani io penso:
domani saranno appassite
E tutte le cose son come le rose
che vivono un giorno un'ora e non più!
Ma l'amore, no
L'amore mio non può
disperdersi nel vento, con le rose
Tanto è forte che non cederà
non sfiorirà
Io lo veglierò
io lo difenderò
da tutte quelle insidie velenose
che vorrebbero strapparlo al cuor,
povero amor!
Forse te ne andrai
d'altre donne le carezze cercherai!
ahimè
e se tornerai
già sfiorita ogni bellezza troverai
in me
Ma l'amore no
L'amore mio non può
dissolversi con l'oro dei capelli.
Fin ch'io vivo sarà vivo in me,
solo per te

NEL BLU DIPINTO DI BLU

Penso che un sogno cosi
Non ritorni mai piu'
Mi dipingevo le mani e la
faccia di blu
Poi d'improvviso venivo dal
vento rapito
E incominciavo a volare nel
cielo infinito
Volare oh oh
Cantare oh oh oh oh
Nel blu dipinto di blu
Felice di stare lassu'
E volavo volavo felice
Piu' in alto del sole ed
ancora piu'su
Mentre il mondo pian piano
Spariva lontano laggiu'
Una musica dolce suonava
soltanto per me
Volare oh oh
Cantare oh oh oh oh
Nel blu dipinto di blu
Felice di stare lassu'
Ma tutti i sogni nell'alba
svaniscon perche'
Quando tramonta la luna li
porta con se
Ma io continuo a sognare
Negli occhi tuoi belli
Che sono blu come un cielo
Trapunto di stelle
Volare oh oh
Cantare oh oh oh oh
Nel blu degli occhi tuoi blu
Felice di stare quaggiu'
E continuo a volare felice
Piu' in alto del sole ed
ancora piu'su
Mentre il mondo pian piano
scompare
Negli occhi tuoi blu
La tua voce e una musica
Dolce che suona per me
Volare oh oh
Cantare oh oh oh oh
Nel blu degli occhi tuoi blu
Felice di stare quaggiu'
Nel blu degli occhi tuoi blu
Felice di stare quaggiu'
Con te
Con te

PARLAMI D'AMORE MARIU'

Come sei bella, più bella stasera Mariù
Splende un sorriso di stella, negli occhi tuoi blu
Anche se avverso il destino, domani sarà,
oggi ti sono vicino perché sospirar, non pensar
Parlami d'amore Mariù
Tutta la mia vita sei tu
Gli occhi tuoi belli, brillano
Fiamme di sogno, scintillano

Dimmi che illusione, non è
Dimme che sei tutta per me
Qui sul tuo cuor non soffro più,
Parlami d'amore Mariù

Occhio una in maliarda sirena sei tu
sò che si perde gli sguardi,
quegli occhi tuoi blu
Ma che mi importa se il mondo si burla di me,
meglio nel gorgo profondo
ma sempre con te,
si con te

ROMA NUN FA' LA STUPIDA STASERA

Roma nun fa' la stupida stasera
damme na mano a faie di de si
scegli tutte le stelle piu' brillarelle
che c'hai e un friccico de luna
tutta pe noi
faje senti' ch'e' quasi primavera
manna li mejo grilli pe fa' cri cri
prestame er ponentino
piu' malandrino che c'hai
roma reggeme er moccolo stasera
roma nun fa' la stupida stasera
damme na mano a famme di' de no
spegni tutte le stelle
piu' brillarelle che c'hai
nasconneme la luna se no so guai
famme scorda' ch'e' quasi primavera
tiemme na mano in testa pe' di de no
smorza quer venticello
stuzzicarello che c'hai
roma nun fa' la stupida stasera

SORA MENICA

A Roma a Roma belle le romane
ma so' più belle le trasteverine
l'arubbacori so' le monticiane
l'arubbacori so' le monticiane

Sora Menica Sora Menica
oggi è domenica. Lassece stà.

Semo trasteverine e nun tremamo
Paura nun avemo de nisuno
c'avemo bona lingua e mejo mano
c'avemo bona lingua e mejo mano.
Sora Menica Sora Menica
oggi è domenica. Lassece stà.

Sete la banderola de Castello
avete dato er core a questo e quello
'na botta ve cercate de cortello
'na botta ve cercate de cortello

Sora Menica Sora Menica
oggi è domenica. Lassece stà.
Er core mio l'ho dato a chi me pare
l'anno tenuto tutti come 'n fiore
er vostro s'è appassito ner cantone
er vostro s'è appassito ner cantone
Sora Menica Sora Menica
oggi è domenica. Lasceme stà.

TANTO PE' CANTA'

'Pe fà la vita meno amara,
me sò comprato 'sta chitara,
e quanno er sole scenne e more
me sento 'n'core cantatore,
la voce è poca ma intonata,
nun serve a fà 'na serenata,
ma serve solo 'a fà in maniera,
de farme 'nsonno a primma sera.

Tanto 'pe cantà
pecchè me sento 'n' friccico ner core,
tanto 'pe sognà
perchè ner petto me ce naschi 'n' fiore,
fiore de lillà
che m'ariporti verso er primo amore
che sospirava alle canzoni mie
e m'arintontoniva de bucie.

Canzoni belle e appassionate,
che Roma mia m'aricordate,
cantate solo 'pe dispetto
ma 'cò 'na smania dentro ar petto,
io nun ve canto a voce piena
ma tutta l'anima è serena,
e quanno er cielo se scolora
de me nessuna se innamora.

Tanto 'pe cantà
pecchè me sento 'n' friccico ner core,
tanto 'pe sognà
perchè ner petto me ce naschi 'n' fiore,
fiore de lillà
che m'ariporti verso er primo amore
che sospirava alle canzoni mie
e m'arintontoniva de bucie.

VECCHIA ROMA

venticello, venticello de roma
venticello profumato de sole e d'amor
se la sera, l'aventino te chiama
je' risponni dar giannicolo in fior.
mentre in cielo mille stelle brilleno

diecimila bocche gia' se cercheno
tu le sfiori e ja' rigali'n brivido
e nell'oscurita'

tu sfarfalli pe' le strade de roma,
venticello che ci aiuti a sogna'.

Finalino

Chi te po' mai scorda'

Venticello de Roma

VA PENSIERO

Va, pensiero, sull'ali dorate;
Va, ti posa sui clivi, sui colli,
Ove olezzano tepide e molli
L'aure dolci del suolo natal!

Del Giordano le rive saluta,
Di Sionne le torri atterrate...
Oh mia patria si bella e perduta!
O membranza sì cara e fatal!

Arpa d'or dei fatidici vati,
Perché muta dal salice pendi?
Le memorie nel petto raccendi,
Ci favella del tempo che fu!

O simile di Solima ai fati
Traggi un suono di crudo lamento,
O t'ispiri il Signore un concento
Che ne infonda al patire virtù!

VECCHIO FRAC

E' giunta mezzanotte
si spengono i rumori
si spegne anche l'insegna
di quel'ultimo caffè
le strade son deserte
desterte e silenzione,
un'ultima carrozza
cigolando se ne và.
Il fiume scorre lento
frusciando sotto i ponti
la luna splende in cielo
dorme tutta la città
solo và un uomo in frac.

Ha il cilindro per cappello
due diamanti per gemelli
un bastone di cristallo
la gardenia nell'occhiello
e sul candido gilet
un papillon,
un papillon di seta blu
s'avvicina lentamente
con incedere elegante
ha l'aspetto trasognato
malinconico ed assente
non si sa da dove vien
ne dove và
chi mai sarà
quel'uomo in frac.
bonne nuite bonne nuite
bonne nuite bonne nuite
Buona notte

va dicendo ad ogni cosa
ai fanali illuminati
ad un gatto innamorato
che randagio se ne va.
E' giunta ormai l'aurora
si spengono i fanali
si sveglia a poco a poco
tutta quanta la città
la luna s'è incantata
sorpresa ed impallidita
pian piano
scolorandosi nel cielo sparirà
sbadiglia una finestra
sul fiume silenzioso
e nella luce bianga
galleggiando se ne van
un cilindro
un fiore e un frack.

Galleggiando dolcemente
e lasciandosi cullare
se ne scende lentamente
sotto i ponti verso il mare
verso il mare se ne và
chi mai sarà, chi mai sarà
quell'uomo in frack.
Adieu adieu adieu adieu
addio al mondo
ai ricordi del passato
ad un sogno mai sognato
ad un attimo d'amore
che mai più ritornerà.

VEENTICELLO DE ROMA

venticello, venticello de roma
venticello profumato de sole e d'amor
se la sera, l'aventino te chiama
je' risponni dar giannicolo in fior.
mentre in cielo mille stelle brilleno

diecimila bocche gia' se cercheno
tu le sfiori e ja' rigali'n brivido
e nell'oscurita'

tu sfarfalli pe' le strade de roma,
venticello che ci aiuti a sogna'.

Finalino

Chi te po' mai scorda'

Venticello de Roma

VOGLIO VIVERE COSI'

Và... cuore mio da fiore a fior
con dolcezza e con amor
vai tu per me ...
Và... che la mia felicità
vive sol di realtà vicino a te...
Voglio vivere così
col sole in fronte
e felice canto
beatamente...
Voglio vivere e goder
l'aria del monte
perché questo incanto
non costa niente
Ah, ah! Oggi amo
ardentemente
quel ruscello impertinente
menestrello dell'amor ah, ah!

La fiorita delle piante
tiene allegro sempre il cuor
sai perché?
Voglio vivere così
col sole in fronte
e felice canto
canto per me.
Ah, ah! Oggi amo
ardentemente
quel ruscello impertinente
menestrello dell'amor
Ah, ah! La fiorita delle piante
tiene allegro sempre il cuor
sai perché?
Voglio vivere così
col sole in fronte
e felice canto canto per me!

VOLA VOLA L'ARITORNELLO

Vola vola l'aritornello
core bello, core mio bello
vola vola l'aritornello
core mio bello nun me scordá.

Le stelle su ner celo so' millanta
er marinaro disse: "conta, conta,".
Er marinaro disse: "conta, conta,
quella che cerchi te, sempre ci ammanca".

Vola vola l'aritornello
core bello, core mio bello
vola vola l'aritornello
core mio bello nun me scordá.

Me ne vorrebbe anná lontano tanto
nun m'ha da ritrová nemmeno er vento.
Nun m'ha da ritrová nemmeno er vento
dove la Maddalena ce fece er pianto.
Vola vola l'aritornello
core bello, core mio bello
vola vola l'aritornello
core mio bello nun me scordà

AZZURRO

Cerco l'estate tutto l'anno
e all'improvviso eccola qua.
Lei è partita per le spiagge
e sono solo quassù in città,
sento fischiare sopra i tetti
un aeroplano che se ne va.
Azzurro,
il pomeriggio è troppo azzurro
e lungo per me.
Mi accorgo
di non avere più risorse,
senza di te,
e allora
io quasi quasi prendo il treno
e vengo, vengo da te,
ma il treno dei desideri
nei miei pensieri all'incontrario va.
Sembra quand'ero all'oratorio,
con tanto sole, tanti anni fa.
Quelle domeniche da solo
in un cortile, a passeggiar...
ora mi annoio più di allora,
neanche un prete per chiacchierar...
Azzurro,
il pomeriggio è troppo azzurro
e lungo per me.
Mi accorgo
di non avere più risorse,
senza di te,
e allora
io quasi quasi prendo il treno
e vengo, vengo da te,
ma il treno dei desideri
nei miei pensieri all'incontrario va.
Cerco un po' d'Africa in giardino,
tra l'oleandro e il baobab,
come facevo da bambino,
ma qui c'è gente, non si può più,
stanno innaffiando le tue rose,
non c'è il leone, chissà dov'è...
Azzurro,
il pomeriggio è troppo azzurro
e lungo per me.
Mi accorgo
di non avere più risorse,
senza di te,
e allora
io quasi quasi prendo il treno
e vengo, vengo da te,
ma il treno dei desideri
nei miei pensieri all'incontrario va

AVE MARIA

Ave Maria, vergine gentile

Di una fanciulla il pianto ascolta

Da questo freddo e incerto asil

La prece mia è a te rivolta

Sicuri qui posar ci lascia da agguato uman sin al mattin!

Ave Maria, mistico fior,

Se qui in sopor cadiam spossati,

ci sembreran col tuo favor

molli origlier i sassi ingrati.

Se arridi a noi nell'altra volta,

di fior profumi aspirerem

De' figli tuoi le preci ascolta

E tu che li puoi li salva insiem.

Ave Maria

O vergin guarda a tanta ambascia, Madre, ascolta il mio pregar.

Ave Maria!

ABETE DI NATALE

S'accendono e brillano
gli alberi di Natale,
s'accendono e radunano
grandi e bambini intorno.
Fra i cantici degl'angeli
ritorna l'alberello,
riposa il bimbo nel lettin,
lo scalda il fuocherello.

Tintinnano e brillano
gli addobbi di Natale,
s'accendono e raccolgono
grandi e piccini intorno.
I rami si trasformano
con bacche rosse e fili d'or,
risplendono, sfavillano
gli alberi di Natale!

ASTRO DEL CIEL

Astro del ciel, Pargol divin, mite Agnello Redentor!

Tu che i Vati da lungi sognar, tu che angeliche voci nunziar,

luce dona alle genti, pace infondi nei cuor!

luce dona alle genti, pace infondi nei cuor!

Astro del ciel, Pargol divin, mite Agnello Redentor!

Tu di stirpe regale decor, Tu virgineo, mistico fior,

luce dona alle genti, pace infondi nei cuor!

Luce dona alle genti, pace infondi nei cuor!

Astro del ciel, Pargol divin, mite Agnello Redentor!

Tu disceso a scontare l'error, Tu sol nato a parlare d'amor,

luce dona alle genti, pace infondi nei cuor!

Luce dona alle genti, pace infondi nei cuor!

TU SCENDI DALLE STELLE

Tu scendi dalle stelle o Re del cielo
E vieni in una grotta al freddo e al gelo
E vieni in una grotta al freddo e al gelo
O Bambino mio divino, io ti vedo qui a tremar
O Dio beato!
Ah! Quanto ti costò l'avermi amato
Ah! Quanto ti costò l'avermi amato
A te che sei del mondo il Creatore
Mancano i panni e il fuoco, o mio Signore
Mancano i panni e il fuoco, o mio Signore
Caro eletto pargoletto, quanta questa povertà
Più mi innamora, giacchè ti fece amor povero ancora
Giacchè ti fece amor povero ancora
Tu lasci del tuo Padre il divin seno
Per venire a tremar su questo fieno
Per venire a tremar su questo fieno
Caro eletto del mio petto, dove amor ti trasportò
O Gesù mio, perché tanto patir, per amor mio

Appendix 15

Elaboration on result Part B

In this Appendix there are some elaboration on the results of Table 7.22. In this part are reported some tables, replicating the scheme of Table 7.22 but with different division of the sample according the income area, age, living conditions, education and EQ-5D-3L thermometer.

Group S, located in the wealthier area, shows higher values for the thermometer than those of the entire sample (Table Appendix 1). Taking into consideration the other two groups, group F has quite a low thermometer level. General health rating values are similar in both the whole sample and the other two groups considered. With respect to the values of EQ-5D-3L, once again the whole sample, group S and T have similar values while group F has lower values (even if there is a marked improvement which leads to the highest average at the end of the experience, with values much lower than those at follow-up). Values for mental and physical component scores show generally better physical component scores in comparison to those for the mental one; their trend mirrors the general situation and, furthermore, a marked increase can be observed over time for the physical component in group F (Table Appendix 2) and the mental component in group T (Table Appendix 3).

Table Appendix 1 Minimum, maximum, mean and standard deviations at baseline (B), end of singing (E), and follow up (F) of the measures employed for group S

	Questionnaire	Minimum	Maximum	Mean	Std. Deviation
EQ-5D-3L Thermometer	B	30	100	76.0	16.4
	E	20	100	74.7	21.2
	F	50	100	76.4	12.2
General health rating	B	1	5	3.17	0.83
	E	2	5	3.26	0,75
	F	2	4	3.19	0.75
EQ-5D-3L Tariff	B	-0.24	1	0.72	0.30
	E	-0.02	1	0.71	0.31
	F	0.26	0.85	0.79	0.20
Physical Component Score	B	27.44	45.69	38.7	5.2
	E	18.89	46.69	38.6	6.5
	F	31.47	47.75	39.5	5.3
Mental Component Score	B	20.03	66.53	51.1	12.3
	E	28.15	63.46	48.4	8.6
	F	39.44	66.40	50.6	9.3

As far as improvement during the experience is concerned, there is general trend from baseline to follow up of improvement, often with a decrease in values at the end of singing, while sometimes values have consistent growth during the whole period analysed. The improvement in mental health in two groups (S and T) should be mentioned while Group F had stronger improvement in physical health.

Table Appendix 2 Minimum, maximum, mean and standard deviations at baseline (B), end of singing (E), and follow up (F) of the measures employed for group F

	Questionnaire	Minimum	Maximum	Mean	Std. Deviation
EQ-5D-3L Thermometer	B	30	80	63.8	16.6
	E	50	100	74.1	17.0
	F	50	90	66.3	13.0
General health rating	B	2	4	3.25	0.71
	E	2	5	3.38	1.06
	F	2	4	3.00	0.54
EQ-5D-3L Tariff	B	-0.02	1	0.68	0.43
	E	0.62	1	0.81	0.17
	F	0.59	0.80	0.61	0.36
Physical Component Score	B	27.82	45.55	38.1	6.0
	E	29.66	50.26	39.6	6.5
	F	33.14	48.25	41.1	4.4
Mental Component Score	B	17.88	66.57	54.1	17.1
	E	38.17	67.70	52.5	9.1
	F	39.20	65.41	51.3	8.6

Table Appendix 3 Minimum, maximum, mean and standard deviations at baseline (B), end of singing (E), and follow up (F) of the measures employed for group T

	Questionnaire	Minimum	Maximum	Mean	Std. Deviation
EQ-5D-3L Thermometer	B	40	100	70.4	15.2
	E	50	90	72.1	14.2
	F	50	90	70.0	14.8
General health rating	B	2	4	3.29	0.61
	E	2	4	3.36	0.63
	F	2	4	3.25	0.87
EQ-5D-3L Tariff	B	0.66	1	0.72	0.15
	E	-0.02	1	0.75	0.06
	F	0.62	1	0.78	0.12
Physical Component Score	B	26.11	48.15	39.9	6.1
	E	29.81	47.27	39.1	5.8
	F	24.44	46.72	38.9	6.4
Mental Component Score	B	32.36	66.40	46.4	9.0
	E	37.89	66.57	51.4	8.1
	F	30.66	59.51	48.1	9.3

The results have been divided into 3 main socio-demographic categories: age (before and after 75 years old), living conditions (alone or with somebody) and education (up to fourteen years old and over).

The first two tables show the result of the whole sample divided by age (Table Appendix 4 and Table Appendix 5). Table Appendix 4 shows the results of the younger part of the sample between 60 and 74 years old while Table Appendix 5displays the results of the older part of the sample (over 75). According to Table Appendix 4, the younger part of the sample shows it is generally healthier than the older part; only in EQ-5D-3L are the values similar and lower on the general health rating. The thermometer values are higher but rather similar while, with respect to the physical and mental scores, the difference between the two groups is more marked even if there is a constant increase in time of the mental component of the York SF-12 in the older section of the group.

As far as the mental and physical components are concerned, it can be said that there is a steady increase over the three questionnaires.

Table Appendix 4 Minimum, maximum, mean and standard deviations at baseline (B), end of singing (E), and follow up (F) of the measures employed for lower age group (60-74 years old)

	Questionnaire	Minimum	Maximum	Mean	Std. Deviation
EQ-5D-3L Thermometer	B	30	95	72.6	14.1
	E	30	100	75.5	17.0
	F	50	100	73.1	14.1
General health rating	B	1	5	3.09	0.79
	E	2	5	3.17	0.78
	F	2	4	3.14	1.07
EQ-5D-3L Tariff	B	-0.24	1	0.71	0.33
	E	0.08	1	0.79	0.19
	F	-0.02	1	0.77	0.22
Physical Component Score	B	27.44	48.15	39.7	6.1
	E	25.36	50.26	40.5	5.4
	F	30.53	48.25	39.8	5.2
Mental Component Score	B	17.88	74.43	51.1	14.3
	E	28.15	66.57	49.9	8.6
	F	30.66	66.40	49.5	10.0

Table Appendix 5 Minimum, maximum, mean and standard deviations at baseline (B), end of singing (E), and follow up (F) of the measures employed for higher age group (over 75 years old)

	Questionnaire	Minimum	Maximum	Mean	Std. Deviation
EQ-5D-3L Thermometer	B	30	100	71.5	18.8
	E	20	100	72.0	19.6
	F	50	100	72.0	13.1
General health rating	B	2	4	3.36	0.66
	E	2	5	3.45	0.74
	F	2	4	3.20	1.12
EQ-5D-3L Tariff	B	0.09	1	0.71	0.24
	E	-0.02	1	0.69	0.27
	F	0.09	1	0.73	0.24
Physical Component Score	B	26.11	45.28	38.2	5.0
	E	18.89	47.27	37.3	6.7
	F	24.44	47.75	39.5	5.7
Mental Component Score	B	32.36	66.57	49.1	10.4
	E	37.89	67.70	50.2	8.6
	F	35.47	65.98	50.5	8.1

The second group of tables displays the results of the whole sample divided by living conditions. Table Appendix 6 shows the results of the people who lived alone while
Table Appendix 7 displays those of the part of the sample who lived with someone (partner, children or both). According to Table Appendix 6, the participants who lived alone show that they are generally healthier than participants living with somebody; more precisely, the thermometer and mental component scores are higher, values of physical component scores and EQ5 are similar, while the general health rating is slightly lower. In addition, two different trends between the groups can be analysed, however. The group living alone shows an increase in York SF-12 mental and physical component as well as EQ-5D-3L with a steady increase over time; conversely, with respect to the thermometer, there is a decrease.

Table Appendix 6 Minimum, maximum, mean and standard deviations at baseline (B), end of singing (E), and follow up (F) of the measures employed for the group who live alone

	Questionnaire	Minimum	Maximum	Mean	Std. Deviation
EQ-5D-3L Thermometer	B	40	100	76.5	15.1
	E	20	100	72.0	20.8
	F	50	100	74.8	13.3
General health rating	B	1	5	3.08	0.83
	E	2	5	3.29	0.81
	F	2	4	3.09	0.75
EQ-5D-3L Tariff	B	-0.24	1	.071	0.29
	E	-0.02	1	0.72	0.27
	F	0.09	1	0.81	0.20
Physical Component Score	B	27.82	48.15	39.4	5.5
	E	25.36	46.69	38.7	5.8
	F	24.44	48.25	39.8	5.8
Mental Component Score	B	20.03	74.43	50.4	12.2
	E	28.15	67.70	49.7	9.3
	F	30.66	65.98	50.3	9.5

Table Appendix 7 Minimum, maximum, mean and standard deviations at baseline (B), end of singing (E), and follow up (F) of the measures employed for the group who live with somebody

	Questionnaire	Minimum	Maximum	Mean	Std. Deviation
EQ-5D-3L Thermometer	B	30	90	67.0	16.6
	E	50	100	75.9	15.0
	F	50	90	70.0	13.5
General health rating	B	2	4	3.38	0.59
	E	2	5	3.33	0.73
	F	2	4	3.26	0.73
EQ-5D-3L Tariff	B	-0.08	1	0.72	0.28
	E	0.09	1	0.76	0.20
	F	-0.02	1	0.73	0.25
Physical Component Score	B	26.11	45.69	38.5	5.7
	E	18.89	50.26	39.2	6.7
	F	31.47	46.72	39.4	5.1
Mental Component Score	B	17.88	66.57	49.9	13.0
	E	36.49	66.57	50.4	7.7
	F	37.94	66.40	49.6	8.8

The third group of tables displays results for the whole sample divided according to education.

Table Appendix 8 shows the results of the less educated part of the sample and Table Appendix 9 displays the results of the more educated part of the sample. According to, Table Appendix 8 participants who have a low level of education have a lower level of health in comparison to the more educated, having better scores only in the general health rating.

There is a manifest difference between the two groups, especially in the York SF-12 mental and physical component as well as on EQ-5D-3L, even if values show a fairly similar trend in the three questionnaires, group values of the more educated participants are higher overall compared to the less educated components. Furthermore, there is a considerably greater increase in all 3 questionnaires, in particular the mental component of York SF-12 that increases significantly in the follow up.

Table Appendix 8 Minimum, maximum, mean and standard deviations at baseline (B), end of singing (E), and follow up (F) of the measures employed for the group with lower education (up to 14 years old)

	Questionnaire	Minimum	Maximum	Mean	Std. Deviation
EQ-5D-3L Thermometer	B	30	100	67.7	18.5
	E	20	100	70.0	20.2
	F	50	100	70.8	13.0
General health rating	B	2	5	3.41	0.64
	E	2	5	3.52	0.76
	F	2	4	3.25	0.74
EQ-5D-3L Tariff	B	-0.24	1	0.67	0.34
	E	-0.02	1	0.72	0.27
	F	-0.02	1	0.74	0.27
Physical Component Score	B	27.82	45.89	37.9	4.6
	E	18.89	50.26	37.3	6.7
	F	24.44	47.75	38.5	5.7
Mental Component Score	B	17.88	74.43	50.0	14.0
	E	28.15	67.70	49.9	9.3
	F	30.66	65.98	48.3	8.5

Table Appendix 9 Minimum, maximum, mean and standard deviations at baseline (B), end of singing (E), and follow up (F) of the measures employed for the group with higher education (over 14 years old)

	Questionnaire	Minimum	Maximum	Mean	Std. Deviation
EQ-5D-3L Thermometer	B	60	95	78.6	9.7
	E	60	100	79.5	13.3
	F	50	100	75.0	14.1
General health rating	B	1	4	3.06	0.80
	E	2	4	3.00	0.69
	F	2	4	3.06	0.75
EQ-5D-3L Tariff	B	0.26	1	0.77	0.18
	E	0.23	1	0.77	0.17
	F	0.66	1	0.82	0.12
Physical Component Score	B	26.11	48.15	40.6	6.5
	E	32.83	47.27	41.4	4.5
	F	31.47	48.25	38.5	5.7
Mental Component Score	B	32.36	66.40	50.4	10.1
	E	37.89	66.57	50.2	7.5
	F	35.47	66.40	52.4	9.5

The fourth group of tables displays the results of the whole sample divided by the results of the thermometer at baseline. Table Appendix 10 shows the results of the part of the sample with a thermometer score of less than 7.0. According to Table Appendix 10, the participants who have a lower thermometer value in general also have a lower level of health with respect to the other group. These differences are marked taking into account EQ-5D-3L and York SF-12 scores.

The two groups have two different trends. While thermometer values in the first group show a steadily increasing trend, the converse can be said of the other group where a decrease leads to minimizing the differences at baseline with those of follow-up. Similar considerations can be made for the EQ-5D-3L where, although there is also an increase in the group with higher thermometer values, this improvement is lower than in the group with lower thermometer values (Table Appendix 11).

Table Appendix 10 Minimum, maximum, mean and standard deviations at baseline (B), end of singing (E), and follow up (F) of the measures employed for the group with lower starting thermometer (<=7.0)

	Questionnaire	Minimum	Maximum	Mean	Std. Deviation
EQ-5D-3L Thermometer	B	30	70	60.0	12.7
	E	20	90	64.8	19.0
	F	50	90	65.5	11.3
General health rating	B	3	5	3.61	0.58
	E	2	5	3.65	0.714
	F	2	4	3.50	0.69
EQ-5D-3L Tariff	B	-0.24	1	0.63	0.31
	E	-0.02	1	0.67	0.26
	F	-0.02	1	0.73	0.25
Physical Component Score	B	26.11	44.38	36.2	5.4
	E	18.89	50.26	36.4	6.9
	F	24.44	46.72	37.0	5.0
Mental Component Score	B	17.88	74.43	46.4	13.7
	E	28.15	66.57	48.8	9.3
	F	30.66	59.51	45.8	7.6

Table Appendix 11 Minimum, maximum, mean and standard deviations at baseline (B), end of singing (E), and follow up (F) of the measures employed for the group with higher starting thermometer (>=7.5)

	Questionnaire	Minimum	Maximum	Mean	Std. Deviation
EQ-5D-3L Thermometer	B	75	100	84.7	8.2
	E	60	100	83.2	11.5
	F	50	100	79.2	11.9
General health rating	B	1	4	2.82	0.66
	E	2	5	2.95	0.65
	F	2	4	2.86	0.66
EQ-5D-3L Tariff	B	0.09	1	0.79	0.24
	E	0.23	1	0.82	0.18
	F	0.09	1	0.82	0.20
Physical Component Score	B	31.96	48.15	41.8	4.2
	E	29.66	46.69	41.6	4.0
	F	31.47	48.25	42.1	4.6
Mental Component Score	B	36.49	66.57	54.2	9.7
	E	37.89	67.70	51.3	7.6
	F	35.47	66.40	54.0	8.7

In the light of the analyses made, the sample shows to be generally healthy, with no modulating factors. However, the better educated and from the wealthier areas seem to be healthier in comparison to the less educated and from the economically disadvantaged areas. The sample shows, overall, it is healthier with respect to physical component scores rather than in the mental health scores.