Self-Actualization through Music Therapy for Older Adults at End of Life:

A Philosophical Inquiry

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A Thesis

in

The Department

of

Creative Arts Therapies

Presented in Partial Fulfillment of the Requirements

for the Degree of Master of Arts (Creative Arts Therapies, Music Therapy Research Thesis Option)

Concordia University

Montreal, Quebec, Canada

September 2021

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CONCORDIA UNIVERSITY

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ABSTRACT

Self-Actualization through Music Therapy for Older Adults at End of Life: A Philosophical Inquiry

Kayley Patterson

The purpose of this philosophical inquiry was to make a case for why older adults need opportunities for self-actualization at end of life, and to understand why music therapy is an ideal avenue through which to facilitate these opportunities. An evolving approach to music therapy for neurotypical older adults at end of life was conceptualized by adapting Zalenski and Raspa's (2006) framework for achieving human potential in hospice, which draws upon Maslow's hierarchy of needs and situates self-actualization as an ultimate end-of-life care goal. This evolving music therapy approach, entitled *Circle of Self-Actualization*, includes six components: *music therapy as pain management* (to address older adults' physiological needs), *music therapy as a safe space* (to address older adults' safety needs), *music therapy as connection* (to address older adults' belonging needs), *music therapy as self-empowerment* (to address older adults' esteem needs), *music therapy as meaning* (to address older adults' self-actualization needs), and *music therapy as transformation* (also to address older adults' self-actualization needs). Limitations of the inquiry as well as potential implications for practice and research are presented. It is the researcher's intent that the rationale and evolving approach presented in this paper will help music therapists to further recognize and support older adult clients in the realization of their needs for self-actualization at end of life.

ACKNOWLEDGEMENTS

A deep and resounding thank you to all of the individuals who have seen me through my own self-actualization process in the writing of this thesis. Thank you to the inspirational Concordia Music Therapy Faculty, and to all of my previous internship supervisors for such a warm welcome into the rich, rewarding, and revolutionary field of music therapy. Thank you to my supervisor, Dr. Laurel Young, for so generously sharing your time, support, and wealth of knowledge with me. Lastly, thank you to my partner, parents, sister, grandparents, in-laws, family, and friends for your unconditional love, encouragement, and faith in me.

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Chapter 1. Introduction

Significance and Need

Palliative care is a holistic and person-centred philosophy of end-of-life care that seeks to improve or maintain a patient's quality of life by addressing their multifaceted health and well-being needs (Rummans et al., 2000; Voumard et al., 2018; WHO, 2020). Rather than pursuing curative treatments, interdisciplinary palliative care teams approach end-of-life care through prevention and treatment of patients' symptoms, with a focus on physical, psychological, social, and spiritual comfort and support (Canadian Hospice Palliative Care Association [CHPCA], 2013; World Health Organization [WHO], 2020). A number of Canadian palliative care models and quality of life scales cite self-actualization as being an integral value in end-of-life patient care, alongside autonomy, dignity, and community (CHPCA, 2013; Dyess et al., 2020; Zalenski & Raspa, 2006).

The concept of self-actualization was originally introduced by psychologist Abraham Maslow in his *Theory of Human Motivation* (Maslow, 1943), where it is positioned as the ultimate goal of human beings in a five-tier hierarchy of human needs. Maslow (1954) originally defined self-actualization as a tendency for a human being to grow into one's full potential by being true to one's nature. He later revised this definition, describing self-actualization as a tendency to become increasingly what one is (Maslow, 1970). With the term self-actualization being cited throughout a large body of end-of-life literature, it is surprising to note that few concrete or practical details exist regarding how this goal might be realized for any given population at end of life. Two physicians, Zalenski and Raspa (2006), address this predicament by offering a guiding framework for achieving human potential in hospice, situating self-actualization as the ultimate goal at end of life. They identify qualities of self-actualization within this framework as: personal journey of growth within one's experience of illness; feelings of generativity and connection with others, and; experiences of "peace, transcendence, and closure" (Zalenski & Raspa, 2006, p. 1124). In the context of this framework, self-actualization is thought to occur at end of life when physiological needs, safety needs, belonging needs, and esteem needs have been partially or wholly satisfied (Zalenski & Raspa, 2006).

Self-actualization may be of particular importance for older adults at end of life. This population constitutes most deaths in Canada and are the fastest-growing age group in Canada and worldwide (CHPCA, 2017; Voumard et al., 2018). Older adults face particular vulnerabilities

in end-of-life settings, including frailty, inadequate institutional standards of care, isolation and loneliness, personal losses, resource scarcity, susceptibility to illness, multiple morbidities, and a lack of access to quality palliative care (Chase, 2020; Downar et al., 2018; WHO, 2011). These vulnerabilities have been particularly evident since the COVID-19 pandemic of 2020-2021, which has had an exceedingly disproportionate impact on older adults in Canada (Chase, 2020). In addition to these challenges, many palliative care models and policies fail to account for older adults' unique and complex care needs, including gerodiversity[1] and intersectionality (Cable-Williams & Wilson, 2017; D'cruz & Banerjee, 2020; WHO, 2011), and many older adults are denied access to formal palliative care programs (Downar et al., 2018). When access is available, it is common for palliative care measures to remain inaccessible until the final hours and/or days of an older person's life (Gardiner, 2011), with insufficient support to address psychosocial and spiritual dimensions of health. In consideration of these challenges, it is necessary for the Canadian healthcare community to establish accessible and holistic forms of end-of-life care that occur in a timely fashion, and prioritize older adults' unique multidimensional end-of-life needs.

Having experienced identity formation, growth, and enhanced well-being through my own musical experiences, I am personally drawn to the subject of personal transformation through creative processes. In my experience as a music therapy graduate student intern throughout the COVID-19 pandemic, I worked with older adults in a palliative care setting and observed the diverse ways in which music therapy can address holistic health needs while connecting to the person behind the patient label. Music therapy played an essential role in supporting older patients' psychosocial and spiritual needs by providing opportunities for them to connect to their inner worlds, values, belief systems, identities, and lived experiences. The music therapy space provided an environment in which older adults could feel accepted and heard while exercising their self-agency, expressing their hopes and fears, and sharing in experiences with others that were filled with meaning and sometimes even beauty. These musical and relational experiences seemed to be one of few opportunities that these older individuals had to live, and even grow, in the midst of their illness. Outside of these meaningful encounters, however, I noticed a hospital environment that was isolating for older adults in particular, due in part to the COVID-19 pandemic, which made family visits rare, and in some cases, not possible. Limited

[1] [1] A multicultural approach to the medical and psychological treatment of older adults that addresses issues of aging.. Gerodiversity accounts for older adults as a hetereogenous group of individuals situated within an ecological context, and considers dynamics of privilege and inequality (D'Cruz & Banerjee, 2020).

resources and time as well as pandemic restrictions made it difficult for interdisciplinary team members to engage in person-centred interactions with these older patients, resulting in inadequate psychosocial and spiritual support. This inquiry is part of a personal commitment that I have made to broaden perspectives, expectations, and practices surrounding aging and dying processes.

Relevance to Music Therapy

The first palliative care music therapy program in the world was established by music therapist Susan Monroe in Montreal, Canada at the McGill Palliative Care Unit of the Royal Victoria Hospital in 1977 (Munro, 2005). Since this time, music therapists have played an increasingly recognized and important role, working with interdisciplinary teams to improve palliative patients' quality of life by addressing their physical, psychosocial/emotional, and spiritual/existential needs (Cadrin, 2009; Clements-Cortes, 2011; Hilliard, 2005; McConnell & Porter, 2016; Salmon, 2001; Tao, 2019; Wlodarczyk, 2007). Music therapists working in palliative care contexts practice from a variety of theoretical orientations, utilizing diverse techniques and experiences to address patients' multidimensional health and well-being needs (Hilliard, 2001; McConnell & Porter, 2016). According to the literature, some primary music therapy goals in palliative care include improving patients' moods, inducing relaxation, managing discomfort or pain, reducing anxiety, enhancing self-expression and self-disclosure, acknowledging difficult emotions, assisting with life review, facilitating reminiscence and relationship completion, achieving awareness of limitations and losses, addressing spiritual/existential concerns, embracing living, and finding meaning in life (Cadrin, 2009; Clements-Cortes, 2011; Dileo & Dneaster, 2005; McConnell & Porter, 2016; Tao, 2019).

Although no explicit connection has been noted in the literature between self-actualization and music therapy at end of life, some studies have drawn parallels between self-actualization and experiences of interactive musical processes (e.g., Ahonen, 2009; Kim, 2010), while others mention patients' experiences of meaning, transcendence, and growth through music therapy at end of life (Cadrin, 2009; Clements-Cortes, 2011; Dileo & Dneaster, 2005; Salmon, 2001). Many music therapists working in palliative care contexts incorporate humanistic values into their practices, which are similar to those of person-centred palliative care philosophies that emphasize patients' rights to agency, dignity, and respect (Abrams, 2015; CHPCA, 2013). Humanistic principles are strengths-based in nature, maintaining that all individuals have creative

and personal potential, and that musical experiences, as well as the therapeutic relationship, are catalysts for growth (Abrams, 2015; Tao, 2019). Experience-oriented and relational practices in music therapy, such as those found in humanistic theoretical models of music therapy (e.g., Creative Music Therapy; see Nordoff et al., 2007), hold significant potential to play a critical role in addressing the self-actualization components contained within Zalenski and Raspa's (2006) modified framework for achieving human potential in hospice (noted above and described in further detail in Chapters 3 and 4). Making opportunities for growth available to older adults, who often lack access to these ways of being due to the aforementioned barriers and challenges, may be of particular relevance when seeking to address this population's end-of-life self-actualization needs.

While literature pertaining specifically to music therapy with older adults at end of life is virtually non-existent, there is evidence for the important role that music-listening and active music-making can play in enhancing older adults' quality of life at large (e.g., Cohen et al., 2002). Music can allow older adults to engage in new and pleasant experiences, bringing about a sense of empowerment, fulfillment, purpose, social cohesion, and personal development while drawing upon their existing strengths and resources (Abbott, 2013; Cohen et al., 2002; Creech et al., 2013; Hilliard, 2004; Kaufmann et al., 2016; White, 2016). Musical engagement can provide a vehicle for older adults to express their identities and lived histories, reminding them of important events and relationships in their lives and helping them to tap into their internal resources and wisdom. Engaging in musical experiences can provide a platform for older adults to exercise their agency, which may be particularly meaningful for those who are terminally ill and increasingly dependent on others for their daily needs (Chen et al., 2009; Hirsch & Meckes, 2000).

For music therapists to fully understand how they can commit to supporting older adults in realizing their needs and potentials at end of life, processes of self-actualization in music therapy at end of life must be clarified and conceptualized. In conducting this research, it was my intent to support music therapists in their understanding and support of these processes, thereby working toward empowering older adults to gain some agency over their health and well-being at end of life. I also hoped that this inquiry would lead to a more nuanced understanding of aging and dying processes for all who read it.

Statement of Purpose

Given the above rationale, the purpose of this philosophical inquiry was to make a case for why older adults need opportunities for self-actualization at end of life, and to understand why music therapy is an ideal avenue through which to facilitate these opportunities. An evolving approach to music therapy in this area of clinical practice was subsequently conceptualized by adapting Zalenski and Raspa's (2006) framework for achieving human potential in hospice.

Research Question

The central question guiding this philosophical inquiry was: Why do older adults need opportunities for self-actualization through music therapy at end of life, and how might this be conceptualized by adapting Zalenski & Raspa's (2006) framework for achieving human potential in hospice?

Assumptions

When initiating this inquiry, I assumed that self-actualization is valuable, achievable, and observable throughout the lifespan, including at end of life for older persons. I assumed that the Zalenski and Raspa (2006) framework for hospice provides a truthful and relevant depiction of end-of-life self-actualization needs, and that these needs can be realized by older adults through music therapy processes. Although palliative care is the principal context referred to in this inquiry, I assumed that this research would have some applications for all healthcare settings wherein end of life occurs for older persons. Finally, I assumed that some older adults would appreciate and benefit from opportunities for self-actualization through their participation in music therapy at the end of their lives. These assumptions are important to note because they influenced how I interpreted and presented the material for this study and, as stated here, are also meant to serve as indicators of transparency and authenticity.

Definitions of Key Terms

Several key terms contained in the research question are defined below. Other notable terms will be defined in context as they arise in the paper.

In the present study, the term *older adults* will refer to all neurotypical individuals above the age of 65 (Black & Csikai, 2015; Creech et al., 2013), although there are instances when age-related differences among these older adults are noted. Neurotypical older adults will refer to those who do not have a developmental disability or a neurocognitive disorder (Happé & Charlton, 2010; Silverman et al., 2013).

Self-actualization is defined as a process of personal transformation that can occur at end of life, after or while basic needs are wholly or partially fulfilled, by accepting oneself for who/what one is (Dyess et al., 2020; Poston, 2009; Zalenski & Raspa, 2006). Self-actualization can occur in any or all of the following ways: personal journey of growth within one's experience of illness; feelings of generativity and connection with others, and; experiences of "peace, transcendence, and closure" (p. 1124) through connection to "Other" (Zalenski & Raspa, 2006, p. 1124). The journey toward self-actualization is valued alongside autonomy, dignity, and community and can transpire when confronting one's own approaching death (CHPCA, 2011; Dyess et al., 2020).

According to the Canadian Association of Music Therapists (CAMT, 2020), *music therapy* is defined as

> a discipline in which Certified Music Therapists (MTAs) use music purposefully within therapeutic relationships to support development, health, and well-being. Music therapists use music safely and ethically to address human needs within cognitive, communicative, emotional, musical, physical, social, and spiritual domains. (About music therapy section, para. 1)

The online Cambridge dictionary (n.d.) defines *end of life* as, "issues [that] relate to someone's death and the time just before it, when it is known that they are likely to die soon from an illness or condition" (End-of-life, para. 1). In accordance with a the concept of *continuous palliation* advocated for within Geriatric Medicine (Gardiner et al., 2011; Voumard et al., 2018), the present inquiry refers to *end of life* as a phase of life in which individuals have been diagnosed with a life-limiting illness, regardless of their remaining lifespan (i.e. days, weeks, months, or years). Hyphens will appear when using this word as an adjective, such as describing *end-of-life care*.

Zalenski and Raspa's (2006) framework for achieving human potential in hospice is an adapted version of Maslow's hierarchy of needs for hospice. Hierarchical needs include: "(1) physiological needs: distressing symptoms, such as pain or dyspnea; (2) safety needs: fears for physical safety, of dying or abandonment; (3) belonging needs: affection, love and acceptance in the face of devastating illness; (4) esteem needs: esteem, respect, and appreciation for the person; (5) self-actualization needs: self-actualization and transcendence" (Zalenski & Raspa, 2006, p. 1120). This framework will be described in further detail in Chapters 3 and 4.

Summary of Chapters

The current chapter outlined the rationale for this philosophical inquiry, and presented its purpose, research question, assumptions, and definitions of key terms. Chapter 2 explains why philosophical inquiry was deemed to be the most appropriate methodology for the present study, and how it was realized. Chapter 3 addresses the first half of the research question by explaining why older adults need opportunities for self-actualization through music therapy at end of life. This includes an examination of literature related to Canadian palliative care services, common end-of-life situations experienced by older adults, barriers that impede older adults' abilities to access quality palliative care, self-actualization as a palliative care concept, music therapy practices in palliative care, and the importance of music for older adults. This chapter culminates in the proposition that music therapy is a viable and ideal vehicle for meeting older adults' self-actualization needs at end of life. Chapter 4 addresses the second half of this inquiry's research question by outlining how opportunities for self-actualization through music therapy at end of life can be conceptualized using an adapted version of Zalenski and Raspa's framework (2006) for achieving human potential in hospice. The fundamental tenants of Zalenski and Raspa's framework are described, along with an explanation for why Zalenski and Raspa's (2006) framework for achieving human potential in hospice is well suited for adaptation and application to music therapy for older adults at end of life. This is followed by a presentation of all aspects of the adapted framework, which cumulatively represent an evolving approach to guide music therapists in their work with older adults when addressing self-actualization needs at end of life, entitled *Circle of Self-Actualization: An Evolving Approach to Music Therapy with Older Adults at End of Life*. Chapter 5 further discusses the results of this inquiry, including a visual diagram that summarizes the fundamental tenets of the *Circle of Self-Actualization*, reflections, limitations, and potential implications for future research and practice.

Chapter 2. Methodology

Design

A philosophical inquiry methodology was deemed most appropriate to address the purpose and research question of this study, as presented in Chapter 1. The research question addresses axiological issues (i.e., those related to value) where truth is determined by the soundness of the researcher's argument alongside empirical and theoretical data (Aigen, 2005). While no standard procedure exists for carrying out a philosophical inquiry, it is customary for a researcher utilizing this methodology to, "identify a question, outline a position, present evidence, refine one's position, and discuss the study's implications" (Byers, 2012, p. 18). In the present inquiry, I utilized critical and analytical thinking while collecting and analyzing available literature on the topic, and questioned fundamental assumptions related to aging and dying processes. One of four fundamental philosophical questions asked by Western philosopher Immanuel Kant was of particular relevance: "What may I hope?" (Stige & Strand, 2016, p. 672). In other words, questions of what we can hope to achieve through music therapy with older adults at end of life and why we should hope for older adults to have access to opportunities for self actualization through music therapy at end of life are addressed. Concepts such as self-actualization are clarified, arguments are supported by existing literature, underlying assumptions are exposed/evaluated, and my argument takes a broad selection of philosophical perspectives into account while addressing the research question (Aigen, 2005). This philosophical inquiry assumes a transformative epistemological position by setting out to improve older adults' experiences at end of life, while aiming to change the ways in which healthcare professionals and public institutions view and respond to older adults' needs in end-of-life contexts. In accordance with a transformative worldview, issues related to inequality, marginalization, and opportunities for personal growth are central to this study (Creswell & Creswell, 2018).

Due to the scope and timeline of a Master's thesis, several delimitations were imposed upon the design of this inquiry: (a) There were no research participants. (b) Sources of data were delimited to English language scholarly literature published within the past 21 years (2000 to 2021), scholarly lectures, and information from reputable organization websites, (e.g., the World Health Organization). A few exceptional sources published before 2000 were included because they contained relevant foundational or historical information. (c) The population addressed was delimited to neurotypical older adults (as defined above) who experience end of life in healthcare

contexts largely structured according to Western philosophical perspectives that often prioritize biomedical approaches. (d) Although a multiplicity of relevant end-of-life organizations exist, the Canadian Hospice Palliative Care Association (2013) and the World Health Organization (2020) served as two primary sources for this inquiry.

Materials

An excel spreadsheet was used to compile salient points derived from relevant literature, including electronic journal articles, organizational websites, scholarly lectures, and scanned book chapters. A personal journal was maintained to record my emerging thoughts and ideas throughout the research process. Zotero software was employed to track and organize sources. All information was stored on a password protected laptop.

Data Collection and Analysis

As previously noted, the primary source of data used in this inquiry was scholarly literature published in English within the past 21 years (2000 to 2021). I made efforts to specifically include literature that contained the voices and perspectives (i.e., direct quotes) of older adults. I also maintained a literature search log. Databases searched included: *Sofia*, *PsycInfo, Spectrum,* and *Google Scholar*. The following key terms were searched using multiple combinations: barriers, Canada, death, dying, end-of-life, good death, geriatrics, gerodiversity, geriatric medicine, hierarchy of needs, holistic, hospice, humanism, interdisciplinary, marginalization, Maslow, meaning-making, music therapy, older adults, pain, palliative care, palliative care goals, peak experience, personal growth, personal transformation, self-actualization, spirituality, transcendence and quality of life. Relevant scholarly music therapy and palliative care journals were also reviewed, including: the *Canadian Journal of Music Therapy, Journal of Music Therapy, Nordic Journal of Music Therapy,* and *VOICES: A World Forum for Music Therapy.* Other journals searched included *Complementary Therapies in Clinical Practice*, *The Arts in Psychotherapy, Journal of Palliative Care*, *Journal of Palliative Medicine,* and *BioMed Central (BCM) Geriatrics*. Organizational palliative care and government websites within Canada and worldwide were also reviewed.

To build an argument using literature as data, I analyzed, organized, and synthesized relevant evidence extracted from the literature onto an Excel spreadsheet. This spreadsheet contained the following categories: author and year, title, concept/counter-concept, and quotes. Sources of data were organized on the spreadsheet based on relevant and emerging concepts,

which were derived from the research question, Zalenski and Raspa's (2006) framework, and the literature. Throughout the research process, I maintained a personal journal. This journal was not used as data per se, but helped to: guide how the evidence was organized and synthesized, identify and evaluate assumptions contained in the literature, make connections between concepts, and recognize limitations (Aigen, 2005). I continuously clarified and refined relevant concepts which were used to build my argument.

Chapter 3. Setting the Scene

This chapter will address the first half of this inquiry's research question and make a case for why older adults need opportunities for self-actualization through music therapy at end of life. First, the current landscape of Canadian palliative care services for older adults will be examined, including some end-of-life situations that older adults find themselves in, and barriers that impede older adults' abilities to access quality palliative care at end of life. This will be followed by an exploration of the concept of self-actualization as it relates to current palliative care practices, and an overview of Zalenski and Raspa's (2006) modified framework for hospice. Thirdly, literature surrounding music therapy practices in palliative care and older adults' relationships to music are examined. Finally, the concept of music therapy as a viable and ideal vehicle for meeting older adults' self-actualization needs at end of life will be introduced.

Palliative Care, End of Life, and Older Adults

Palliative Care in Canada

Palliative care and end-of-life care for older adults is provided in a variety of settings, including individual homes and larger institutions such as hospices, nursing and assisted living homes, retirement communities, and hospitals (Davis et al., 2019; Menec et al., 2007; O'Callaghan et al., 2015). Palliative care is a holistic, specialized, and person-centred philosophy of care that seeks to address patients' multifaceted health and well-being needs, including the physical, mental, social, and spiritual dimensions of health (WHO, 2020; Voumard et al., 2018). Rather than pursuing curative treatments, a palliative approach to end-of-life care involves preventing and treating patients' symptoms, with a focus on comfort and holistic health support. The World Health Organization (2020) defines palliative care as :

> …an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (para. 1).

Palliative care practices in Canada were established in the 1970s as a means of support for patients living with terminal illnesses and have continued to adapt and evolve in accordance with peoples' experiences of illness and dying (CHPCA, 2013). Although some conceptual confusion exists between the terms end-of-life care and palliative care, end-of-life care is typically understood as being provided within minutes, hours, or a few days of an expected death (Cable-

Williams & Wilson, 2017), while palliative care is implemented when death is expected, but not necessarily imminent (Gardiner et al., 2011). Canada is generally viewed as having advanced integration of palliative care in its healthcare network, due in part to its universal health care system, yet most end-of-life care delivery in Canada occurs in hospitals (Hsu & Tanuseputro, 2017). Accessibility and equitable access to palliative care differs across provinces and territories, according to provincial and territorial policies and resources (Hsu & Tanuseputro, 2017). For a patient to be provided with free access to palliative care in Canada, they must be registered as *palliative* by a physician and deemed as having a maximum of six months to live (Menec et al., 2007).

A primary goal in palliative care is to maintain or improve quality of life (Rummans et al., 2000). Rummans et al. (2000) claim that poor quality of life can lead to devastating outcomes for dying patients and their caregivers, such as premature death through passive suicide or surrender. To avoid these tragic outcomes, holistic health and well-being needs must be identified and responded to by an interdisciplinary palliative care team (Arnold, 2011; CHPCA, 2013). These teams typically consist of physicians, nurses, pastoral or spiritual counsellors, and mental health practitioners such as social workers, psychologists, and music therapists (Breitbart, 2006; Clements-Cortes, 2016), who make collaborative efforts to address various aspects of patients' multifaceted needs while continuing to offer their unique professional perspectives and skills. The Canadian Hospice Palliative Care Association (CHPCA, 2013) describes palliative care teams in hospice as working in a therapeutic "Circle of Care" (p. 8) that consists of a knowledgeable and skilled interprofessional team who maintain standards of professional conduct set by licensing bodies and professional associations while creating desired change. Palliative care professionals work to not only identify and respond to patients' needs, but to improve quality of life in collaboration with patients and their families (Hirsch & Meckes, 2000; Voumard et al., 2018).

Hospice care is an integral branch of the larger continuum of palliative care and is distinguished by its explicit focus on end-of-life best practices (O'Callaghan et al., 2015). The CHPCA (2013) provides a comprehensive national model to standardize a person-centered approach to end-of-life care delivery in Canada, which consists of eight domains to be identified and responded to by an interdisciplinary palliative care team. These domains vary in significance for each individual, and include: disease management, physical, psychological, loss/grief, social,

spiritual, practical, and end-of-life care/death management (CHPCA, 2013). All activities within this and other hospice palliative models are driven by humanistic values of autonomy, self-actualization, dignity, and community (CHPCA, 2013; Dyess et al., 2020). These standardized practices are centered around enabling individuals to make decisions for themselves, encouraging healthcare teams to see patients' humanity while working toward understanding their multidimensional end-of-life needs (Arnold, 2011; Tao, 2019). For each patient's humanistic right to autonomy to take shape, they must be personally engaged and involved in the direction of their care (CHPCA, 2013; Tao, 2019).

It is crucial for palliative care teams to remain sensitive to each patient's personal, cultural, and religious beliefs and practices, as well as ability-levels (Breitbart, 2006). Dyess et al. (2020) call for a "multiethnic and multigenerational inclusive perspective" (p. 326), which addresses the sociocultural aspects of each person. Efforts are currently being made towards sustainably integrating a generalist palliative care approach into all healthcare delivery systems, including home care and long-term care, which may have a significant impact on the many older adults who experience their last stage of life in these spaces (WHO, 2011).

Situations of Older Adults at End of Life

Most deaths in Canada and the rest of the world occur among older people, who have distinct and individual end-of-life and palliative care needs. Older adults are the fastest-growing age group globally, predicted to account for 23% to 25% of the total Canadian population by 2036 (CHPCA, 2017). The result of this significant rise in population size calls for "an increase in the need for older adult services, including the need to meaningfully attend to this burgeoning population during the end of life period" (Moulder, 2019, p. 33). Profound physical changes often accompany the final two decades of many older peoples' lives, such as chronic multimorbidity, functional dependency, frailty, and general decline (Voumard et al., 2018). This can be a lengthy period consisting of complex treatment decisions, arduous symptom management, various psychosocial problems, and "easily overlooked spiritual distress" (Voumard et al., 2018, p. 2). Coupled with these health conditions, older adults may experience other age-related declines that can limit their ability to live independently and impact their quality of life, such as cognitive impairment, problems with bladder and bowel control, and issues related to vision and hearing (WHO, 2011).

The CHPCA (2017) reports that 74% of older adults are affected by one or more chronic conditions, including cancer, chronic obstructive pulmonary disease, congestive heart failure, cardiovascular disease, diabetes, emphysema, multiple sclerosis, amyotrophic lateral sclerosis, dementia, neuromuscular diseases, and end-stage kidney failure (CHPCA, 2017; Downar et al., 2018; WHO, 2011). Chronic diseases account for 70% of all deaths in Canada (CHPCA, 2017), and are more likely to be experienced by older adults simultaneously, thereby making this population susceptible to comorbidities and disabilities, as well as more dependent on support from others (WHO, 2011). Although symptoms can be managed, chronic conditions can result in a decline in physical and mental functioning, increased dependence on others, repeated hospital admissions, and eventual or sudden death (Downar et al., 2018).

Confounding health problems and disabilities call for multiple treatments, making many older adults' health needs more complex than those of other palliative patients (Goldstein, 2005; Menec et al., 2007). Declines in an older person's physical and/or mental health are sometimes rooted in or coupled with the loss of a spouse, serious financial concerns, and "all the other difficulties that confront people in later life" (Fisher & Specht, 1999, p. 470), and can have a significant impact on their psychosocial, emotional, and spiritual health. Despite the fact that these elements of an older person's health and well-being are worthy of being addressed and are accounted for by palliative care philosophies, many Western biomedical approaches utilized in the care of older adults prioritize physiological needs and pharmacological interventions over holistic health needs and non-pharmacological treatments. This one-dimensional approach to treatment can result in older adults being over-medicated, sometimes leading to a higher rate of adverse drug reactions, thus complicating matters further (WHO, 2011).

Where an older person resides can dictate where they will die and influence the type or level of end-of-life care they receive. Whether an older person lives alone, with others, or within an institution is dependent on their ability-level, health status, and availability of family/friend caregivers. Recent studies demonstrate that many terminally ill patients, including older adults, would prefer to experience end of life in their homes and/or in their own community (Gomes et al., 2013; Hsu & Tanuseputro, 2017), while others place more trust in institutional care, surrounded by medical technologies and expertise (Gardiner et al., 2011). Despite the fact that a majority of older adults in Canada (93%) continue to live in their private dwellings, many older adults' wishes to die at home are not granted (Downar et al., 2018). The WHO's (2011)

publication on best practices in palliative care for older people maintains that there has been a steady shift away from older people dying at home and towards dying in hospitals and long-term care facilities, with the largest rise in hospital and care-home deaths occurring among older adults above the age of 85.

Long-term care homes provide services and formal support for older individuals who are unable to independently carry out activities of daily living. In Canada, approximately 50% of residents living in these homes die each year, making these institutions complex care environments (Cable-Williams & Wilson, 2017; Kortes-Miller et al., 2018). With such a large percentage of older adults living and dying in these homes, one would hope that an established palliative care approach that tailors its practices to older adults' end-of-life care needs would exist. Unfortunately, many older adults continue to lack opportunities to access quality palliative care at end of life (Cable-Williams & Wilson, 2017; Voumard et al., 2018; WHO, 2011).

Barriers to Accessing Quality Palliative Care for Older Adults

To meaningfully attend to older adults at end of life, there is an increasing need to provide accessible, high quality palliative care, regardless of the end-of-life context. The World Health Organization (2011) states, "increasing numbers of older people in almost every society will face the risk of indifferent or poor health care, dependence and multiple illnesses and disabilities. This will also inevitably lead to higher demand for palliative care for this group" (p. 3). Multiple barriers currently exist in relation to older people accessing quality palliative care, some of which can be attributed to location of death, timing, types of illness, care delivery systems, healthcare providers' attitudes toward older populations, and national/provincial policies (Cable-Williams & Wilson, 2017; Downar et al., 2018; Gardiner, 2011; WHO, 2011).

As previously mentioned, it is common for long-term care homes not to provide adequate palliative care to meet older adults' end-of-life needs. A recent report by the Canadian Institute for Health Information (2018) revealed that on average, only 1 in 20 older adults who died in Canada in a long-term context received palliative care. Furthermore, even when palliative care is an option, many older adults in long-term care residences experience lengthy death trajectories, and formal palliative support is often not provided until the final hours and/or days of a resident's life (Cable-Williams & Wilson, 2017). The question of when to provide palliative care is raised in many end-of-life settings, as palliative care is typically viewed as being synonymous with dying (Gardiner, 2011). Due to a *get better* mentality in hospitals and a focus on interventionist

care, doctors can be reluctant to refer older patients with life-limiting conditions to palliative care, maintaining hope that they will recover (Gardiner, 2011). This reluctance is at odds with the geriatric medicine concept of *continuous palliation*, which views long-term chronic disease management for older adults as being interconnected with end-of-life care (Gardiner, 2011; WHO, 2011).

A third barrier lies in the fact that palliative care services were originally intended to meet cancer patients' needs, utilizing expertise and equipment designed to manage pain (Downar et al., 2018). This makes traditional palliative care services difficult to translate to chronic, non-cancer conditions. Non-cancer illnesses, including frailty, account for two thirds of deaths in Canada, with people over the age of 85 more likely to die from cardiovascular disease than cancer. Yet many older patients with non-cancer related illnesses are not provided with palliative care consultations and admissions, and are rarely offered advanced therapies (Downar et al., 2018).

A fourth barrier relates to palliative care provision in acute hospital settings, where most deaths occur in Canada (Downar et al., 2018). In these settings, some confusion exists among physicians surrounding whose responsibility it is to refer older adults to specialized palliative care and to oversee palliative care provision. Gardiner et al. (2011) indicate that this hesitancy towards referral is sometimes based on stereotyped beliefs that older adults find it easier to come to terms with a terminal diagnosis and therefore do not require palliative services (Gardiner et al., 2011). Older patients also tend to have limited social supports who can advocate for access to quality care on their behalf, which impacts their ability to access psychosocial supports in hospital settings (Gardiner et al., 2011).

One final barrier impeding older adults' access to quality palliative care occurs at the policy level. According to the WHO (2011), little policy exists concerning older adults' specific needs at end of life. These policies are necessary, particularly at a time when an increasing number of older adults in Canada and worldwide are reaching the final phase of their lives. In addition to this barrier, insufficient institutional resources can lead to decreased staffing levels and increased time pressures on palliative care providers, once again making psychosocial supports a lower priority in care settings (Gardiner et al., 2011).

This multitude of barriers is the tip of the iceberg with respect to older adults' abilities to access quality palliative care. Fortunately, many healthcare providers and governmental institutions recognize the need for more specialized geriatric approaches in palliative care

provision, as well as more accessibility in terms of navigating these systems. Geriatric Medicine is one model that was developed in response to older adults' barriers in healthcare contexts and can be described as a holistic form of care that focuses on the prevention, assessment, and management of older adults' health concerns across the spectrum, including in physical, mental, social, and spiritual domains (Voumard et al., 2018). Voumard et al. (2018) recently unified geriatric and palliative care approaches, establishing an emerging field of Geriatric Palliative Care (GPC) in response to the various sociodemographic changes and challenges faced by older adults with life-limiting conditions. There lies great potential in this model, which shares many of the same values of a more universal palliative care approach but uniquely focuses on improving older adults' quality of life at end of life by increasing or enhancing personal capabilities and social participation (Voumard et al., 2018). This model is still young in its development and as such, most palliative care to date continues to fall under a more universal scope that does not account for older adults' unique needs (Voumard et al., 2018; WHO, 2011). Recommendations put forth by Open Society Foundations (2016), an international grantmaking network whose mission includes the advancement of public health, call for a national palliative care strategic plan that supports older adults' abilities to make individual choices, and makes palliative and social care accessible and acceptable, free from barriers such as discrimination. For end-of-life care to be truly in line with palliative care values, older adults' voices must not only be heard but must directly influence palliative care processes in accordance with their values and beliefs. These voices might help healthcare workers to move away from a deficit-perspective on aging to a human developmental perspective, where aging is understood as a multidirectional process consisting of both growth and decline throughout all phases of life (Coffman, 2002).

Situating Self-Actualization in End-of-Life Care for Older Adults

Origins of Self-Actualization

Self-actualization is considered a core value in a number of palliative and hospice care models (CHPCA, 2013; Dyess et al., 2020; Zalenski & Raspa, 2006). The term was first coined by American psychologist Kurt Goldstein, which he defined as, "a [person's] desire for self-fulfillment, and the propensity of an individual to become actualized in [their] potential" (Gopinath, 2020, p. 11591). Although Goldstein is responsible for the creation of this concept, it is Abraham Maslow who has become most closely associated with the term, applying it to his psychological theory centred around human potential and wholeness (Ballard, 2006; Bridgman et

al., 2019). Maslow introduced his five-tier hierarchy of needs to the world in a 1943 paper titled *A Theory of Human Motivation*, in which self-actualization is positioned as the ultimate goal of human beings. The theory is constructed around five separate human needs that, according to Maslow, must be met for human beings to live fulfilling and satisfying lives (Raspa & Zalenski, 2006). He considered the first four needs within the hierarchy as deficit needs, meaning a need that must be temporarily satisfied (Poston, 2009). Maslow presented these in the following chronological order: physiological needs, such as eating and drinking; safety needs, such as feeling secure where one lives; belonging needs, such as having built relationships with others, and; esteem needs, such as having respect for oneself (Raspa & Zalenski, 2006). According to Maslow, self-actualization is an independent and internally experienced *being* need, set apart from these deficit needs, as it is based on internal rather than external experience (Poston, 2009). Although Maslow believed that true self-actualizers were a rare in the Western world and that one must be extraordinarily accomplished to be self-actualized, self-actualization has evolved into a more inclusive concept that considers everybody as being self-actualized according to their individual stage of development (Poston, 2009). Over time, Maslow's hierarchy of needs, and more particularly his concept of self-actualization, have evolved and become a significant force in both humanistic therapies and organizational philosophies (Gopinath, 2020).

Certain aspects of Maslow's original theory have become misinterpreted and/or criticized in their understanding and application over time, and will be clarified here for the purpose of situating older adults' self-actualization needs in end-of-life contexts. One example of misinterpretation can be found in the widespread visual diagram of a pyramid depicting Maslow's hierarchy. This popular pyramid was not in fact constructed by Maslow, but by a consulting psychologist named C. D. McDermid in his 1960 book titled *How Money Motivates Men*, where he utilized Maslow's theory as a tool for consultants and managers (Bridgman et al., 2019). Although the pyramid has become synonymous with Maslow's theory, his personal presentation of the hierarchy was in words rather than figures and diagrams (Bridgman et al., 2019). Another example of misrepresentation can be found in the belief that Maslow's hierarchy requires each need to be chronologically fulfilled. This notion has become criticized for its cultural bias, as it arranges and universalizes needs according to Western world values (Hadley & Thomas, 2018; Poston, 2009). Many humanistic and critical humanistic psychologists have acknowledged that the hierarchy should not be organized sequentially, but rather understood

according to an individual's personal and sociocultural needs and values (Poston, 2009; Zalenski & Raspa, 2006). For example, an individual or culture may value self-actualization needs over lower-level needs, or may place value on needs outside of those listed in Maslow's hierarchy. In an unpublished essay written in 1966, *Critique of Self-Actualization Theory* (1991), Maslow himself acknowledged that there were a number of exceptions regarding the arranging and rearranging of needs for clinical patients (Bridgman et al., 2019). Finally, while Maslow (1943) acknowledged that self-actualization is not ultimate or universal for all cultures, the hierarchy is inherently value-laden, representing individualism over collectivism, or put more directly, Western values over non-Western values (Blackstock, 2011; Hadley & Thomas, 2019). Hadley and Thomas (2018) state, "even if one embraces a relational worldview that understands intersubjectivity as central to self-realization, the individual is still given priority over the community when self-actualization is the goal" (p. 169). In other words, Maslow's general concept of self-actualization carries with it a sense of the individual over the community, which can be problematic when implemented institutionally. For the purpose of this inquiry, self-actualization for older adults at end of life is understood as being interrelated and contextually influenced within healthcare systems. This notion of community and interrelatedness leads to an important point regarding influences behind Maslow's theory.

Although the concepts found within Maslow's motivational theory are attributed to his clinical background in behavioral psychology, other important cultural influences are missing from this account. In 1938, prior to publishing his motivational theory, Maslow travelled to Alberta, Canada, where he spent six weeks partaking in research with the First Nations people of the Siksika Nation, one of four nations under the Blackfoot Confederacy (Blood & Heavy Head, 2007; Ravilochan, 2021). The original reason for Maslow's visit was to investigate his evolving hierarchical social domination theory (Blood & Heavy Head, 2007; Ravilochan, 2021), which hypothesized that primates' natural tendencies were towards social domination. However, this hypothesis was "upended" (para. 1) after his visit with the Siksika Nation, with whom he found high amounts of cooperation, minimal inequality, implementation of restorative justice, basic needs met, and high levels of life satisfaction (Ravilochan, 2021, para. 1). As Maslow observed Blackfoot values and practices, he noticed stark contrasts between the Western world and the world of the Blackfoot people. For example, Maslow discovered that the Siksika Nation valued cooperation and community over possession of material goods, and found that the vast majority

of the Siksika Nation had qualities of self-actualization compared to a small percentage he had witnessed in his own Western upbringing (Blood & Heavy Head, 2007). Blood and Heavy Head (2007) assert that although there is no official Blackfoot model for self-actualization, the ideas contained within Maslow's theories can be understood as an altered version of the Blackfoot way of life. In the Siksika language, the closest term for self-actualization is *niita'pitapi*, meaning someone who is completely developed or who has arrived (Heavy Head, as cited in Ravilochan, 2021). While self-actualization is described by Maslow as something one becomes, the Blackfoot believe that people are innately self-actualized, connected to the divine spirit, which can be experienced in a variety of ways, such as through ritual, ceremony, and education (Ravilochan, 2021). The Western world relates Maslow's hierarchy of needs to individual actualization, while the Blackfoot emphasize community and collectivity, with a reliance on the cooperation of the group while living together in the same space (Blackstock, 2019; Blood & Heavy Head, 2007). This idea of community extends itself to the First Nations acknowledgment of the interrelationship of human needs. First Nations scholar, Cross (2007), reinterprets Maslow's hierarchy of needs from a relational worldview model, arguing that human needs are interdependent and interrelated in nature. Cross (2007) proposes that human needs go beyond the individual, and are contextually influenced by cultural values and laws that balance how needs are met on personal and collective levels. In this way, meeting older adults' needs at end of life might be understood as a collective responsibility in end-of-life contexts.

Self-Actualization as a Palliative Care Value

Self-actualization is prioritized as an integral value in a number of palliative care models (CHPCA, 2013; Dyess et al., 2020), yet details surrounding the realization of this value at end of life with any given population are seemingly non-existent, aside from one- or two-sentence definitions put forth by various organizations, such as the CHPCA. The CHPCA (2013) defines self-actualization by stating, "Dying is part of living, and both living and dying provide opportunities for personal growth and self-actualization" (p. 7). The association indirectly acknowledges self-actualization by mentioning that, although end-of-life processes can be exceptionally difficult, this stage of life can also be a time for developing a new understanding of life, the future, death, and dying (CHPCA, 2013). Ultimately, the CHPCA views challenges surrounding the dying process as opportunities for growth. This sits in stark contrast to the notion of aging and dying as decline and decay. It acknowledges the full spectrum of patients' needs and

potentials, including psychosocial and spiritual well-being, as being important and transformative aspects of health. From this perspective, opportunities for growth and development should be cornerstones of palliative care practices. Unfortunately, the holistic nature of palliative care philosophies does not always translate into practice.

Palliative care teams make efforts to provide patients and their loved ones with emotional support, spiritual care, communication, and reduction of unnecessary treatments (Dyess et al., 2020). However, much of the literature to date surrounding palliative care for specifically older adults indicates a lack of support for needs beyond the physical dimension, such as psychosocial and spiritual needs, and disregards the interrelationship of these needs (Banner et al., 2019; Dyess et al., 2020; Kaasalainen et al., 2019; Kortes-Miller et al., 2018; Open Society Foundations, 2016; WHO, 2011). The WHO (2011) states, "Physical and psychosocial symptoms are a major burden for people in the final stages of life and can significantly reduce their quality of life" (p. 38). As indicated previously, conventional end-of-life care for older adults in long-term care contexts is often substandard, with even basic physical needs, such as pain, being poorly managed (Kaasalainen et al., 2019). When older adults do receive palliative care, it is typically in a hospital setting where previously mentioned barriers to accessing quality end-of-life care, alongside unique challenges such as multimorbidity and frailty, can have a detrimental impact on older patients' level of care (Gardiner et al., 2011; Voumard et al., 2018). Generalist palliative care in acute hospital settings, particularly for non-cancer-related illnesses, can consist of inadequate staffing levels and increased time pressure, thereby impacting the quality of care received (Gardiner et al., 2011). In some cases, staff are unable to satisfy even basic requirements, much less engage in a meaningful dialogue with patients (Gardiner et al., 2011).

End-of-life conversations and preparation are important elements of quality palliative care. Banner et al. (2019) highlight a growing amount of evidence supporting the importance of adequate end-of-life preparation for older adults, as these conversations can decrease unnecessary medical interventions, enhance quality of life, improve patient and family satisfaction, and promote greater illness adaptation. Unfortunately, older adults and their caregivers often delay these discussions until an older person's health has declined significantly (Im et al., 2019), and it is common for these discussions to focus exclusively on medical treatment and advanced directives, rather than addressing the "wider goals of care" (Banner et al., 2019, p. 211). For many older adults, emotional distress can be caused not only by physical pain, but can include

concerns related to their property, their family, and freedom over their health and well-being (Open Society Foundations, 2016). A multimethod study completed in Prince George, British Columbia by Banner et al. (2019) highlights perspectives regarding older adults' preparedness at end of life, with 25 community members, 10 stakeholders, and 97 older adults participating in focus groups and interviews. Both stakeholders and older adults alike confirmed the importance of psychosocial support in end-of-life preparedness, emphasizing the need for appropriate resources and supports. Some older adults in the study defined end-of-life preparedness as having their "affairs in order and their wishes and preferences honored", which involved a spiritual process for themselves and their loved ones (Banner et al., 2019, p. 215). To create possibilities for older adults to experience self-actualization at end of life, there is a need for psychosocial and spiritual dimensions of care to be prioritized alongside physical needs. When aging is understood as a multidimensional and multidirectional process, and when older patients are directly involved in decisions surrounding their care, then palliative care teams might begin to better address the full scope of older adults' end-of-life care needs (Open Society Foundations, 2016)

Having a clear conceptual framework that guides practice and assumes a whole person approach could help to facilitate the implementation of more effective and consistent palliative care practices for older adults. For interdisciplinary teams to intentionally work with older patients towards realizing values and goals related to self-actualization, it is important for their practices to be conceptualized by a comprehensive, person-centred framework: one that, in alignment with the CHPCA's values, considers all domain areas and health needs as being equivalent, and is ultimately determined by each patient and their loved ones. The term *needs* may in fact misrepresent or underrepresent ideals in palliative care. According to Dyess et al. (2020), healthcare teams should join forces toward a collective purpose to provide patients with transformative experiences that are, "rich in artfully skilled holistic caring" (p. 320). From this perspective, palliative care teams consider opportunities for personal growth and transformation as being of equal value to basic needs.

Many healthcare educational programs utilize Maslow's hierarchy of needs as an effective assessment tool to address patients' psychological health and well-being, since the hierarchy can help healthcare workers to identify and address the individualistic and intersectional well-being of each patient (Poston, 2009). Zalenski and Raspa (2006) are two physicians who have created a theory-driven framework to guide interdisciplinary teams and patients toward realizing self-

actualization and transcendence at end of life. They have adapted and applied Maslow's hierarchy of needs to a palliative care and hospital context, in which self-actualization is positioned as an ultimate care goal. Within this modified framework, Zalenski and Raspa (2006) include the following *deficit* needs: physiological, safety, belonging, and esteem. Zalenski and Raspa (2006) define self-actualization as being the ultimate goal at end of life, and describe this as involving a personal journey of growth within one's experience of illness, feelings of generativity and connection with others, and experiences of "peace, transcendence, and closure" (p. 1124) through connection to "Other" (p. 1124). By defining, understanding, and positioning human needs and self-actualization as a central feature in end-of-life interdisciplinary practices, older adults at this stage may come to recognize their inner resources while being supported in their journeys towards transformational growth.

Music Therapy and Self-Actualization for Older Adults at End of Life

Music Therapy in Palliative Care

Music therapists are gradually becoming more integrated into interdisciplinary palliative care teams in Canada, since research and documentation have demonstrated the efficacy of music therapy practices in meeting patients' holistic care needs (Clements-Cortes, 2016; McConnell & Porter, 2016). Although music therapy is considered by some to be an essential service in palliative care contexts (Potvin et al., 2021), no official statistics regarding the number of music therapy palliative care programs in Canada are currently available (Davis et al., 2019). The first palliative care music therapy program in the world was established at the McGill Palliative Care Service of the Royal Victoria Hospital in Montreal, Canada by music therapist Susan Monroe in 1977 (Munro, 2005). Since then, these programs have expanded internationally, and the profession has gained respect within palliative care interdisciplinary teams and healthcare communities (Hilliard, 2001). According to the Canadian Association of Music Therapists, music therapy is a discipline in which certified music therapists (MTAs), "use music safely and ethically to address human needs [and potential] within cognitive, communicative, emotional, musical, physical, social, and spiritual domains" (CAMT, 2020, About music therapy section, para. 1). Music therapy has been shown to reduce medication costs, improve staff utilization, and support patients' loved ones in palliative care contexts (Clements-Cortes, 2016; Davis et al., 2019). It assumes a unique role in interdisciplinary hospice teams, helping to address aspects of patients' physiological, psychosocial, and spiritual issues at end of life in a "non-threatening

way" (Hilliard, 2001, p. 166). With the non-verbal nature of music as its primary therapeutic mechanism, music therapy can be less intimidating and more accessible for patients who are unable or uncomfortable to articulate their needs, thoughts, or feelings verbally (Bradt & Dileo 2010; Hilliard, 2001). In a recent critical realist literature review, McConnell & Porter (2016) found both quantitative and qualitative evidence indicating that music therapy can improve quality of life for palliative patients. More specifically, there is evidence that music therapy at end of life can have a positive impact on pain, physical comfort, energy levels, anxiety and relaxation, time and duration of treatment, mood, spirituality, and quality of life (Hilliard, 2005).

Music therapists working in palliative care contexts are often responsible for contributing to patient assessment and care plan documentation. They utilize verbal therapy techniques and personalized music experiences, also referred to as *interventions*, to identify and support palliative patients' individual needs and strengths in purposeful and sensitive ways while working towards care goals (Hilliard, 2001; Magill, 2005; McConnell & Porter, 2016). Common music therapy experiences implemented at end of life include: song choice, song writing, lyrical analysis, entrainment, Guided Imagery and Music (GIM), toning, singing, playing instruments, music listening, music and movement, life review, music and art, as well as improvisation (Dileo and Dneaster, 2005). The palliative music therapist selects a music therapy experience based on clinical judgment, personal preferences of the patient, and the patient's multidimensional health-related goals. After receiving informed consent, the music therapist monitors a patient's well-being within and throughout sessions by carefully observing verbal and non-verbal qualities such as the patient's facial expressions, verbal language, body language, and musical language while remaining attuned to their diverse and interrelated health needs (Abbott, 2013; Magill, 2005). Many music therapists working in palliative care incorporate a variety of theoretical orientations and approaches into their work, such as psychodynamic, humanistic, medical, and cognitive-behavioral perspectives, while others adhere to a particular music therapy model that may be informed by one or more philosophical perspective(s) (Wheeler, 2015). Among this variety of orientations and models is the shared belief that working through obstacles will create change and maximize functioning in the present (Isenberg, 2015). Ultimately, music therapy serves a multitude of functions in palliative care and is implemented in accordance with a patient's preferences, while considering a range of holistic health needs.

Older Adults and Music/Music Therapy at End of Life

To date, research pertaining specifically to music therapy with older adults at end of life is scarce. Diversity of settings, theoretical orientations, and individualized experiences at end of life make the process of identifying measurable and standardized variables difficult (Davis et al, 2019). However, a few exceptions exist. A study completed by Hilliard (2004) utilized an ex post facto design to investigate the influence of music therapy sessions on 40 older adults who had received hospice care prior to their death in a nursing home. Hilliard analyzed patients' medical records and found that music therapy experiences facilitated by a certified music therapist, including singing with instrumental accompaniment, instrument playing, and improvisation, contributed to older adults' emotional, spiritual, social, and physiological well-being, as measured by independent *t-tests*. Similar results have been reflected in palliative care literature that investigated music therapy with general adult populations. This included a literature review completed by Hilliard (2005) and a systematic review completed by McConnell and Porter (2016). Both reviews indicated that music therapy has made significant and measurable contributions to meeting general adult populations' emotional, spiritual, social, and physiological needs at end of life. While these results are encouraging, researchers have noted the need for more randomized controlled trials regarding music therapy at end of life, as this objective evidence can open up possibilities for funding, creating, and maintaining music therapy positions in hospices (Bradt & Dileo, 2010; Davis et al., 2019; McConnell & Porter, 2016). There is a clear demand for more substantial, reliable, and methodologically relevant research for all adult populations, including older adults.

It is important to keep in mind that music therapy can be viewed as both an art and a science. Many music therapists and palliative patients have described powerful physiological, psychosocial, and spiritual influences of music therapy at end of life through case studies, qualitative studies, and detailed descriptions of music therapy processes (e.g., see Cadrin 2009; Clements-Cortes, 2011; Dileo & Loewy, 2005; Hilliard, 2001; Salmon, 2001). Dileo and Loewy's (2005) book, entitled *Music Therapy at End of Lif*e, contains chapters written by 36 music therapists who share their knowledge and expertise on the subject. They present an array of experiences and philosophical orientations to illustrate their work with patients in their final phase of life. Throughout this book, music therapy is presented as an effective transitional tool at end of life for individuals in hospitals, nursing homes, home care, and hospice. While a demand

for more experimental designs is warranted, anecdotal qualitative evidence reveals music therapy as a meaningful process in the final phase of adults' and older adults' lives.

It is surprising that more has not been written on the use of music for older adults at end of life given the noted importance of music in older adults' lives at large (Chen et al., 2009; Cohen et al., 2002; Creech et al., 2013). An older person's musical history can be tied to important life events and past relationships, connecting them to their sense of personhood and reminding them of the knowledge they carry from life experience (Abbott, 2013). Active music-making and music-listening are creative endeavors that can support older adults' abilities, inviting them to draw upon their strengths and resources while providing a source of purpose, fulfillment, and growth (Abbott, 2013; Creech et al., 2013). For example, a qualitative study by Saarikallio (2011) investigated the use of music-listening and active participation in music with 21 Finnish adults between the ages of 21 to 70. Participants above the age of 65 found singing and instrumental ensembles to add a depth of meaning to their lives, helping them to feel a sense of progression, enjoyment, and connection with others, while increasing their ability to cope with aging-related challenges. A number of other researchers identify music as a source of enhanced well-being for older people, noting its "powerful potential" (Creech et al., 2013, p. 87) to bring about social cohesion, enjoyment, personal development, and empowerment (Cohen et al., 2002; Creech et al., 2013; Hilliard, 2004; Kaufmann et al., 2016; White, 2016). In another large study carried out in eastern Canada, Cohen et al. (2002) set out to examine the significance of music in older adults' lives with over 300 participants, who completed a questionnaire about their musical involvement and interests. Results demonstrated that, although only a small minority were involved in active music-making, a vast majority of participants listened to music daily and considered music to be an important part of their lives, regardless of their specific age, geographical location, and level of mental competence. Cohen et al. (2002) concluded that music can contribute to older adults' quality of life, and suggested that government agencies prioritize creating more opportunities for older adults to access musical activities. This idea is further complemented by White (2016) in an article investigating the role of musical activity in the lives of older adults. White highlighted the need for public institutions, including healthcare professionals and long-term care providers, to recognize music's ability to meet older adults' multidimensional health and well-being needs, and to find ways in which music can be made more accessible in these contexts.

Music therapy offers viable and accessible musical opportunities for older adults to experience in healthcare contexts. Both qualitative and quantitative research indicate that music therapy can help to support older adults' health and well-being by positively impacting their psychosocial behaviors, levels of anxiety, and depressive symptoms (Davis, 2019; Lin et al., 2012; Raglio et al., 2010; Zhao et al., 2016). A qualitative study by Chen et al. (2009) held music therapy sessions and focus groups to examine elderly nursing home residents' experiences of movement to music, playing percussion instruments, and music listening. Participants indicated that they benefitted from the sessions in various ways, including: deriving strength, enhanced energy, distraction from suffering, improved quality of life, and confirmation of their identities as people. These first-hand affirmations reveal the multitude of ways in which older adults' multidimensional health and well-being needs were supported by music therapy experiences. A systematic review and meta-analysis completed by Zhao et al. (2016) examined 19 randomized controlled to determine the efficacy of music therapy in managing older adults' depression. Results of the meta-analysis indicate that, when added to standard treatment, music therapy can have a statistically significant impact on reducing depressive symptoms in older adults. Despite evidence for the important influence of music and music therapy in older adults' lives, and perspectives noted previously regarding expressed support for a holistic approach to palliative care, gaps in the literature point to limited opportunities for older adults to experience personal transformation/self-actualization through music therapy at end of life.

Self-Actualization in Music Therapy

While not explicitly stated, qualities related to self-actualization can be found throughout music therapy literature. For example, music therapy can stimulate feelings of empowerment, or tap into one's inner resources, through creative, positive, and agentive musical experiences (Hirsch & Meckes, 2000). Several researchers have noted music therapy's capacity to inspire feelings of peak experience and transcendence in individuals. In a phenomenological study that examined six Master of Music Therapy students' journeys of self-actualization in musical improvisation, Ahonen (2009) made links between Maslow's descriptions of peak experience and students' descriptions of musical experiences. The student participants described musical engagement as allowing them to "let everything else go, be carried by music, experience release and the present moment more clearly and accurately" while also acquiring a sense of "calmness, centeredness, openness, energy, purity, groundedness, timelessness, and playfulness" (Ahonen,

2009, results, peak experiences). Kim (2010) conducted a qualitative study that investigated eight female music therapists' experiences of using a Nordoff-Robbins approach to musical improvisation in their training. The Nordoff-Robbins approach is a humanist-oriented music therapy orientation that views all individuals as possessing innate creative potentials, and more specifically, an inner *music child* (see, Robbins & Robbins, 1998). In therapy contexts, this approach uses musical experiences as catalysts for individuals to overcome emotional, physical, and cognitive limitations (Kim, 2010; Robbins & Robbins, 1998). Participants in Kim's study stated that through improvisation and activating their *music child*, peak experiences occurred that involved feelings of freedom, joy, focus, and empowerment. These feelings helped participants to become more accepting of themselves and others, more courageous in taking on growth challenges, and more aware of their motivation to grow. While both of these studies involved students as research participants, a qualitative study by Moss (2019) examined the health and well-being benefits of general adult populations singing in a choir, in which survey data analysis revealed transcendence as a main theme. Participants included 1779 choristers from 14 countries, who described singing as being spiritually uplifting while noting its meditative and mindful benefits. They described a sense of feeling lifted into a higher realm, away from daily concerns, gaining an awareness of a higher purpose that connected them to a state of consciousness beyond themselves (Moss, 2019). Cumulatively, these studies indicate a clear connection between self-actualization, in the form of peak experiences and transcendence, and engaging in musical processes, including music therapy.

To support older adults in achieving self-actualization at end of life, music therapists could more intentionally integrate specific aspects of a humanistic music therapy approach into their practices. While not all music therapists working in palliative care contexts adhere exclusively to a humanistic theoretical framework, many find it to provide a helpful framework within which to conceptualize their practices (Tao, 2019). Abrams (2018) states the possibility that all music therapy is in some way humanistic, due to its "fundamental relationship to other persons, within humanity" (p. 139), and that humanistic approaches are implemented across a wide range of music therapy models and methods (Abrams, 2015). Fundamental tenets of humanistic music therapy are strengths-based in nature, asserting that all persons have innate capacities and unique potentials for actualization when provided with conditions that serve as opportunities for change (Abrams, 2015). These approaches differ from medical models, in that

they are less concerned about the product of therapy, including “technical manipulations and deterministic outcomes”, and more about relational experiences in which patients are given opportunities to act and respond using their “agency to promote [their] self-actualization" (Abrams, 2015, p. 154). From this vantage point, music therapists view every person as a musical being with something creative and valuable to offer. By practicing from a non-judgmental and empathetic perspective, which includes understanding and accepting patients for who they are as people and as creative beings, music therapists can help patients to experience personal growth. Rather than directing experiences, the music therapist collaborates with the patient to support and reflect their musical and personal exploration while taking their personal, cultural, and religious beliefs, as well as abilities and potentials, into account**.** In doing so, patients are encouraged to rely on their personal resources and capabilities.

Self-actualization processes in music therapy can occur within various models and approaches, some of which position transformation and growth at the centre of therapy, and are integrated into various contexts, including end-of-life care. The Bonny Method of Guided Imagery (GIM) is a receptive music therapy approach where an individual “[accesses] and [sustains] an altered state of consciousness” (p. 196), listening and responding to carefully designed classical music programs while being supported by a therapist who is trained in this method (Ventre & McKinney, 2015). Cadrin (2009) describes (2009) this as a “transformation therapy that allows self-regulating growth and development, opportunity for expanded self-awareness, and for physical, psychological, social, and spiritual integration” (para. 13). GIM can promote creativity and exploration in persons who are facing a loss of physical abilities and roles (Cadrin, 2009), which is applicable to older adults, who often face multiple personal losses, such as autonomy, functional abilities, and their health. When viewed from this perspective, one could speculate that GIM has the potential to help older adults (in various contexts, including at end of life) to surpass suffering through experiencing feelings of wholeness. Another music therapy model with personal growth at its core is Dileo and Dneaster’s (2005) Model of Music Therapy in Palliative Care, consisting of three levels of end-of-life practice: supportive, communicative/expressive, and transformative. At the transformative level, music therapy is implemented to facilitate growth and insight at end of life by reconnecting a person to oneself, others, and in some cases, *Other* (i.e. the “Divine”, nature, the universe, etc.), in whatever way this is defined by the person (Dileo & Dneaster, 2005). This level of practice involves engaging

in music experiences that facilitate: life review and coming to terms with one's life, resolution of conflicts and feelings, forgiveness toward oneself and/or others, examination of spiritual/existential issues, and exploration of after-life beliefs to find a sense of peace (Dileo & Dneaster, 2005). For older adults at end of life, these transformative elements may be an important step towards reaching a sense of peace and closure before departing from this world. The emphasis on personal development and transformation in music therapy literature reveals ways in which self-actualization might be realized for older adults at end of life.

Conclusion

While palliative care philosophies are humanistic in nature, aiming to address individuals' physiological, psychosocial, and spiritual/existential needs, these philosophies are not always implemented in practice, particularly with older adults. Older adults have unique and complex end-of-life care needs that should be accommodated for within palliative and all other end-of-life contexts. Since self-actualization is considered to be a core value in palliative and hospice care models, it is imperative for healthcare systems to provide older adults with opportunities to feel holistically supported as they approach the end of their lives. This includes having a sense of agency over their own health and well-being. Music therapy may play a critical role in this regard, as research and practice indicate that it can be an effective transitional tool for palliative patients, addressing their physiological, psychosocial, and spiritual/existential needs. This is further supported by the important roles that music has been found to play in the lives of many older people. Humanistic music therapy practices, which value patients for their strengths, resources, and capacities for growth, may hold significant potential to support older adults in meeting their self-actualization needs at end of life, through facilitating moments of transcendence and peak experience.

The following chapter will describe how opportunities for self-actualization through music therapy at end of life may be conceptualized using an adapted version of Zalenski and Raspa's framework (2006) for achieving human potential in hospice. This conceptualization may be especially helpful in supporting music therapists to implement this approach as well as enhance other interdisciplinary professionals' understandings of the multifaceted role and potential of music therapy for older adults in end-of-life contexts.

Chapter 4: An Evolving Approach for Music Therapy as a Means of Self-Actualization for Older Adults at End of Life

The present chapter addresses the second half of this inquiry's research question: how opportunities for self-actualization through music therapy at end of life may be conceptualized using an adapted version of Zalenski and Raspa's framework (2006) for achieving human potential in hospice. First, I will present the fundamental tenants of Zalenski and Raspa's framework and outline why I chose to adapt this framework for use in music therapy with older adults at end of life. I will then present all aspects of the adapted framework, which cumulatively represent an evolving approach/conceptualization to guide music therapists in their work with older adults when addressing self-actualization needs at end of life. I consider this approach as evolving since all types of music therapy experiences for meeting older adults' various end-of-life needs have not been exhausted, and I expect that myself and other music therapists will further develop this approach.

Adapting Zalenski and Raspa's Framework for Use in Music Therapy with Older Adults at End of Life

Zalenski and Raspa's (2006) framework for achieving human potential in hospice includes five levels of end-of-life needs, all of which are relevant to older adults: (1) physiological needs, including "distressing symptoms such as pain or dyspnea" (p. 1120); (2) safety needs, including "fears for physical safety, of dying or abandonment (p. 1120); (3) belonging needs, including "affection, love, and acceptance in the face of devastating illness (p. 1120); (4) esteem needs, including, "esteem, respect, and appreciation for the person" (p. 1120), and; (5) self-actualization needs, including "self-actualization and transcendence" (p. 1120). To lay the groundwork for an evolving approach that can be used by music therapists to address self-actualization with older adults at end of life, each need has been presented chronologically and defined in relation to older adults' health and well-being at end of life. Conceptualizations of how and why each need can be addressed through music therapy are presented. These include: *music therapy as pain management* in addressing older adults' physiological needs, *music therapy as safe space* in addressing older adults' safety needs, *music therapy as connection* in addressing older adults' belonging needs, *music therapy as self-empowerment* in addressing older adults' esteem needs, *music therapy as meaning* in addressing older adults' self-actualization needs, and

music therapy as transformation in addressing older adults' self-actualization needs. These are described below in further detail.

Zalenski and Raspa's framework was selected as an ideal framework within which to situate this evolving approach for several reasons. First, the framework can be understood by interdisciplinary professionals working in end-of-life contexts, as it is a theory-driven practical schema created specifically to guide these professionals in assessing and supporting end-of-life holistic health needs of their patients. Second, this framework is based on Maslow's hierarchy of needs, which has become an influential institutional theory, referenced frequently in palliative care literature worldwide. Third, the framework provides a unique comprehensive description of how self-actualization needs can be defined and addressed at end of life. Fourth, the framework is simple, accessible, and flexible in nature, which leaves it open to interpretation and conceptualization, thus making it easy to apply to specific needs of older adults at end of life. Finally, the various health domains that music therapy typically addresses in end-of-life contexts intersect with this framework's conceptions of health.

An Evolving Approach to Music Therapy for Older Adults at End of Life

Older Adults' Physiological Needs at End of Life

According to Zalenski and Raspa (2006), physiological needs are a first level need at end of life that can include, "biological needs, pain, symptom control, and restoring [a person's] ability to meet basic life needs such as pain or dyspnea" (p. 1124). Untreated pain is described by the authors as a psychologically overwhelming, subjective experience in human consciousness that can, at times, interrupt patients' experiences of self. Thus, Zalenski and Raspa conceptualize pain through a *total pain* (Saunders, 1964) perspective, which views pain as permeating physical, social, emotional, and/or spiritual domains in unique ways, depending on a person's physical and psychological state. This perspective shares some traits with gate control theory, a popular model for pain created in the 1960s, which recognizes processes in attention, affect, memories, and interpretation as influencing the level of pain experienced by a person (McConnell & Porter, 2006). Total pain has been known to mystify palliative care professionals (McConnell & Porter, 2016), including Zalenski and Raspa, who paradoxically propose a one-dimensional treatment for pain in the form of pharmacological interventions. While these interventions can provide temporary alleviation, the origins of pain are diverse and complex, requiring effective healthcare

solutions from a variety of pharmacological, physical, and psychosocial modalities (Albu & Voidăzan, 2016; Hirsch & Meckes, 2000; O'Callaghan, 1996).

To better address the unique needs of older adults, the WHO (2011) advises interdisciplinary professionals and specialists to participate in skills exchange and collaboration, including pain and symptom management at end of life. As many as one third of residents in care homes experience pain as a result of disabling conditions and comorbidities (WHO, 2011), and approximately 25 to 50% of older adults living in the community experience major problems with pain (Open Society Foundations, 2016). In the case of comorbidity, pain can be rooted in several sources, which can lead to confusion among healthcare teams and inadequate palliative treatment for this population (WHO, 2011). While self-reports of pain tend to be most reliable indicators, older adults' communication of pain can be "complicated by cognitive and sensory impairment" (WHO, 2011, p. 29). In some cases, older people underreport their pain, perhaps due in part to their expectations that pain is a natural part of the aging process (Open Society Foundations, 2016). The unique physical changes that can accompany aging and illness suggest a need for more diversified healthcare solutions to older adults' physical needs

Addressing Older Adults' Physiological Needs at End of Life Through Music Therapy: Music Therapy as Pain Management

Since advanced age and illness correspond with changes in the body's response to drugs, nonpharmacological approaches to pain are a valuable form of pain management for older adults (McConnell & Porter, 2016). Research indicates that music therapy can be an effective, non-pharmacological solution for the alleviation of pain and physical discomfort at end of life (Cadrin, 2009; McConnell & Porter, 2016; O'Callaghan, 1996; Singer et al., 1999). A systematic review of randomized control trials completed by McConnell & Porter (2016) substantiates this by demonstrating reduced pain and physical discomfort in palliative patients as an outcome of music therapy. Unfortunately, this review does not contain details regarding specific musical approaches, therapeutic approaches, or patients' specific physical and/or psychosocial symptoms. Physical goals in music therapy at end of life are most often associated with pain sensation and perception, and include increasing comfort, decreasing agitation, decreasing anxiety, inducing sleep, enhancing mood, and regulating breathing (Bradt & Dileo, 2010; Clements-Cortes, 2016). Both receptive experiences, such as listening to music, and active music-making, such as

improvising or recreating a piece of music, can impact such symptoms as labored breathing and agitation (Bradt & Dileo, 2010).

Since pain can be rooted in psychological experience, the loss of an important relationship in an older person's life, such as the loss of a spouse or losses associated with illness, can influence pain perception. In these cases, music therapy can provide an older person with a sense of emotional closure, helping them to reconcile these losses by addressing and expressing them through musical experiences, thereby positively impacting their perception of pain (McConnell & Porter, 2016). Creative experiences have been proven to restore patients' emotional balance by helping to provide them with a sense of psychological control over their physical pain (Stuckey & Nobel, 2010). Music therapy can also provide a form of distraction, in accordance with the gate control theory's conceptualization of pain alleviation. For example, on an emotional level, distraction can be achieved when a patient selects a familiar piece of music that elicits positive memories. These memories help to release endorphins, allowing the body to provide its own form of pain relief while decreasing the need for pharmacological interventions (Hirsches & Meckes, 2000; McConnell & Porter, 2016).

A number of music therapy techniques are useful when accounting for age-related changes in a persons's motor and cognitive functioning. For example, receptive methods offer more accessible options for older adults at end of life, who tend to experience physical challenges such as decreased energy levels and physical limitations. Music imaging is one of these, described by Abrams and Kasayka (2005) as the "process of inner experience that occurs while listening to music" (p. 159). Music imaging can divert a patient's focus away from pain and towards relaxation while connecting with their inner experiences in the form of visualizations, physical sensations, emotions, memories, or fantasies. This can be particularly beneficial for older people with physical limitations because it allows them to enter into an experience that is unrestricted by the physical body, imbued with a sense of freedom and exploration. Entrainment is another standard receptive relaxation technique in which a patient's brain waves, breathing, and heart rate changes in response to music (Clements-Cortes, 2016). The therapist facilitates this by matching the music to the patient's breathing, guiding them to lower their heart rate by slowing down the tempo in a gradual, synchronized fashion. A third, more conceptual, technique is the iso-principle, in which music is used to reflect and then shift a patient's mood to a more desirable psychological state. For example, a therapist might match a person's mood with

musical tensions, followed by a gradual shift into a more relaxed and peaceful musical direction (Bradt & Dileo, 2010). Other common techniques include: music imagery, in which the music therapist provides live, improvised, or recorded music alongside descriptions of imagery; GIM, which was already described in this inquiry (see p. 29), and; environmental music, wherein the music therapist provides an atmosphere of calm within the end-of-life context (Dileo & Dneaster, 2005).

From a medical music therapy perspective, Dileo & Dneaster's (2005) Model of Music Therapy in Palliative Care highlights the importance of addressing physical needs before progressing to more in-depth therapeutic work. However, this perspective does not account for the holistic nature of *total pain*. Tao (2019), on the other hand, presents clinicians' perspectives of humanism in adult/geriatric palliative care, who describe these approaches as frequently assisting patients' experiences of pain by viewing patients' for their capacities while looking beyond their illness. Since humanistic approaches to music therapy are not applied *to* a person at end of life, but rather centred on the person's experience in terms of what they bring and express in sessions, music therapy can awaken patients' capacities by providing a "way for this person who is very limited to participate and be the protagonist of the entire process" (Tao, 2019, p. 8). This connection between physiological outcomes and a patient's sense of personhood emphasizes the importance of caring for the whole person, with an understanding of the interrelationship between older patients' physiological, psychological, and spiritual needs.

Older Adults' Safety Needs at End of Life

Safety needs are viewed as a second priority end-of-life need within Zalenski and Raspa's (2006) modified hierarchy. This need is defined as being both emotional and physical, "free of fears for physical safety, dying or abandonment" (Figure 2, p. 1124). The fears that accompany individuals at end of life are diverse, complex, and commonly intersect with physiological challenges. People with a terminal illness often experience fears related to decline in their ability levels, loss of independence and control, loss of previous identity, and disfigurement and/or alterations to their physical bodies (Cadrin, 2009; Chochinov, 2000). Chronic pain has been associated with fears related to, "death, and how the family system will cope" (O'Callaghan, 1996, p. 44; Tao, 2019). Zalenski and Raspa mention that an open dialogue with patients can lessen fear of death, anxiety, insomnia, and isolation. This has been substantiated by patients, who report the need for others to listen compassionately as they speak about their dying (Dileo &

Starr, 2005), and by clinicians, who indicate the importance of allowing palliative patients to verbally express emotions related to fear while remaining attentive to their non-verbal cues (Tao, 2019). However, the language patients use to express their needs can differ from that of their healthcare providers, resulting in inadequate assessments and interactions (Arnold, 2011).

As indicated previously, end-of-life discussions and preparations with older adults are often postponed due to the inaccessibility of psychosocial resources (Banner et al., 2019), impacting whether fears related to death can be adequately addressed in end-of-life contexts. In addition, there is a tendency for healthcare professionals to perceive older patients as finding it easier to come to terms with a terminal illness, which can contribute to a lack of referral to specialized palliative care and psychosocial supports (Gardiner et al., 2011). Stakeholders and older adults alike have described conversations about death and dying as being challenging, due in part to contemporary society's views of death as failure or defeat (Banner et al., 2019). In a qualitative study by Lewis et al. (2018) examining end-of-life priorities of six terminally ill older adults and their caregivers, participants named the importance of end-of-life discussions and described the difficulties they encountered when talking about death at every level, including with patients, family, health professionals, and in society. Participants stated that these discussions were either lacking, too late, or overly emotionally triggering. There is a clear need for psychosocial supports to be made accessible and available, where time and space is provided for older adults to safely express their personal concerns related to dying.

To receive appropriate support, older adults must be understood as a diverse group of individuals, with unique concerns related to illness and dying. This is particularly important when considering minoritized groups, who may have specific fears in healthcare contexts, such as discrimination and safety concerns (Kortes-Miller et al., 2018). In Ontario, Canada, Kortes-Miller et al. (2018) interviewed 23 LGBTQ2+ older adults (65+) regarding their concerns about end-of-life care in long-term care homes. Although many participants shared similar concerns with their heteronormative counterparts, such as fears related to loss of community, loss of autonomy, and social isolation, they highlighted unique concerns related to their sexual identities. These included fear of discrimination, lack of ability to advocate for themselves and navigate healthcare and social systems, lack of familial support or large social networks, and most notably, a need for safe and inclusive spaces within healthcare contexts. Participants envisioned these safe spaces as non-judgmental, inclusive, and accepting of their identities, "where they would be treated fairly

by healthcare providers and other residents" (Kortes-Miller et al., 2018, p. 219-220). A place for all older adults to feel safe and secure as they express concerns related to their identities, illness, aging, and death is both necessary and conceivable.

Addressing Older Adults' Safety Needs at End of Life through Music Therapy: Music Therapy as a Safe Space

Music therapists are trained to use music and their therapeutic selves safely and ethically with patients to address human needs within all health domains (CAMT, 2020). They follow an ethical code of conduct that includes keeping client information confidential while working towards psychosocial and emotional goals. These goals include acknowledging and addressing fears, anxiety reduction, and expressing emotions in both individual and group contexts (Clements-Cortes, 2011). Music therapists working from a humanistic lens practice from a place of empathy and unconditional positive regard (Abrams, 2015; Rogers, 1951), providing a therapeutic space in which patients' difficult emotions can be expressed and processed while feeling heard and held. Integrating these traits into music therapy sessions and the experiences contained therein provides a space of acceptance. Here, patients can become more fully aware of their inner experiences, helping them to express emotions, such as fear, both verbally and non-verbally while feeling supported in their personal exploration.

It is the unique, non-verbal nature of music, alongside the music therapist's *being there* (i.e., personal and musical presence; Bruscia, 1995), that appears to provoke less anxiety in patients than verbal discussions (McConnell & Porter, 2016). When working from a psychodynamic perspective, such is the case in Analytical Music Therapy (AMT; see Priestly, 1994), acquiring insight via verbal or musical means is a central feature of therapy. Music therapists working from this perspective view musical holding or containing techniques as promoting the full spectrum of emotional expression (Isenberg, 2015). Salmon (2001) refers to this as a "containing space" (p. 142), wherein patients' can feel safe to be themselves and where quality of life is enhanced using music as a medium for reminiscence, exploration, and expression of feelings. Here, not only can fears related to aging and dying be addressed, but people's diverse cultural and social identities can be expressed. This may be particularly important for minoritized patients who experience discrimination in healthcare contexts. In this safe space, older patients can embrace the present moment while addressing their fears head-on. To further ensure a safe environment for patients, music therapists should practice self-care and

self-centering techniques, which can assist them to hear (i.e., experience) patients with all of their senses (Magill, 2005).

Some music therapy experiences have been shown to have a positive impact on specifically older adults' psychosocial behaviors and anxiety levels, which may be particularly effective in helping them to cope with their anxieties and fears surrounding the end-of-life process (Davis et al., 2019). For instance, illnesses such as cancer and coronary heart disease are known to invoke anxiety in patients, due to the major life changes that accompany them (Hirsch & Meckes, 2000). Relaxation in music therapy can reduce this anxiety, as well as the nausea patients experience during chemotherapy, by lowering apical heart rates and increasing peripheral temperature (Stuckey & Nobel, 2010). Active music-making, such as music improvisation, provides a structure wherein patients can work through their anxiety and grief, engage in non-verbal expression, and safely explore their emotions (Hilliard, 2001). Music imaging (see p. 34) is another experience that can alleviate stress, helping patients to feel supported while accessing their personal resources within an otherwise chaotic experience of illness (Abrams & Kasayka, 2005). In all of these ways, the music can be used as a vehicle for communication, expression, and emotional release, with music sounding externally how emotions feel internally. In accordance with humanistic music therapy practices, balancing of verbal and non-verbal techniques can be negotiated according to an older person's needs, desires, and potentials within each session.

Magill (2005) eloquenty describes the spectrum of emotional possibilities in music therapy at end of life: "The compassion, love, empathy, and energy that the therapist brings to others, along with the intangible grace of music, creates the temple within which others may safely experience their feelings, hopes, wishes, dreams, images, memories, and prayers" (p. 7). Ultimately, emotions at end of life can include suffering, as well as joy and release (Tao, 2019). Through building a therapeutic relationship based on principles of trust, empathy, and unconditional positive regard, and providing a space for emotional expression and release, older patients may begin to reconcile with their fears, stepping into a more balanced state of psychological well-being. There is also a possibility for this exploration of older peoples' inner lives to, "provide the way forward for growth and greater self-knowledge" (Priestly, 1994, p. 3).

Older Adults' Belonging Needs at End of Life

Zalenski and Raspa (2006) refer to belonging needs as third level needs at end of life that include, "social needs such as affection, love, and acceptance in the face of devastating illness" (p. 1120). They emphasize the need for family members, caregivers, and health providers to demonstrate love for the patient, beyond their illness, and for the patient to reciprocate this love. By treating patients with respect and empathy while acknowledging their individual needs, a more life-affirming collective community of caring can emerge, in which patients feel a sense of inclusion. This idea aligns with the CHPCA's (2013) concept of the *Circle of Care*, in which the interprofessional team forms a circle of care around the patient and their loved ones.

Belonging is based on a sense of connection to oneself, others, and conceivably one's culture, since cultural ties are so intimately integrated into one's social identity. Unfortunately, healthcare providers often overlook gerodiversity in ageing populations, which can result in homogenous, one-dimensional healthcare strategies that fail to meet the intersectional needs of aging individuals (D'cruz & Banerjee, 2020). Westwood (2019) stresses the importance of cultural identity, stating, "Equality of recognition involves social status, cultural visibility, and cultural worth" (p. 6). For older members of minoritized groups in Canada, valid concerns regarding discrimination in care contexts can lead to distrustful attitudes toward care providers and institutions (Furlotte et al., 2016; Kortes-Miller et al., 2018). For example, in the previously discussed study by Kortes-Miller et al. (2018), many older members of the LGBTQ+ community desired *nuanced care*, including a sense of mutuality and support between residents and care providers. Rather than assimilating patients into dominant cultural norms within end-of-life contexts, healthcare providers must commit to discovering more about each patient. This includes aiming for cultural competency in their areas of practice, and creating a "difference-friendly" (p. 6) world of cultural belonging, in which patients' cultural identities are valued and integrated into end-of-life care practices (Westwood, 2019).

Aging and illness are also accompanied by changes in health and personal losses, which can impact an older person's sense of social belongingingness in the world. Research has shown older adults as having less substantial social and family supports to advocate on their behalf than younger people have (Choi et al., 2008; Gardiner et al., 2011; Hutchinson et al., 2011), which can lead to a lack of proper palliative care provision and psychosocial support, and accentuate feelings of isolation and loneliness (D'cruz & Banerjee, 2020; Gardiner et al., 2011). While some

palliative patients experience isolation as a result of having no one to share emotions with, isolation may also be caused by holding onto emotions that are too difficult to share (McConnell & Porter, 2016). In some cases, patients hide challenging emotions to protect their caregivers, who may be experiencing their own set of emotional difficulties, such as depression, social isolation, hopelessness, and anticipatory grief (Abbott, 2013; Clair & Memmott, 2008; Krout, 2015). These caregivers can learn to better support themselves and their dying loved ones by engaging in self-care practices, including seeking psychosocial support, learning stress management techniques, and developing constructive emotional expression (Abbott, 2013; Clair & Memmott, 2008).

With cultural and social aspects of older adults' identities in mind, end-of-life environments should make efforts to create an atmosphere that feels less isolating and more like home to its inhabitants. In a phenomenological study regarding person and environment factors of elders' cultural heritage, Hutchinson et al. (2011) facilitated in-depth interviews with 23 newly admitted African American and Caucasian long-term care residents. Many participants indicated a lack of meaningful interactions with others in their lives and described the various types of loss they had encountered, including loss of relationship and family members through death. Residents yearned for a sense of their cultural, personal, and environmental backgrounds to be reflected in their lives within the long-term care home, and described family and home as generating especially pleasant memories. Interestingly, enjoyment of music was named by both ethnic groups as a major component of their cultural heritage. For older peoples' conceptualizations of home to be fulfilled, inclusive opportunities for social and cultural connection must be created, where older patients can feel a sense of support from and for others while engaging in meaningful activities and working towards common goals in collaboration (Abbott, 2013).

Addressing Older Adults' Belonging Needs at End of Life Through Music Therapy: Music Therapy as Connection

Music therapy has the potential to serve as a source of creative community in end-of-life settings. According to Magill (2005), patients and their loved ones can experience the essence of their beings in music, resulting in a feeling of connectedness with themselves, others, and the "Divine" (p. 4). From a humanistic perspective, the music therapy process is relational, with interpersonal and intermusical connections laying the groundwork for change (Abrams, 2015).

Through building and maintaining unique therapeutic relationships, music therapists can help to identify family caregivers who are not coping well, and in these cases, sessions can be offered to caregivers with a focus on teaching coping skills, providing emotional support, and addressing anticipatory grief (Dileo & Dneaster, 2005; Krout, 2015). By addressing their own needs, caregivers may acquire an improved capacity to handle their dying loved ones' emotions, and patients may feel more prepared to express difficult emotions in the presence of their caregivers. Music therapy sessions provide an outlet for both parties to share emotions, such as grief, through music and a verbal dialogue, in collaboration with the music therapist. Here, they can be validated, normalized, and explored (Krout, 2015). By engaging in meaningful music-based experiences, patients and their loved ones are welcomed into a world beyond their illness. This may be a particularly powerful experience for patients who are unable to communicate with family members due to a medical condition, since music provides a medium for saying the unsayable, connecting to others without the need for words.

Music therapy sessions can include active or receptive participation of family members and patients, such as recreating or listening to a preferred piece of music, which helps to stimulate discussions related to music's shared significance in their lives (Krout, 2015). In legacy work, a variety of music therapy experiences can unfold through the collection and compilation of memories, stories, songs, artwork, and music to create a multi-media or "Living Legacy Project" (p. 136) in the form of CD recordings, DVDs, and/or playlists for patients to gift to their families (Wlodarczyk, 2009). This is a particularly effective tool for improving communication and social bonds with loved ones while helping older adults to share their values. Through reflecting on and consolidating their life experiences, legacy work can provide older adults with a sense of continuity and their loved ones with a sense of comfort (McConnell & Porter, 2016).

Due to its its potential to elicit powerful emotional responses, music may be an overwhelming medium for some patients and/or their loved ones, resulting in contraindicative effects such as eliciting very strong grief and/or loss responses (Abbott, 2013). In these instances, music therapists may consult with patients and their families, as well as use their clinical judgment to decide if music therapy or certain music therapy experiences are contraindicated. Music therapists can seek out a variety of techniques and resources to inform their decisions in these cases, such as Bright's (2002) book *Supportive Eclectic Music Therapy for Grief and Loss*, which contains several approaches and experiences to be used sensitively with a variety of patient

populations, including older adults. Individual sessions may be warranted for older adults who feel the need to conceal difficult emotions from their caregivers out of concern for their well-being, and who are in need of connection to their own emotional responses to illness and death.

The shared historical and universal understanding of creative and healing rituals contributing to health and well-being among various cultures can also be a connecting force in bringing older adults together (Callinan & Coyne, 2018; Stuckey & Nobel, 2010). Kim and Whitehead-Pleaux (2015) state, “The beauty of music is that it can touch and unite people who are quite diverse (e.g. with different outlooks, ethnicities, sexual orientations, and socioeconomic classes) and who otherwise might not perceive common ground between themselves" (p. 51). Group music therapy sessions can establish and maintain an inclusive environment for older adults to engage in collaborative music therapy processes, resulting in patients of all cultural backgrounds and identities feeling a sense of connection and belonging. To uphold inclusivity, the music therapist is advised to model openness, accept diversity, and encourage group members to reflect these behaviors towards one another (Moulder, 2019). The music therapist must also commit to lifelong learning toward understanding patients’ cultures and the roles that music plays within them (Kim & Whitehead-Pleaux, 2015). Self-reflexivity, cultural humility, effective facilitation, and upholding the CAMT code of ethics (1999) are all important and necessary components of culturally competent facilitation. Staff members and loved ones may also decide to participate in group sessions, which may involve each group member sharing a familiar piece of music (recorded or live) that reflects their personal, cultural, and/or social experiences. These creative opportunities, combined with social engagement, provide moments for older adults to feel seen and heard by others. This can be particularly significant for older patients who have no surviving loved ones or close caregivers. In these ways, music as a creative process of connection can be understood as a ritual to evoke a sense of collective healing.

Older Adults’ Esteem Needs at End of Life

As a fourth level need at end of life, Zalenski and Raspa (2006) define esteem needs as a patient’s sense of self-esteem and self-worth. Addressing this need involves recognizing a patient for who they are and who they have been, working towards restoring their sense of value and worth by maintaining appreciation for them. Zalenski and Raspa advise interdisciplinary team members to listen to patients and embrace connections to their memories, which can result in a sense of healing and closure. Esteem needs can be particularly important for patients who are

experiencing depression caused by personal losses, including decreased control over one's health needs and increased dependence on others (Albu & Voidăzan, 2016). Unfortunately, psychological challenges, such as depression, are both underdiagnosed and undertreated in palliative care contexts (Albu & Voidăzan, 2016), due in part to deficit-perspectives that fault patients for their emotional responses to illness (Rykov, 2006). Interdisciplinary teams need appropriate resources and training to adequately support patients as they face these personal challenges.

As individuals reach the final stage of their lives, they may experience various types of losses, including loss of family members, relationships, jobs, missed opportunities, health, functional abilities, and their future (Hutchinson et al., 2011). Some older adults may also anticipate their capacity for decision-making being taken away, having watched their role in society change from being independent to dependent, or in some cases, being one of a few remaining from a social group (Abbott, 2013). This combination of losses can significantly impact older adults' psychosocial and emotional well-being, bringing about feelings of powerlessness, uselessness, and indignity (Abbott, 2013; Bright, 1997). According to Hutchinson et al. (2011), the loss that is most profoundly felt by many older adults is a loss of control over their present circumstances. Since many terminally ill older adults increasingly depend on others for support as they navigate their health circumstances, they may lose sight of their perceived identity and sense of dignity as they face the prospect of dying, having little control over their lives (Magill, 2005; WHO, 2011).

Many older adults wish to continue to make their own decisions in end-of-life care, and it is especially important for them to do so when they are lacking social supports. Advance care planning, which involves discussions with older adults regarding their preferences for future care, is an integral component of respecting and prioritizing older adults' values and views about health and well-being (WHO, 2011). Providing a platform for older adults to exercise this type of agency over their health needs can influence whether an older person feels valued (WHO, 2011). Integrative approaches to health, such as collaborative medicine and education, also encourage patients to contribute to their treatment, providing them with opportunities to make choices in this regard (Hirsches & Meckes, 2000). To reengage with life and maintain a stable sense of self-esteem, older adults need to have opportunities to recognize and communicate their life experiences with others. This can be achieved by having their spirituality affirmed, experiencing

a sense of control over their lives, having realistic expectations of themselves, and expressing their losses as well as their creativity (Abbott, 2013).

Addressing Older Adults' Esteem Needs at End of Life Through Music Therapy: Music Therapy as Self-Empowerment

Humanist-oriented practices in music therapy that focus on meaning, pleasure, empowerment and agency hold significant potential to address self-esteem and self-actualization needs for older adults in end-of-life contexts (Baker, 2015). In Dileo and Dneaster's (2005) Model of Music Therapy in Palliative Care, esteem needs are included at the second, communicative level of music therapy practice. Goals include: achieving awareness of one's limitations and losses, maintaining identity, enhancing feelings of control/reducing helplessness, and enhancing one's self-esteem. In the therapeutic space, patients are provided with a platform to reconnect to their identities while feeling supported and listened to. Music therapy offers a unique opportunity for older adults with a terminal illness to exercise agency and express their identities while making their values and life experiences known to others. As stated previously, music involves creative action, self-direction, and self-identification which can stimulate empowerment, or tap into one's inner resources, through creative, positive, and agentive musical experiences (Hirsch & Meckes, 2000).

Music therapists utilize a variety of experiences and techniques in end-of-life settings, realized according to an individual's strengths and needs (Hilliard, 2001; McConnell & Porter, 2016). By adapting sessions to align with older adults' capabilities, and collaborating with them in goal formulation and care planning, older adults have a platform upon which to exercise agency and autonomy over their health needs. Within an oncological hospital context, Hirsches and Meckes (2000) assert that, "Music and art are a means for helping patients with cancer explore and develop their personal potential for growth" (p.68). This implies that when a seriously ill individual has an opportunity to guide creative experiences in music therapy on their own terms, they can gain a sense of control and empowerment in an otherwise uncontrollable situation.

Control and empowerment may be particularly beneficial for older adults, who often lack access to these ways of being due to the aforementioned losses, challenges, barriers, and stigmatization they face as terminally ill people. In music therapy sessions, older adults can make decisions regarding their preferred music experiences. For some, selecting a favourite piece of

music to listen to or recreate can connect them to their history and identity, validating the healthier, vibrant parts of themselves that may be neglected by care providers, or that they themselves may have forgotten. Cognitive reframing is a technique used by some music therapists to help shift patients' complicated self perceptions (Dileo & Dneaster, 2005). Through reframing, patients can move from a perspective of one's self as a sick person to viewing one's self as a capable and creative being. This occurs via engaging in new musical experiences that "[enable] a space for contemplation of 'being'" (O'Callaghan et al., 2015, p. 473) while living in the present moment (McConnell & Porter, 2016). For instance, a case study by Cadrin (2009) describes GIM sessions with a 47-year-old female palliative patient. After developing a sense of self-awareness over a course of insight oriented GIM sessions involving deep music listening and reflection, the patient moved towards reclaiming her sense of identity and self by acknowledging feelings of shame related to her cancer diagnosis, addressing her fears, and surrendering the former, healthy identity she had been attached to (Cadrin, 2009). Active music-making, such as singing or playing an instrument, can also provide patients with a source of personal accomplishment and fulfillment, which can contribute to role identity (Creech et al., 2013; White, 2016). Through engaging in music-making, older adults can express their losses and gain a realistic expectation of their potentials (Abbott, 2013; Weissman, 1983). Accessibility in sessions is an important factor in determining whether older adults feel empowered, such as ensuring that patients can see and hear properly, providing adaptive equipment when needed, and accounting for any changes in cognitive and motor abilities (Abbott, 2013).

Another important element related to a patient's sense of empowerment lies within the therapeutic relationship. Music therapists working within a humanistic orientation attempt to attune to patients' needs while conveying empathy, respect, support, validation, and affirmation towards the person behind the patient label (Magill, 2005). By modelling acceptance and non-judgment, patients may begin to reflect these attitudes towards themselves. Reflective listening, which includes restating and paraphrasing patient's expressed thoughts and feelings, is a key component of effective therapy, because it demonstrates understanding and support for the patient's perspective (Magill, 2005). In deficit-oriented environments where palliative patients are perceived according to the things they lack, the music therapist's ability to recognize and meet older adults' capacities beyond their illness, disabilities, limitations, and age can have a significant impact on their sense of dignity and esteem (Tao, 2019).

Older Adults' Self-Actualization Needs at End of Life

Self-actualization is a process and experience that is unique to every individual. While the end-of-life period can bring forth significant suffering and hopelessness, this chapter of life can also compel individuals to find meaning, closure, and a sense of peace. Dyess et al. (2020) state, "The journey toward attaining that potential [self-actualization] within a life is often hastened with the imminence of death" (p. 324). As a fifth level need and ultimate end-of-life care goal, self-actualization is positioned at the peak of Zalenski and Raspa's (2006) hierarchy. Although it is perceived as occurring after basic needs are met, self-actualization can be achieved after or while basic needs are wholly or partially fulfilled, since these may no longer serve a person at end of life. The authors describe self-actualizing as taking a person away from total pain and toward human fulfillment. Self-actualization can appear in any or all of the following ways: personal journey growth within one's experience of illness; feelings of generativity and connection with others, and; experiences of "peace, transcendence, and closure" (p. 1124) through connection to "Other" (Zalenski & Raspa, 2006, p. 1124). Zalenski and Raspa describe self-actualization as being interchangeable with transcendence, which they liken to Saunder's (2006) description of a patient's being oneself. Transcendence is a form of deep connection with others, nature, or the "Divine", and "the perception of beauty, truth, goodness, and the sacred in the world" (Zalenski & Raspa, 2006, p. 1121). For patients at end of life, these experiences of beauty and connection can be particularly potent, bringing with them a sense of meaning, aliveness and enlightenment.

Suffering is a central barrier that can limit potential for growth. When a person reaches the end-stage of life, expectations and understandings of the world can change, which may challenge meaning and purpose (Cadrin, 2009). Dying patients can experience suffering in the form of fear, anger, hopelessness, helplessness, as well as symptoms of withdrawal, isolation, and depression (Magill, 2005), which can further compromise their well-being. However, when patients are provided with opportunities to work through this suffering, the potential for growth is made possible. As Cadrin (2009) states, working through suffering can result in a "heightened sense of well-being with new resolutions, insights, and a quality of life in which acceptance and peace are experienced"(para. 10). Spirituality is one answer to a person's suffering.

Spirituality in health contexts can be defined as meaning-making, which may or may not be influenced by religion (Daaleman & VandeCreek, 2000; McConnell & Porter, 2016; Tao,

2019). Meaning-making is understood and expressed in different ways according to age, religion, culture, and health status (Gholamnejad et al., 2019). For older people with chronic disease, spirituality can create a sense of calm, vitality, and resolution (Gholamnejad et al., 2019, p.210). This is demonstrated in Banner et al.'s (2019) study regarding end-of-life preparation, in which older patients mentioned the importance of spiritual processes for themselves and their loved ones. One participant commented, "There's a lot more to being prepared than just signing a load of documents … there's a spiritual and lasting legacy. How we reach peace with ourselves and get ready to die that way." (Banner et al., 2019, p. 216). Here, spirituality is viewed as a preparatory act, where a person takes stock and finds meaning in their existence. In finding meaning, patients can experience "subtle existential shifts" (Dyess et al., 2020, p. 323) that occur in moments of emotional reflection and aesthetic experience, where beauty and meaning are embodied and felt (Aldridge, 1995; Dearmond, 2013). These shifts can occur in the form of transcendence, or transcendent moments through peak experience, and include a sense of flow, self-forgetfulness, and living in the present moment. There is a possibility for these small moments to transfer into long-term feelings of connection with others, nature, the universe, and/or the *Divine*, bringing with them a sense of awe, wonder, gratitude, and possibility (Zalenski & Raspa, 2006). As one clinician stated in Tao's (2019) study, "I believe that spirituality is really that which can be growing until we die. [When] our physical, mental, and functional capacities are shutting down, then, above all, the spiritual can have a greater development" (p. 7).

A number of psychological and spiritual theories make a case for older adults' inherent capacities to strive toward self-actualization, in which the aging process is viewed as a progression away from selfishness and toward selflessness (D'Souza & Gurin, 2016). For example, Erik Erikson's (1963) psychosocial developmental theory asserts that a person's final developmental task is to attain deeper integrity over despair. To obtain this sense of integrity, older adults are advised to find a sense of cohesion, integration, and meaning through reflecting on their lives (D'Souza & Gurin, 2016), which can help them to arrive at feelings of peace and well-being (Moulder, 2019). When interdisciplinary teams support older patients in their journeys toward self-actualization, patients can achieve new insights about the world and their place within it. According to Zalenski & Raspa (2006), one way to achieve this is to provide opportunities for patients to dream. Another is to discuss with patients how love, time, and faith have consolidated to create meaning in one's life (Dyess et al., 2020). A final way can be found

in Maslow's conjecture that organizations should encourage individuals to realize their inherent ability to appreciate and express creativity (Greene & Burke, 2007).

Addressing Older Adults' Self-Actualization Needs at End of Life Through Music Therapy: Music Therapy as Meaning

"Ironically, it is the feared realm of depth which has the potential to offer experiences of wholeness, integrity, and meaning" (Salmon, 2001, p. 143). Meaning-making is viewed as one of the most important mechanisms in music therapy for improving spiritual/existential well-being outcomes at end of life (McConnell & Porter, 2016) and a large body of literature attests to its unique role in spiritual care (Krout, 2015; Magill, 2005; McConnell & Porter, 2016; Tao, 2019). In music therapy, spirituality is often understood more broadly as being related to both religious and non-religious personal challenges (McClean et al., 2012). Some end-of-life spiritual goals in music therapy include: facilitating new ways of being, discovering the purpose of living/dying, embracing living, forgiving others or oneself, and discovering meaning in life/suffering (Dileo & Dneaster, 2005). Humanistic music therapy views the patient as whole and contextually situated, possessing self-agency and self-insight (Abrams, 2015, p. 153). When music therapists support patients to be agentive and insightful by collaborating in goal formulation or selecting a piece of music, for example, they can help patients to understand what holds meaning in their lives. Meaning-making can occur through experiences of song-writing, listening to a patient's preferred music, musical improvisation, life review, and legacy work (McConnell & Porter, 2016). By establishing and building a therapeutic relationship based on respect, trust, and empathy, music therapists can support patients to review their lives through musical experiences, where meaning can be found in the sharing of values, beliefs, lived histories, and present circumstances (McConnell & Porters, 2016). Music therapy experiences such as engaging in life review can result in patients working through suffering, feeling and expressing love, connecting to their belief systems, and arriving at a sense of peace (Tao, 2019).

While music therapy can help older adults achieve non-musical goals, such as consolidating and integrating their life experience through legacy work, music alone can help patients to find meaning in the present, musical moment. Aldridge (1995) views meaning-making, or spirituality, as being linked to hope and creativity, and describes music therapy as a creative act in which patients are required to be self-defining while opening themselves up to possibility, taking initiative, and making form out of chaos while creating something beautiful. In

this way, the value of music lies in its visceral qualities, such as beauty. The concept of aesthetic experience is often undervalued and unexplored in healthcare and end-of-life contexts, yet aesthetic experiences can constitute meaning in a person's life and "breathe life into living" (Pangborn, 2017, p. 1182). Aesthetic experience can have both a preventative and curative effect on patients (Kenny, 2012), drawing them into the here-and now with the music therapist, where possibility and imagination exist in the unfolding of the process. These experiences can inspire presence and appreciation for life, calling upon a person's strengths and resources while opening the gates to their inner belief systems and emotional worlds. Rather than aiming for a specific outcome, aesthetic experiences in music allow patients to pursue new understandings of hope, where, although decline and death are inevitable, there is still life (Moss, 2019). For music therapists to inspire older adults to engage in these acts of beauty and creativity, that which holds meaning for them must be prioritized (Panborn, 2017). Essentially, music can act as a medium rather than a means to an end, allowing older adults to experience and appreciate life with all of their senses.

This concept of music as a medium will be revisited in the next section, in which music is understood as a vehicle for transcendence and transformation. While many connecting threads exist between the concepts of meaning and transformation, they have been divided in this inquiry for the purpose of clarity.

Addressing Older Adults' Self-Actualization Needs at End of Life Through Music Therapy: Music Therapy as Transformation

As stated previously, transcendence and peak experiences are viewed as essential components of music therapy in addressing spiritual concerns at end of life (Aldridge, 1995; Moss, 2019; Cadrin, 2009; McConnell & Porter, 2016; Salmon, 2001; Magill, 2006). Interpersonal and musical experiences offer unique potential for personal transformation and transcendence, since music can facilitate transpersonal experiences containing beauty and meaning (Salmon, 2001). For instance, a cornerstone of GIM lies in its helping clients to achieve personal growth through reaching a higher state of consciousness and peak experience, where the music draws a person completely into an experience, both physically and psychologically (Wheeler, 1981). In humanistic music therapy, when music is understood as a medium, musical goals met within a musical experience can, "signify the actualization of agency that represents a fundamental shift in being, even after only one occurrence in a single session" (Abrams, 2015, p.

153). This reflects the subtle shift that occurs in moments of transcendence, helping a patient to feel closer to themselves, to others, and to the *Divine*.

Music offers a medium for processes of transcendence, where patients can reach a state of being that extends beyond time, distress, and suffering (Magill, 2005). As Moss (2019) states, "Music can remind people of their connection with creativity and ultimately with the creative life force" (p. 213). Accordingly, music can help older people at end of life to accept themselves through musical experiences that transcend their limitations. The concept of the *music child*, mentioned earlier in Kim's (2010) study (see p. 28), can be harnessed by young and old, through spontaneity and expression. Salmon (2001) describes music therapy as providing a unique experience in which the therapist and the terminally ill patient, along with the music, can travel beyond ordinary awareness into the realm of "psyche and spirit" (p. 145), where they can have deep and meaningful experiences, returning safely to regroup afterwards (Salmon, 2001). In these moments, a patient may transcend their bodies and minds, leave behind their illness and limitations, and connect to a force beyond themselves. This deep awareness can bring insights and emotions into conscious awareness, leading to transformation of suffering, where a greater sense of meaning, integrity, and well-being is experienced (Moss, 2009; Salmon, 2001). Transcendence and transformation can also be felt in subtler ways within music therapy processes, by engaging in simple pleasures, including laughter, relaxation, and having fun (McClean et al., 2012; McConnell & Porter).

According to the third, transformative level in Dileo and Dneaster's (2005) Model of Music Therapy, transformative experiences at end of life can also occur through relationship. This is reminiscent of Zalenski & Raspa's (2006) definition of self-actualization, which includes "closure and generativity" (p. 1124). Older adults can create lasting connections with younger people in their lives by writing a song or gifting a piece of music that holds meaning for them (Wlodarczyk, 2009). Sharing personal messages and values through music can provide older adults with an opportunity for personal growth, and a lasting link to future generations. A study completed by Clements-Cortes (2011) regarding music therapy's role in relationship completion and closure with older adults at end of life used Dileo and Dneaster's (2005) three levels of practice, including supportive, communicative, and transformative levels to describe music therapy sessions (24-35) with four older adults over a course of 14 to 20 weeks. After moving through each level of practice, findings showed that music therapy helped to facilitate a sense of

closure over time in participants' relationships between their loved ones and themselves. Six themes were identified: love, loss, gratitude, growth/transformation, courage/strength, and goodbye (Clements-Cortes, 2011). Clements-Cortes stated that when participants used their last weeks to live, "they were open to growth, learning, and the possibility of transformation" (p. 36).

Ultimately, when music therapy is understood as meeting older adults' self-actualization needs at end of life, it is both a process and product, where older adults can experience beauty, discover meaning, acknowledge suffering, consolidate life experiences, transcend limitations, connect to the present moment, find inner peace, activate their capacities for living, and, as an answer to Zalenski and Raspa's proposal, dare to dream.

Chapter 5: Discussion

Circle of Self-Actualization: An Evolving Approach to Music Therapy with Older Adults at End of Life

The purpose of this philosophical inquiry was to make a case for how older adults' self-actualization needs at end of life might be realized through music therapy, utilizing Zalenski and Raspa's (2006) framework for achieving human potential in hospice as a reference point. The central question that guided this philosophical inquiry was: Why do older adults need opportunities for self-actualization through music therapy at end of life, and how might this be conceptualized using an adapted version of Zalenski and Raspa's framework for achieving human potential in hospice? By examining and analyzing literature, it was affirmed that music therapy, particularly when realized within a humanistic theoretical orientation, can play a unique and critical role in addressing older adults' journeys of self-actualization at end of life. This was easily accommodated for using an adaptation of Zalenski and Raspa's framework.

The *Circle of Self-Actualization* is a visual depiction and summary of the fundamental tenets of the evolving approach described in Chapter 4 (see Figure 1).

Figure 1

Circle of Self-Actualization: An Evolving Approach to Address Older Adults' Self-Actualization Needs through Music Therapy at End-of-Life

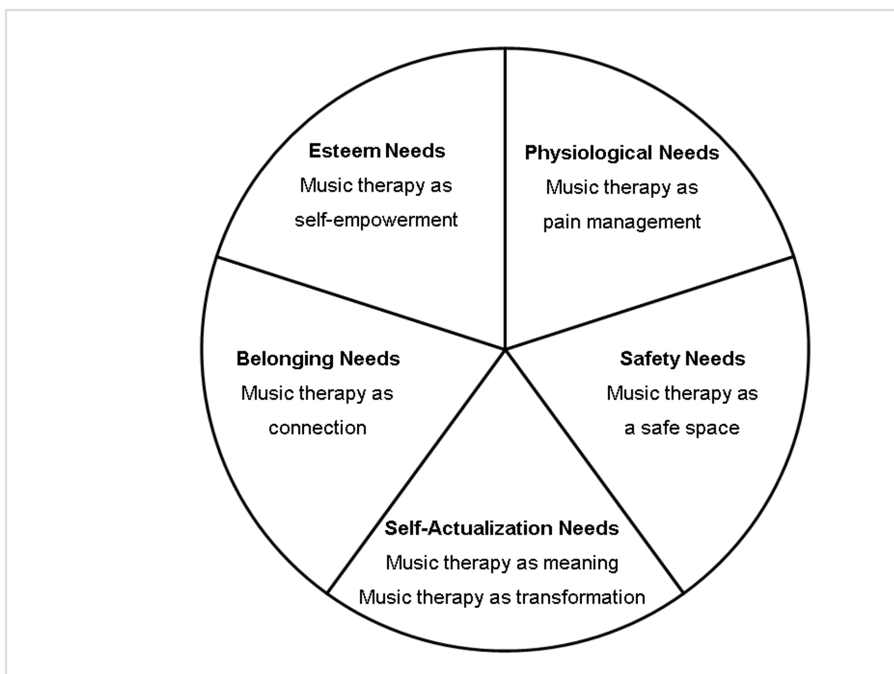

Image description: The *Circle of Self-Actualization* is a circular visual diagram in the form of a pie graph, which presents each need and its corresponding music therapy conceptualization as an equally distributed triangular piece of pie, separated by lines. These lines connect at the centre of the circle.

While Zalenski and Raspa (2006) present their framework as a pyramid, with the less frequently realized need of self-actualization at its apex, I opted to use a circular visual diagram. There are two primary reasons for doing so, which draw upon humanistic (Abrams, 2015), critical humanistic (Hadley & Thomas, 2018), and relational worldview (Blackstock, 2011; Cross, 2007) models. First, each end-of-life need contained within the *Circle of Self-Actualization* is recognized as being interdependent, interrelated, and of equal significance in music therapy. Although each need was described in isolation, the circle represents each need as being "viewed within the larger context of a client's whole being" (Abrams, 2015, p. 154). The circular formation represents an opportunity for older adults to decide which needs are most important for their well-being, according to their personal and sociocultural values and preferences. Although self-actualization is situated as an ultimate care goal in this inquiry, self-actualization is understood as being both a sum and a component of end-of-life needs. For example, a patient may experience moments of transcendence by having their belonging needs met.

Second, the *Circle of Self-Actualization* presents self-actualization as being inherently relational and context-dependent. How music therapists and other interdisciplinary team members relate to older patients is a two-tiered experience that includes their relationship as individuals, and their relationship as socio-cultural beings (Hadley & Thomas, 2018). These relational aspects influence the level of end-of-life care older adults receive. For example, whether an older person's safety needs are met may depend on their sense of belonging, such as whether they feel culturally recognized and valued within their end-of-life environment. The *Circle of Self-Actualization* has been purposefully left open to interpretation, to be realized according to each older patient's preferences and needs and the music therapist's clinical judgment.

Limitations

This research contained limitations that must be acknowledged. I am a novice researcher and a new music therapy practitioner, who completed a one-year internship in palliative care.

Additional clinical experience in this area and with older adults in particular may have provided me with additional insights on how to organize and interpret the data and perhaps strengthened the practical applicability of the results. This research pertains specifically to neurotypical older adults, meaning its applications to older adults with neurocognitive disorders, such as dementia, may be limited. Music therapy literature pertaining specifically to older adults at end of life was lacking, therefore some generalizations were drawn from palliative care and music therapy literature pertaining to general adult populations, as well as articles pertaining to older adults' relationship to music. However, efforts were made to include literature that contained older adults' voices (i.e., direct quotes). Since no research participants were involved in this inquiry, older adults' direct perspectives are lacking. As a result, important needs and perspectives may be missing from the *Circle of Self-Actualization* that could be of value to older adults at end of life and their families.

Implications for Music Therapy Practice

The concise and visual accessibility of the *Circle of Self-Actualization* may help music therapists to conceptualize, implement and communicate their work with other staff members, patients, and/or their loved ones in a comprehensible way. Music therapists might more readily identify and support older adults' resources, capabilities, and transformative potentials at end of life by conceptualizing self-actualization as a core aspect of their practice. This might also include recognizing end-of-life needs as interconnected, interrelated, and context-dependent. Music therapists could use this evolving approach as a tool for collaborating with older persons in care plan formulation, while accomodating for individualistic conceptions of health. This approach may be used as a preventative measure with older adults who are not terminally ill and with other populations. Since the *Circle of Self-Actualization* is based on a framework designed specifically for interdisciplinary teams, it offers potential utility as a conceptual, practical and collaborative tool for healthcare teams to recognize and address older adults' self-actualization needs at end of life, reflecting the CHPCA's concept of the *Circle of Care*. The *Circle of Self-Actualization* is open to interpretation, and is therefore adaptable for a variety of music therapy approaches.

Recommendations for Future Research

The *Circle of Self-Actualization* is an evolving approach based on literature and my understanding to date, as a new music therapist, of music therapy in end-of-life care with older

adults. Further research examining how the *Circle of Self-Actualization* can be realized by music therapists working in various end-of-life contexts with older adults would help to refine and develop this approach. Music therapists and other professionals might collaboratively examine the *Circle of Self-Actualization* from a theoretical or practical lens, using their unique professional perspectives to reconceptualize and build upon it. This may include finding additional connections between other models, techniques, and approaches that resonate with Zalenski and Raspa's framework. Researchers could investigate older adults' perspectives on self-actualization as a concept, or the capacity of the *Circle of Self-Actualization* to meet their end-of-life care needs. There is potential for music therapists and other professionals to conduct research to understand how this approach can be realized at end of life with older adults who are experiencing specific challenges, such as those living with dementia.

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