ABSTRACT

As our elderly population increases, more music therapists will be providing services to the elderly in a variety of settings: community-based programs, skilled nursing facilities, and assisted living facilities. Our society takes a dim view of aging, attempting to perpetuate youthful activities and physical appearance. There is little in the literature connecting music therapy with the field of gerontology, and even less on the connection between music and spirituality. This thesis is an attempt to fill these gaps, and to provide a starting point for music therapists so they can begin to examine their own philosophies and theories of music therapy and the elderly. The purpose of this thesis is to describe the journey of one music therapist's process in developing a theory of elder music therapy. The researcher provides a survey of music therapy literature describing music therapy research with the well- and unwell-elderly; an examination of Erikson's theory of human development and the aging theories of activity, disengagement, continuity, successful aging, and gerotranscendence; and a discussion of aging and spirituality. The researcher discusses a model of integral aging and the role of music and spirituality in the context of developing a theory of elder music therapy. Implications for music therapists are discussed.
DEFINITIONS

Generativity

The Oxford English Dictionary (2012a) defines generativity as "the fact or quality of contributing positively to society through activities such as nurturing, teaching, and creating."

Religion

"A particular system of faith and worship" (Oxford English Dictionary, 2012b).

Spirituality

"The quality or condition of being spiritual; attachment to or regard for things of the spirit as opposed to material or worldly interest" (Oxford English Dictionary, 2012c).

Transcendence

"The action or fact of transcending, surmounting, or rising above; . . . excelling, surpassing; also, the condition or quality of being transcendent, surpassing eminence or excellence" (Oxford English Dictionary, 2012d).

Transcendent

"Surpassing or excelling others of its kind; going beyond the ordinary limits; pre-eminent; superior or supreme; extraordinary. Also, loosely, Eminently great or good; cf. 'excellent'" (Oxford English Dictionary, 2012e).

Transpersonal

"That transcends the personal, transindividual; spec. designating a form of psychology or psychotherapy which seeks to combine elements from many esoteric and religious traditions with modern ideas and techniques" (Oxford English Dictionary, 2012f).
Well-being and wellness

The National Wellness Institute (NWI), in collaboration with health and wellness leaders, has developed three tenets of wellness:

• Wellness is a conscious, self-directed and evolving process of achieving full potential
• Wellness is multi-dimensional and holistic, encompassing lifestyle, mental and spiritual well-being, and the environment
• Wellness is positive and affirming (National Wellness Institute, 2012, para. 2)

and define wellness "an active process through which people become aware of, and make choices toward, a more successful existence" (National Wellness Institute, 2012, para. 3).

According to the World Health Organization (WHO) (2012), "health" is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (p. 1), and MedlinePlus (2012) defines wellness as "the quality or state of being in good health especially as an actively sought goal."

While the NWI and the WHO relate wellness to all aspects of an individual and his or her life, MedlinePlus defines it more narrowly to apply to physical health. In order to avoid confusion, I will use the term well-being, as a stand-alone term, to refer to overall health that encompasses physical, psychological, social, economic, intellectual, and spiritual well-being.

Well-elderly

It is not clear from my perusal of research specifically targeting the "well elderly" what is meant by the term. A cursory search via the SUNY Fredonia online databases of approximately 30 articles provided no definition of well-elderly. In a book specifically targeting music therapy for the elderly that includes a chapter on the well-elderly (Clair & Memmott, 2008), the term is not specifically defined. When using the search term "well-elderly" in the AMTA database
covering the years 1964 through 2008, it was referenced in only three articles. One article provided a definition taken from the field of gerontology: "those individuals who are living independently in the community and currently see no need for any intervention techniques" (Palmer, 1989, p. 52).

What "wellness" means to one person may be different to another person. A person with chronic obstructive pulmonary disease (COPD) may see themselves as a well-elderly person since she can engage in activities she enjoys and requires no assistance other than regular visits to her physician. Another person with COPD may view himself as unwell because he can no longer sing in the choir, but is still able to live independently. This makes it difficult to determine who the well-elderly are. Additionally, the definitions of well-being do not provide clarity. A person who is a quadriplegic may have a sense of well-being, while an individual with no apparent health issues may have no sense of well-being. The common denominator in the research I have found regarding the well-elderly is that they are able to live independently. For purposes of this discussion I will define the well-elderly as individuals who are able live independently in the community without harm to themselves or others.

Unwell-elderly

It was difficult to settle on a descriptive phrase to encompass the varieties of conditions, illnesses and diseases that may contribute to an individual's feelings of lack of well-being or quality of life. I prefer to avoid the use of the word "pathological" because of its negative connotations (e.g., "pathological killer" and no hope of recovery). Other terms such as "health-challenged" are cumbersome to use. For these reasons I have chosen to use the term "unwell-elderly" to describe individuals who cannot or do not experience wellness as defined above. This does not exclude an unwell-elderly individual from experiencing well-being.
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A THEORY OF ELDER MUSIC THERAPY AS INTEGRAL AGING

CHAPTER 1
INTRODUCTION

In the original proposal for this thesis, I had planned to explore the development of a philosophy of elder music therapy through the lens of Tornstam's (2005) theory of gerotranscendence. I had intended to provide a brief overview of some of the major psychosocial theories of aging in one chapter, followed by a full chapter devoted to gerotranscendence. During the research process, I realized there are valid concepts from several theories of aging that could be woven into a philosophy of elder music therapy. Since there are probably as many theories of aging as there are gerontologists, sociologists, anthropologists, and various medical practitioners working in the field of gerontology, I found it necessary to limit myself to a few of the major theories. The investigation portion of this project led me to look at concepts such as "successful aging" and "conscious aging" as well as the theories of gerotranscendence, continuity, disengagement, and activity. All of this has brought me back to my overall personal philosophy that we human beings, while sharing many similarities, are unique. We each have our own realities of the world around us. We have different responses to the supposedly same experience. This is most clearly seen in children who grow up in the same household, but have different memories of the same event. So why should aging be any different? One person's experience of being 80 years old can be quite different from his neighbor down the street even though they may have been children together. They may have the same ethnic background, married at the same time, raised children of relatively the same ages, attended the same church and social clubs, worked at the same company, and reached those age-related milestones (e.g., turning 65) together. This does not mean they experience aging in the same way.
Perhaps it is because I am nearing my sixth decade, or perhaps it is because my work as a hospice music therapist over the past three and a half years has brought me into the lives of elderly individuals that I have developed an increasing interest in what it means to be elderly and what it means to be a music therapist who serves the elderly. How do my own beliefs about aging affect my choice of intervention? How am I responding to my patients? What unconscious beliefs do I have that are affecting my therapeutic relationship with my patients? How can I put myself into the "moccasins" of my patients so that I might walk, as best as is possible, alongside them, learn from them, and share their journey with them? It is my hope that this thesis raises more questions than it answers because as Socrates suggests "the unexamined life is not worthy living" (Apology 38a).

The Current Situation

While aging and the concerns of aging, and music used for healing purposes are not new topics, the professional fields of gerontology and music therapy only had their births in the first part of the 20th century.

According to the Center on an Aging Society at Georgetown University (Friedland & Summer, 2005), between 1950 and 2000 the population of Americans age 65 and older almost tripled while the overall population only doubled. The Administration on Aging (2012) predicts that by 2020 the population of Americans age 65 and older will be approximately 16% of the overall population, and by 2040 that number will increase to 20%.

The Sourcebook for the American Music Therapy Association (2010) shows that 14.7% of music therapists¹ work with seniors, and 15.3% work in geriatric facilities (e.g., adult day care

¹ Working full time and a member of the American Music Therapy Association
centers or assisted living facilities), the second-largest work setting category. The latter figure does not include nursing homes, geriatric psychiatric units, senior centers, or wellness centers.

As the population of those aged 65 and older increases, there will be an increased need for music therapists in a variety of settings. This aging population includes individuals who are considered to be living independent active lives as well as those who are suffering from a variety of physical, neurologic, and psychiatric diseases and conditions requiring partial or complete care. More recent developmental theories of aging discuss “positive,” “successful,” or “healthy” aging, correcting the original focus on pathological aging rather than aging as a developmental process. The majority of music therapy literature addresses the pathological aging, i.e., the diseases of aging. While music therapy has provided significant benefit to many elderly individuals, I wonder if the predominantly medical model that we are obliged to operate within has overshadowed the holistic view that is promoted in undergraduate music therapy education.

The more I delve into aging as a developmental process and as a spiritual process, the more frequently I experience questions about my own approach with the elderly individuals I serve. Our society has, for many years, painted the picture that senior citizens have worn out their usefulness and are now a burden. Perhaps, as Tornstam (2005) suggests, we are basing our picture of what aging should look like from the perspective of career-oriented, active adults in our 40s and 50s.

The Problem, Purpose, and Process

Our aging population is growing. More music therapists are beginning to work with the elderly in a variety of settings: nursing homes, assisted living facilities, community-based music programs, and hospice. There are a number of theories of aging, but they all appear to place the person who is not aging according to the theory's protocols into a category of pathological or
unsuccessful aging, or not aging well. I believe we need to examine our own music therapy philosophies to determine if they support a holistic perspective of aging and are free from aging stereotypes and prejudices. To that end, the purpose of this thesis is to present my journey of thinking through this process by exploring music therapy in elderly populations and theories of aging, discussing where this journey has led me in forming a possible philosophy of elder music therapy, and offering suggestions for music therapists working with the elderly.

My Perspective

I suppose I would have to say I am a generalist. I am also interested in learning new ideas and concepts. I believe that we are spiritual beings having a human experience. I attempt to avoid subscribing to any one particular theory or philosophy because I believe that as we have new experiences, they affect our current theories and philosophies. While it is extremely difficult to avoid the dualistic thinking introduced by Descartes, I believe we need to attempt to do so as much as possible. I have been undergoing Jungian analysis for over 10 years, and that experience plus my readings of Jung and other Jungian analysts have heavily influenced my worldview. I believe we have a responsibility to take care of the disenfranchised and our planet.

My work as a hospice music therapist has made a significant impact on my decision to explore the issues regarding older adults. From my first days of shadowing nurses, social workers, and chaplains in skilled nursing facilities, I began to experience a sense of injustice and helplessness regarding the less-than-ideal conditions a number of residents were experiencing. The prevailing beliefs regarding the uselessness of old people are evidenced quite plainly in many of these facilities. Instead of staff members regarding their charges as someone to learn from, the elderly are many times addressed as children. In contrast, elderly individuals who

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2 Attributed to Pierre Teilhard de Chardin, Steven Covey, and Wayne Dyer
The final months of life are generally given the respect that their elder years might presume.

When I first began my training in hospice music therapy, I was experiencing challenges regarding my spiritual beliefs, and I had no clear ideas about spirituality. As I continued to work in hospice, spirituality began to become more defined in my own life. I believe this is due, at least in part, if not entirely, to the spiritual connection inherent within a musical experience. When I say, "defined," I do not mean dogmatic. I began to have a clearer sense of what it means to be a spiritual person.

Undoubtedly all of these experiences cannot help but influence my approach to developing this theory. In alignment with my perspective, this discussion can only be considered valid at the time it was written, because tomorrow I may have an experience that changes how I perceive aging, music therapy and spirituality, and my overall worldview.
CHAPTER 2
MUSIC THERAPY AND THE ELDERLY

Historical Background

Music has been used throughout the ages as an approach to healing as far back as Biblical times where it is recorded that David played the harp to soothe King Saul when an evil spirit came up on him (Samuel 16:23). Aristotle believed that melodies, instruments, and harmonies have an effect on the soul and the body, and that music could be used for relaxation (Aristotle, trans. 1984). During the 14th through 16th centuries music was used as a remedy for various illnesses as well as for preventive medicinal purposes, and from approximately 1600 to 1750, healers were required to know how to choose the correct musical qualities for medical treatments (Carapetyan, 1948). While there was a shift in perspective at the end of the eighteenth century away from music as a part of medical practice (Wigram, Pedersen, & Bonde, 2002), the use of music as a medical intervention began to be discussed in various professional publications including medical journals and psychiatric periodicals as early as 1804 (Heller, 1987).

It was not until the early twentieth century that music therapy began to make advances as a clinical practice, due in large part to the efforts of three pioneers, Eva Augusta Vescelius, Ilsa Maud Ilsen, and Harriet Ayer Seymour (Davis, 1993). Vescelius, a professional musician with training in mental health issues, established the National Society for Music Therapeutics in 1903, and worked in a number of hospitals and asylums. She was also responsible for establishing Music and Health in 1913, the first American periodical devoted to music therapy.

Ilsen became interested in music's therapeutic properties as an undergraduate nursing student, and moved to Canada to work with injured soldiers returning from Europe during World War I (Davis, 1993). She returned to the United States in 1918 when the US entered the war and
worked for the War Department as a music therapist. After directing a music therapy program for the Red Cross, she was offered a position as a lecturer in “Musico-therapy” at Columbia University in New York City in 1919. This was the first university music therapy course offered in the United States, and was established by Margaret Anderton, a pianist who had worked as a music therapist with Canadian World War I soldiers suffering from physical and mental wounds (Davis, Gfeller, & Thaut, 2008). In 1926, Ilsen founded the National Association for Music in Hospitals to provide appropriate music programs to be used adjunctively to medical treatment in hospitals.

Seymour began her active clinical work with World War I soldiers and published *What Music Can Do for You* in 1920, which contained a chapter titled, “Music and Health” (Davis, 1993). She continued to publish books on music therapy, and in 1944, published *An Instruction Course in the Use and Practice of Musical Therapy*, what is thought to be the first music therapy textbook.

Since the first university course was offered in 1919 at Columbia University, over 70 colleges and universities offer approved undergraduate, graduate, and doctoral programs in music therapy in the United States (American Music Therapy Association, 2012a). The American Music Therapy Association defines music therapy as the “clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program” (American Music Therapy Association, 2012a). A board-certified music therapist must have completed a four-year bachelor’s degree in music therapy, a minimum six-month internship, and passed the board examination of the Certification Board for Music Therapists. Several states have instituted additional requirements such as a specific license for music therapists and/or
creative arts therapists that require graduate-level education and training.

Music therapists are found in a variety of settings including schools, psychiatric hospitals, veteran's hospitals, nursing homes, facilities for the developmentally challenged, hospices, community music programs, substance-abuse clinics, oncology facilities, and correctional facilities. Music therapy is used to address the physical, psychological, cognitive, and social needs of individual clients. The music therapist assesses the client's strengths and needs, and develops a treatment plan based on the findings of the assessment. Interventions may include singing, movement, playing instruments, lyric analysis, composing, or listening to music. Clients' skills and abilities are strengthened and their needs are addressed through these interventions. Music therapy interventions provide opportunities for communication when verbal communication is difficult or hindered (American Music Therapy Association, 2012b).

While religion and spirituality are mentioned as an area to be assessed in the standards of practice for music therapists, there is no mention of spirituality as a treatment area. The standards encourage music therapists to seek knowledge regarding spirituality as a continuing education goal. To me these facts indicate there is a need to review the standards of practice and address this missing domain, and a need for music therapists to begin examining their treatment plans to determine if the plans are meeting the spiritual needs of their clients.

The American Music Therapy Association (2012b) has developed a specific definition of music therapy treatment for the elderly:

Music therapy treatment is efficacious and valid with older persons who have functional deficits in physical, psychological, cognitive, or social functioning. Research results and clinical experiences attest to the viability of music therapy even in those who are resistive to other treatment approaches. Music is a form of sensory stimulation, which provokes responses due to the familiarity, predictability, and feelings of security associated with it. (p. 1)
This definition focuses on deficits the individual may be experiencing, and it does not address the individual's spiritual needs. While improvement of quality of life or well-being is implied as a result of addressing the client's needs, there is no specific mention of building on the client's existing strengths.

Out of 84 journal articles related to the elderly published in Music Therapy, Journal of Music Therapy, and Music Therapy Perspectives from 1964 through 2012, there were 21 articles containing research in which the participants could be considered part of the well-elderly population. The participants of the studies in the remaining 57 articles, or 68% of all articles, were individuals experiencing pathological aging, i.e., diagnosed with dementia, Alzheimer’s disease, Parkinson’s disease, psychiatric disorders, or osteoarthritis, and they resided in long-term care facilities. Other fields, such as nursing, are examining the use of music for the well-elderly, but the same problem exists: research related to pathologies far outweighs any research regarding the benefits of music for the well-elderly.

**Music, Music Therapy and the Well-Elderly**

This section will review several studies conducted to examine the use of music and music therapy with the well-elderly. As mentioned above, there has been much less research conducted with the well-elderly, which is indicative of the fact that there are fewer music therapists working with this population. Most of the music therapists who work with the elderly do so in nursing homes and in hospice. These studies range from examining participants' experiences in music groups to responding to surveys and engaging in interviews.

Coffman & Adamek (1999) examined the benefits of participating in a wind band toward elders' quality of life. The 52 participants were members of a Midwestern, United States wind band. The researchers found that, overall, participants believed that social relationships were the
most important to quality of life; however, the main reason participants joined the band was the desire to make music. Coffman and Adamek made the recommendation that music therapists and music educators need to provide more opportunities for music engagement for healthy, active older adults.

In a study designed to explore how music facilitates well-being and to determine its importance to the elderly, Hays (2005) interviewed 38 participants (20 men and 18 women) of various backgrounds, 60-98 years of age. Participants had a wide range of music experience, from no training to professional musicians, and were from various cities and rural areas of Australia. The themes that emerged from ongoing analysis of the four rounds of interviews were the use of music for understanding self-identity, including a sense of one's spiritual self; maintaining health and well-being; as stimulation and motivation; and as a way to reduce boredom and feelings of loneliness.

Hays and Minichiello (2005) conducted in-depth interviews with older individuals to examine how they might use music to contribute to their self-identity and quality of life, and to understand the importance and meaning of music in their lives. Initial data were collected from discussions facilitated with two focus groups. Participants in the first focus group were two men and five women with some interest and exposure to music. The eight participants in the second focus group (gender not specified) were active amateur musicians. After analyzing the data for primary themes, the researchers conducted in-depth interviews with 38 participants (19 men and 19 women), 60-98 years of age, residing in various cities and rural areas of Australia. From their analysis of the interviews, Hays and Minichiello concluded that music can be used to promote wellness, increase continuity and life meaning, create or increase social connections, and provide a means of self-knowledge and understanding others and the community. They suggested that
further studies are needed to understand what types or genres of music are important to the elderly, and if there are socioeconomic, educational, or life-experience factors that affect individual music preferences.

Hamburg and Clair (2008) combined Laban/Bartenieff-based movement with music to determine if the interventions would improve gait speed and the speed with which individuals could put on and take off a jacket. Participants were 20 healthy older adults (3 men and 17 women), age 66 to 84. After five weeks, participants' speeds showed statistical improvement. Participants also provided anonymous comments expressing physical improvement and enjoyment of the program.

In a phenomenological study, Southcott (2009) interviewed three members of The Happy Wanderers, a singing group in the Yarra Ranges, Victoria, Australia, to explore their lived experiences of being a part of the group. Three themes evolved from the researcher's analysis of the data: having a sense of purpose, forming relationships with others, and personal growth. Participants felt that providing concerts to individuals in skilled nursing facilities gave them a sense of purpose, that the relationships they developed within the group and the support they gave each other enhanced their performance, and their commitment to ongoing education and maintenance of cognitive skills was motivated by their desire to meet their audiences' needs by adding new repertoire.

Laukka (2007) surveyed 280 Swedish residents (138 women with a mean age of 69.3, and 131 men with a mean age of 69.1) to explore everyday uses of music and the relationship between music listening and well-being. Results showed that 64% of participants listened to music at least once a day and that music was most important in the greater than 65 years of age range. The results also showed that it was more important to the older participants to have
control over when they listened to music and how often. Almost all participants frequently experienced positive emotions related to music listening, but music listening was generally not the main activity. An important finding of this study was that the listening strategies employed by participants were significantly correlated with well-being. One of the important conclusions that can be made regarding this study is music listening may assist individuals in feeling a sense of control when they are no longer able to control other factors such as declining health.

Solé, Mercadal-Brotons, Gallego, and Riera (2010) evaluated and compared the effect of participation of 83 individuals recruited from senior centers in Barcelona, Spain who engaged in a choir ($n=52$), a music appreciation class ($n=19$), or a preventive music therapy program ($n=12$) on their quality of life. The results of the survey showed the most common reasons for enrolling in the programs were to meet people and make friends, and to learn about music. Because their satisfaction ratings on the quality of life pre-test were already high, there was no significant difference between the pre-test and the post-test scores to measure quality of life. Participants reported on a subjective level that the programs improved their social relationships and personal development.

The results of these studies, as well as other studies not discussed in detail (Barton, 2004; Coffman, 2008; Cohen, Bailey, & Nilsson 2002; de Vries, 2010), demonstrate strong support for the use of music to increase well-being and physical agility. These results suggest that the establishment of music therapy and music programs within the community would be beneficial to the well-elderly.

**Music therapy and the unwell-elderly**

The majority of studies conducted with the unwell-elderly have involved individuals with dementia, including Alzheimer's type. A few researchers have conducted studies with
individuals with physical conditions or diseases such as osteoarthritis or cancer, and mental disorders, such as psychosis. The studies discussed here are a representative sample of the many studies involving the unwell-elderly.

Zelazny (2001) examined the use of keyboard playing as a means of rehabilitation for individuals with hand osteoarthritis. Four women (age 88=1, age 84=3) residing in the independent living section of a Midwestern, United States residential facility participated in the study. Researchers conducted sessions four days a week for 30 minutes, and a student occupational therapist measured finger pinch meter and range of motion. Participants reported their arthritic discomfort pre- and post-session using a Likert scale (0-10). Results were varied. Participant 1 experienced little improvement in muscle strength probably due to the fact that her muscle strength was within the average range at the beginning of the study. Participant 2 experienced increased range of motion. Participant 3 experienced an overall decline in health, which probably accounted for the decrease in finger muscle strength. Participants 2 and 4 reported significant decreases in discomfort after keyboard playing. While Participant 3 demonstrated no improvement in finger muscle strength, she reported that it was easier to work with the small beads for her jewelry-making hobby. Researchers stated that not only were there physical improvements in three out of four participants, all participants reported enjoyment of the sessions, an opportunity to socialize with the residents of the facility, and increased cognitive challenges.

Mercado and Mercado (2006) measured the effects of a music therapy program designed to reduce agitation behaviors in nursing home residents with psychiatric disorders. There were a total of 135 residents (average age of 68 years) living in five units of a state mental health institution nursing facility. The initial part of the study required that noise levels were reduced
(e.g., discontinuation of unnecessary intercom announcements, reduced volume of conversations between staff members, and reduced purposeless television and radio time). Music selections to play throughout the units were chosen to correspond with the time of day. Patients who did not show any reduction in aggressive behaviors after the implementation of this first intervention ($n=3$) were referred to individual music therapy sessions, which began three months after the first intervention. Results showed significant changes in the atmosphere of the facility after the implementation of the first intervention. Assaults and self-inflicted injuries decreased to zero. As-needed medications decreased by 91% and emergency physician medication orders decreased by 36%. Two of the three residents who received individualized music therapy sessions demonstrated decreased agitation. They also developed positive behaviors, which was an unexpected outcome.

Takahashi and Matsushita (2006) carried out a two-year study on the effects of weekly music therapy sessions for elderly residents with dementia. Saliva samples were collected and blood pressure was recorded before and after each music therapy session for six months, then again at one and two years from the first session. The control group samples and readings were taken at the time of the first music therapy session, at six months, one year, and two years. Intelligence was measured for both groups at the start of the treatment, six months, one year, and two years. At the end of the two years, 18 of the 43 participants had continued with the music therapy. While there was no statistically significant change in salivary cortisol levels over the course of the two years with the experimental group compared to the control group, there was a statistically significant change in the systolic blood pressure in the experimental group, rising in the control group and decreasing in the experimental group. Since increases in cardiovascular issues are related to a rise in systolic blood pressure, these results are important to note. Non-
measured results of the weekly group were opportunities for residents to sing songs and play instruments, which were reported as being enjoyable activities for the residents.

Ziv, Granot, Hai, Dassa, and Haimov (2007) observed 28 residents (3 men and 25 females with a mean age of 83) in a long-term care facility in Israel to determine the effect of background music on positive and negative behaviors during times when participants were not engaged with another activity. Results showed a significant increase in positive behaviors (e.g., conversing with or smiling at another person) and a significant decrease in negative behaviors (e.g., repetitive behaviors, such as fidgeting and wandering, and aggressive behaviors, such as screaming and attacking another person).

Bruer, Spitznagel, and Cloninger (2007) used a cross-over design to measure the effects of weekly group music therapy interventions on the Mini Mental State Exam (MMSE) scores of cognitively-impaired elderly psychiatric inpatients (n=28, mean age=74) pre- and post-treatment, and the morning following the intervention. Weekly post-test scores were also compared. There was a significant decline in attendance over the course of the eight-week study from 81% to 58%. While there was an improvement in MMSE scores immediately following the music therapy intervention compared to the control group, it was deemed to be insignificant. Next-morning scores showed a significant improvement over the scores of the control group. When measured a week later, there was no significant difference between MMSE scores within the experimental group and compared to the control group, indicating that the effects of the music therapy intervention are only temporary. These results would appear to support frequent music therapy interventions. The researchers did not explain the decline in attendance, but stated that the cause was not related to the music therapy intervention itself.
Ahmadi (2011) conducted semi-structured interviews with 17 cancer patients, ages 24 through 73 to examine their experiences with using music to cope with their illness. The researcher provided four case studies, two of which concerned older individuals. Peter (age 73) stated that listening to Christian music sung by individuals with an illness strengthened his faith and helped him to see himself as a unique individual and someone with a strong faith, not as a patient with cancer. Christine (age 62) stated that music had always been important to her, and she sang continually through the chemotherapy treatment. While singing along with the music she visualized herself dancing. She stated that singing transported her to another world where she was not a 62-year old woman with breast cancer. The image that she created for herself while listening to music was the opposite of the person others saw. She felt happy, healthy and strong, and was able to overcome her sadness and stress related to her illness.

Lin, Lu, Chen, and Chang (2012) measured the effect of music listening on elderly hemodialysis patients on stress and adverse reactions during hemodialysis. Eighty-eight patients over the age of 60 (44 in the experimental group; 44 in the control group) with end-stage renal failure participated in the study for at least three months. Participants selected their own music from a database of melodic instrumental music at a tempo of 60 to 80 beats per minute. They listened to music during the first 20 minutes of the first three hours and the last 20 minutes of the fourth hour three times per week. The control group did not listen to music. Adverse reactions during hemodialysis decreased significantly in frequency and severity after the first three sessions, as did stressors related to receiving hemodialysis. Respiratory rate and finger temperature showed a significant decrease, and oxygen saturation showed a significant increase. The researchers believed listening to music provided participants an alternate focal point away
from the physical discomforts of hemodialysis and changed their perception of the passing of time, improving their sense of well-being.

Sung, Lee, Li, and Watson (2012) conducted an experimental study to determine the effects of a twice-weekly, 30-minute group music intervention on lowering occurrences of anxiety and agitation in elderly, long-term care residents diagnosed with dementia. Participants were randomly assigned to either the experimental group (n=27, average age=81) or the control group (n=28). The group music intervention consisted of warm-up stretches, active music making with percussion instruments, and a cool down, with music for each section selected based on patients' preferred or music that would be familiar to patients. Results showed a significant reduction in anxiety scores for the experimental group compared with the control group and no significant reduction in agitation compared with the control group. When agitation scores of the experimental group were compared between the first session and the final session, there was a significant decrease in behaviors of agitation. While the researchers do not believe the results are generalizable due to the fact that participants resided at one care facility, they do believe group music interventions can be effective in reducing anxiety and agitation in individuals with dementia.

In a study involving 10 participants, age 59-94, with Parkinson's disease (seven men and three women), Yinger and LaPointe (2012) modified Haneishi's (2001) Music Therapy Voice Protocol for group use (G-MTVP) to measure the effects of the protocol on vocal intensity, vocal fundamental frequency, and vocal fundamental frequency variability. The results for improvement in vocal intensity were significant; however, there was no significant difference in either fundamental frequency or fundamental frequency variability between pre-test and post-test results. Yinger and LaPointe believe the results of this study point to an overall benefit of G-
MTVP in that the technique can be used to maintain, if not improve, vocal functioning. Additionally, participants expressed that the protocol helped to develop new relationships.

While this is only a sample of the research available, I believe these studies demonstrate the efficacy of music therapy for individuals with dementia, psychotic disorders, and physical conditions and disorders. The importance of these studies cannot be over-emphasized when proposing music therapy programs to health care facilities.
After reading about a number of theories of aging, it appears that the creation of one over-arching model or theory of aging may be impossible. Although, there may be a variety of reasons for this, I believe it is due to the fact that people are individuals. Even within our Western culture, from which the primary theories originate, there are a variety of societal views regarding aging and the elderly. It is not my intention to enter into a debate about the various theories, although, I may make observations from time to time. I will provide a general overview of the early theories from which all subsequent theories appear to have been developed, as well as provide information on theories that have been of greatest influence and interest to me as I have been contemplating what a philosophy of elder music therapy might look like. I will present them in as much of a chronological order as is possible, considering some of the concepts overlap. This also approximates the order in which I learned about these theories.

When I first read about Tornstam's theory of gerotranscendence, I became quite enamored with it, and perhaps, as I continue to discuss, evaluate, and apply these theories, it will continue to prove the most useful. In my exploration, I realized that there are valuable insights to be gained from each of the theories I reviewed, as well as other theories not included in this discussion. Most aging theories omit the spiritual aspect, which is one of the reasons Tornstam's theory of gerotranscendence appealed to me: spirituality is a major component of the theory. Spirituality seems to be an almost taboo word in the aging and music therapy fields, although, this has been changing over the past few decades. I believe this is something that needs to be corrected sooner rather than later. I do not believe the cause of this is because spirituality is absent, because I believe it is very much present. I believe we choose not to recognize it or
discuss it. Through my readings and my experience as a hospice music therapist, I have become convinced that spirituality cannot be separated from aging or from a musical experience.

I will begin with a discussion of Erikson's theory of human development, followed by activity theory and disengagement theory, continuity theory, and successful aging theories. Next I will discuss Tornstam's theory of gerotranscendence, which is in some sense, a re-examination of disengagement theory, but it goes far beyond disengagement theory, providing a significantly more positive view of aging. I will close the chapter with a discussion of spirituality and aging.

**Erickson's Theory of Human Development**

Although based on Freudian theory, Erikson incorporated biological, cultural, and social theories and themes into his theory of human development. Unlike Freud, who believed that our personality is formed in infancy and stops developing after the age of five, Erikson believed that we continue to develop into old age (Erikson, 1980). Each of the original eight stages is viewed as a pair (e.g., trust vs. mistrust, autonomy vs. shame, etc.). The individual experiences particular ego crises during each stage. These crises must be completed before going on to the next stage, and the successful resolution of each stage strengthens the individual's ego and personality structure. In this thesis, I am primarily concerned with the eighth and the lately-added ninth stage, and the other stages only as they relate to old age.

Erikson's eighth stage concerns ego identity versus despair. It is during this stage where wisdom is developed and the ability to integrate all aspects of one's accumulated experiences occurs. The unsuccessful traversing of this stage results in despair. When Erikson and his wife, Joan, entered their eighties, they realized that the theory was incomplete. In a revised edition of Erikson's book, *The Life Cycle Completed*, (Erikson, 1997), Joan Erikson, details a ninth stage. Her first step was to clarify the terms wisdom and integrity to enable a better understanding of
the eighth stage. She believed that the usual lofty interpretations, if accepted, present an undue burden and challenge to the elderly; whereas, if wisdom is viewed as the ability to see and hear what is around us and to integrate these experiences, and integrity is the way we come into contact with the world around us, then:

What is demanded is the aliveness and awareness that it takes to live with tact and vision in all relationships. One must join in the process of adaptation. With whatever tact and wisdom we can muster, disabilities must be accepted with lightness and humor. We all have taken our youthful capacities for granted and enjoyed them hugely. Let us applaud the performers now with tact and true appreciation. With hearing and sight we are privileged; keep on looking and listening. (Erikson, 1997, p. 9)

Erikson reversed the order of each of the prior eight stages, placing the dystonic term before the syntonic term (e.g., trust vs. mistrust becomes mistrust vs. hope), and described the stage from the perspective of being in old age (at the time of writing, Erikson was 93). In the first stage, she states, elders are likely to begin mistrusting their own abilities and despair may set in. In the second stage, doubt versus autonomy, elders may begin to experience doubt as they are no longer able to trust their bodies, and they begin to experience a lack of autonomy. One may become willful in order to maintain some sense of control. This increase in mistrust and doubt can lead to a decrease in initiative (the third stage), which may produce guilt. In the fourth stage (inferiority vs. industry), one may begin to feel inferior as one begins to sense a lack of competence. This may lead to identity confusion (the fifth stage), isolation (the sixth stage), and stagnation (the seventh stage) because one may begin to feel left out and unable to contribute to the lives of their loved ones and to society in general. And finally, despair and disgust (the eighth stage), may set in. If, however, one is able to reflect back and embrace one's life experiences with wisdom and integrity and view life as well-lived, then despair and disgust can be mitigated to the extent one is able to accomplish this.

For simplicity, Erikson, from this point forward, will refer to Joan Erikson.
Erikson completed her discussion of the ninth stage with a look at transcendence and Tomstam's theory of gerotranscendence. She opened the dialogue with an examination of the meaning of *transcendence*, which she boiled down to a more attainable occurrence:

Perhaps the really old find a safe place to consider their states of being only in privacy and solitude. After all, how else can one find peace and acceptance of the changes that time imposes on mind and body? The race and competition are over and done with; to release oneself from hurry and tension is mandatory in old age. Some learn this early, and some too late. (Erikson, 1997, p. 125)

She continued to reflect on those individuals who do not have a choice in when, how, or if they withdraw:

Many elders are faced with enforced withdrawals. Physical deterioration of eyes, ears, teeth, bones, and the body's systems often inflicts an inevitable reduction in contact with others and the outside world. Emotional psychological responses to decline may also inhibit one's range of contact. Of course this is all compounded by society, which often places elders where they are rarely seen or heard. The differences between chosen and imposed withdrawal in the orbit of a nursing facility are clear. If loss of physical aptitude occurs, the patient may naturally shift in attitude; a major improvement in physical abilities could also reverse an imposed withdrawal. Transcendence in the face of imposed withdrawal is perhaps less likely, though certainly not impossible. (Erikson, 1997, pp. 125-126)

In her exploration of gerotranscendence as it pertains to old age development, Erikson rightly posed the question, "What should normal psychic development from maturity to death be?" and then answered this question with, "In truth we are called to become more and more human; we must discover the freedom to go beyond limits imposed on us by the world and seek fulfillment" (Erikson, 1997, p. 126). Erikson criticized gerontologists for not taking into the account the compensations elderly people are required to make and inadequately exploring the spiritual aspects of aging when they use the term gerotranscendence. Erikson enlivens the term by modifying transcendence to *transcendance*, "which speaks to soul and body and challenges it

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4 See below for a full explanation of Tomstam's theory of gerotranscendence.
to rise above the dystonic, clinging aspects of our worldly existence that burden and distract us from true growth and aspiration" (Erikson, 1997, p. 127). She continues:

To reach for gerotranscendance is to rise above, exceed, outdo, go beyond, independent of the universe and time. It involves surpassing all human knowledge and experience. How, for heaven's sake, is this to be accomplished? I am persuaded that only by doing and making do we become. Transcendence need not be limited solely to experiences of withdrawal. In touching, we make contact with one another and with our planet. Transcendance may be a regaining of lost skills, including play, activity, joy, and song, and, above all, a major leap above and beyond the fear of death. It provides an opening forward into the unknown with a trusting leap. Oddly enough, this all demands of us an honest and steadfast humility. (Erikson, 1997, p. 127)

Erikson's narrative is a rich description, providing a picture of someone still able and willing to process her experiences. I am not sure that every individual is capable or desirous of traversing the territory of old age in this fashion, but at least for me, it provides hope that the journey into old age can continue to be an adventure. While she briefly touched on the effects of physical deterioration and the transcendence process, she did not address aging and for individuals who are experiencing declines in cognition.

**Activity Theory and Disengagement Theory**

It is not clear from the literature which theory came first: activity theory or disengagement theory. Some researchers state that activity theory was a response to disengagement theory (Achenbaum, 2009, Austrian, 2008; Hooyman & Kiyak, 1993; Ryff & Singer, 2009). Others state that activity theory had been formulated prior to disengagement theory (Cumming & Henry, 1961; Donahue, 1963; Knapp, 1977; Williams, 1963). What seems to be the important element is that these theories form a continuum of development, one theory being the catalyst for further examination and analysis for a subsequent theory. This points back to my comment in the introductory paragraphs of this chapter that aging is an individual process, and it appears to be impossible to explain aging from only one theoretical perspective.
The basis for activity theory is that individuals should engage in the activities and
mindsets of middle age for as long as possible, and to substitute the activities of middle age with
other activities as they are forced to give up such interests as their jobs, clubs and associations,
and socializing (Cavan, Burgess, Havighurst, & Goldhamer, 1948; Havighurst, 1961; Havighurst
& Albrecht, 1953). Havighurst (1961) describes four characteristics for measuring successful
aging according to activity theory:

1. A way of life that is socially desirable for this age group
2. Maintenance of middle-age activity
3. A feeling of satisfaction with one's present status and activities
4. A feeling of happiness and satisfaction with one's life (Havighurst, 1961, pp. 9-10)

Havighurst states that the older person's "way of life" is determined by society's opinion
for what is appropriate. A question I cannot help ask is, "How can a society that denies aging
determine what is appropriate aging?" I have to disagree with Havighurst's comment, "Public
opinion is rather tolerant with respect to the behavior of older people in the United States . . ."
(Havighurst, 1961, p. 10). Perhaps this was the viewpoint in the late 1950s and early 1960s.
However, when Butler published his article that introduced the term "ageism" in 1969, 37% of
the elderly population was living below the poverty line (Butler, 1969). This situation could not
have occurred overnight. As Achenbaum (1978) reveals, between 1865 and 1914, writers began
to use disparaging adjectives to describe the elderly; whereas, prior to 1865, writers idealized the
elderly. After World War I, old age began to be perceived as a national problem (Achenbaum,
1978).

Havighurst (1961) points out researchers must use caution when selecting measurements
to determine successful aging. For instance if a researcher has a bias for activity theory, he may
be satisfied with results that indicate the person is experiencing successful aging through activity.
If the researcher has a bias toward disengagement theory, she may not be satisfied with those same results. While Havighurst appears to be promoting a general theory of successful living, his measurement tool demonstrates his bias for activity theory. The tool measures "Zest vs. Apathy," "Resolution and Fortitude," "Goodness of Fit between Desired and Achieved Goals," "Positive Self-Concept," and "Mood Tone." In each of these items, the desired response is activity- or action-based. In Havighurst's defense, he notes that an individual's personality will influence how that individual views life satisfaction. Some individuals may be satisfied with greater disengagement-type activities; however, he suggests that individuals who are fully engaged are living more successfully than those who are disengaged from life.

Disengagement theory was developed as a response to the dearth of social-psychological theories of aging and the cessation of Erikson's developmental theory at adult maturity (Cumming, Dean, Newell, & McCaffrey, 1960). Cumming, Dean, Newell, and McCaffrey (1960) proposed a tentative theory, which was more clearly defined by Cumming and Henry (1961) from data collected from the longitudinal Kansas City Studies of Adult Life. Cumming and Henry disputed the idea that aging is a continuation of middle age. They developed nine postulates as a formal statement of the disengagement theory, beginning with the definition that disengagement "is an inevitable process in which many of the relationships between a person and other members of society are severed, and those remaining are altered in quality" (Cumming & Henry, 1961, p. 211):

- Postulate 1: Although individuals differ, the expectation of death is universal, and decrement of ability is probable. Therefore a mutual severing of ties will take place between a person and others in his society.
- Postulate 2: Because interactions create and reaffirm norms, a reduction in the number or variety of interactions leads to an increased freedom from the control of the norms governing everyday behavior. Consequently, once begun, disengagement becomes a circular, self-perpetuating, process.
Postulate 3: Because the central role of men in American society is instrumental, and the central role of women is socio-emotional, the process of disengagement will differ between men and women.

Postulate 4: The life cycle of the individual is punctuated by ego changes—for example, aging is usually accompanied by decrements in knowledge and skill. At the same time, success in an industrialized society is based on knowledge and skill, and age-grading is a mechanism used to insure that the young are sufficiently well trained to assume authority and the old are retired before they lose skill. Disengagement in America may be initiated by either the individual because of ego changes or by the society because of organizational imperative, or by both simultaneously.

Postulate 5: When both the individual and society are ready for disengagement, completed disengagement results. When neither is ready, continuing engagement results. When the individual is ready and society is not, a disjunction between the expectations of the individual and of the members of his social systems results, but usually engagement continues. When society is ready and the individual is not, the result of the disjunction is usually disengagement.

Postulate 6: Because the abandonment of life's central roles—work for men, marriage and family for women—results in a dramatically reduced social life space, it will result in crisis and loss of morale unless different roles, appropriate to the disengaged state, are available.

Postulate 7: (a) If the individual becomes sharply aware of the shortness of life and the scarcity of the time remaining to him, and if he perceives his life space as decreasing, and if his available ego energy is lessened, then readiness for disengagement is begun. (b) The needs of a rational-legal occupational system in an affluent society, the nature of the nuclear family, and the differential death rate lead to society's giving echelons of people its permission to disengage.

Postulate 8: The reductions in interaction and the loss of central roles result in a shift in the quality of relationship in the remaining roles. There is a wider choice of relational rewards, and a shift from vertical solidarities to horizontal ones.

Postulate 9: Disengagement is a culture-free concept, but the form it takes will always be culture-bound.

The overall response to Cumming and Henry's proposed theory was non-supportive (Austrian, 2009; Havighurst, 1961; Hooyman & Kiyak, 1993; Maddox, 1991; Rose, 1964). Because of the response, Cumming published a further explanation of her theory (Cumming, 1963) in which she proposed that the level of disengagement is affected by temperament. In spite of this, it remains one of the more controversial theories of aging, and has been largely ignored or discredited (Bowling, 2007; Ryff & Heincke, 1983). A few researchers have conducted studies supporting the theory or developed new theories that include some facets of
disengagement theory (Johnson & Barer, 1992; Poorkaj, 1972; Tornstam, 1989). Cumming and Henry proposed that disengagement is not bound by culture (Postulate 9); however, I believe these postulates reflect a Western worldview. Several of the postulates, as they were presented in 1961, are no longer valid or are in need of revision. For example, the role of women has changed significantly in this country, and many women lead more "instrumental" lives than they did in 1961. I wonder if it is possible for any theory of aging to withstand societal changes and be free of cultural influences.

As a response to the shortcomings of the activity and disengagement theories, Atchley (1972) developed continuity theory. He criticized activity theory for promoting homeostasis or equilibrium (Atchley, 1989). When change occurs in a system, the goal is to return it to equilibrium; however, as Atchley points out, changes occur in the aging process that cannot be brought back to the status quo. Continuity theory was developed to provide another way to explain aging.

**Continuity Theory**

At first glance continuity theory may appear to promote the "continuation" of middle age activities; however, what Atchley (1989) proposes is that the individual uses familiar strategies to address the changes that are occurring. The individual has a basic structure for experiencing her life. It is orderly and logical, but at the same time fluid enough to allow her to adapt to physical, social, and environmental changes. These strategies allow the individual to maintain her existing internal and external structures. One of the major differences between continuity theory and disengagement theory is that Atchley says that normal aging will vary between cultures. While continuity theory is less helpful for understanding the aging process in individuals experiencing pathological aging (e.g., dementia, Parkinson's disease, etc.), Atchley
states that they may be able to experience internal continuity even though external continuity is being disrupted by physical deterioration.

Internal continuity and external continuity are the two major components of continuity theory. These are subjective constructs. Internal continuity comes from an individual's relationship to an inner structure that includes temperament, experiences and skills, and it requires that a person's memory be intact. Individuals with dementia or amnesia lack this internal framework, and they lose the ability to place themselves in relationship with other people and events.

External validity involves the individual's relationship with his roles in life, daily activities, and physical and social environments. An individual perceives external continuity when they are engaged in familiar activities and environments with familiar people. External continuity patterns "can be validated only by making reference to the person's own internal set of ideas about what is typical for her or him" (Atchley, 1989, p. 185). Thus, internal and external continuity function in concert; however, "continuity's existence and effects can only be studied in retrospection . . . by a here-and-now assessment made by the individual based on her or his remembered past" (Atchley, 1989, p. 185).

Atchley (1989) describes four motives individuals have for preserving internal continuity:

- Internal continuity acts as a foundation for effective day-to-day decision making. For example, continuity of cognitive knowledge is a major element of the individual's capacity to interpret and anticipate events. Without persistent cognitive knowledge, there is no predictability to the world.
- Internal continuity is essential to a sense of ego integrity. Consistency and linkage amid change over time are necessary conditions for concluding that one's life has integrity.
- Internal continuity also helps meet the need for self-esteem. The continuity principle with the self contains the ideas used as the basis for self-esteem.
- People can also be motivated toward internal continuity as an effective means of meeting important needs. For example, most of us have ideas that quite effectively lead us to the food, housing, income, transportation, and clothing
needed. Internal continuity also promotes easy maintenance of social interaction and social support. (Atchley, 1989, p. 185)

Motivations for preserving external continuity are:

- People are expected by others to present themselves in a way that is obviously tied to and connected with their past role performances.
- External continuity of relationships is motivated by desire for predictable social support.
- External continuity increases the possibility that feedback received from others about the self-concept can be accurately anticipated.
- External continuity is seen as an important means of coping with physical and mental changes that may accompany aging.
- External continuity reduces the ambiguity of personal goals that can come with changes such as widowhood, retirement or the empty nest. (Atchley, 1989, 185-186)

The degree of continuity a person experiences can be classified into "too little continuity," meaning that the individual feels life is too unpredictable; "optimum continuity," meaning that the individual is experiencing change at a pace he or she is able to cope with; and "too much continuity," meaning that the individual feels her life is in a rut, and there is not enough change for her to feel enriched by life.

Atchley (1989) acknowledges that certain roles or relationships may decrease in importance as one ages. He also acknowledges that changes in identity and physical decline can affect one's support systems. When an individual experiences a lack of support, he or she may begin to withdraw and become isolated. He emphasizes the need for friends, family, and caregivers to understand an individual's internal and external continuity structures to provide environments and situations that are in line with the individual's perceived structures.

While not specifically referred to as a theory of successful aging, continuity theory is one way to explain what has become an almost iconic term for aging. In the next step in this journey to develop a theory of elder music therapy, I examine the development of successful aging theories.
Successful Aging Theories

The term "successful aging" has been referenced prior to the establishment of disengagement theory. Williams and Loeb (1968) presented a paper in 1956 describing successful aging as the ability of a person "to maintain an optimal position within his social life space in relation to his psychological and biological capacities" (p. 381). Havighurst's (1961) theory of successful aging is based upon an individual's level of activity throughout the aging process and the ability to maintain the activities of middle age.

It was not until Rowe and Kahn (1987) compared "usual" aging with "successful" aging that the concept of successful aging became the byword of gerontological theories. Either usual, defined as "non-pathologic but high risk" (Rowe & Kahn, 1997, p. 433), or successful aging, defined as "low risk and high function" (Rowe & Kahn, 1997, p. 433), can occur within "normal" aging. Rowe and Kahn address the division of pathological versus non-pathological theories and suggest that both have neglected the heterogenic nature of people. They also criticize the relegation of physical and cognitive decline into "normal" aging. They suggest that age-related physical and cognitive decline (e.g., decreased carbohydrate metabolism, osteoporosis, decreased cognitive function, and loss of autonomy and control), and the subsequent effect on social and psychological roles can be improved by changes in diet, exercise, personal habits, and psychosocial factors.

In their later publication, Rowe and Kahn (1997) "define successful aging as including three main components: low probability of disease and disease-related disability, high cognitive and physical functional capacity, and active engagement with life" (p. 433). They believe the research, at that time, suggests that:

First, intrinsic factors alone, while highly significant, do not dominate the determination of risk in advancing age. Extrinsic environmental factors, including elements of lifestyle,
play a very important role in determining risk for disease. Second, with advancing age the relative contribution of genetic factors decreases and the force of nongenetic factors increases. Third, usual aging characteristics are modifiable. (Rowe & Kahn, 1997, pp. 435-436)

Rowe & Kahn reiterate that maximization of cognitive and physical function and continuing life engagement to promote successful aging can be achieved through, as mentioned in their initial presentation of their concept of successful aging, diet, exercise, and a program of cognitive and psychological stimulation.

As a result of the concern within the gerontological community that Rowe and Kahn's theory excluded individuals with pathologies from being able to age successfully, new theories and concepts of multidimensional successful aging, and positive, conscious, and harmonious aging have since evolved (Fernández-Ballesteros, 2011; Liang & Luo, 2012; Moody, 2009; Shenfil, 2009; Young, Frick, & Phelan, 2009). Additionally, researchers have become concerned that there has been no input from aging individuals themselves and studies interviewing elderly participants are beginning to be published (Bryant, Corbett, & Kutner, 2001; Phelan, Anderson, LaCroix, & Larson, 2004; Reichstadt, Sengupta, Depp, Palinkas, & Jeste, 2010; Williamson, 2010).

One more theory requires discussion, that of the theory of gerotranscendence. It was developed, as it appears almost all theories have been, out of a dissatisfaction with the pathological, activity, developmental, and continuity theories (Tornstam, 2005).

**Theory of Gerotranscendence**

Tornstam began to question his own perspective on aging, examining the "misery perspective" that was pervasive at the time, as well as Western society's penchant for productivity, effectiveness, and independence (Tornstam, 1992). He also examined how current research is affected by researchers' views of the elderly and society, and how those views affect
research design and interpretation. He encourages researchers to "push the borders," considering research from the perspective "that ineffectiveness, unproductiveness, and interdependency are guiding values. This could result in focusing on concepts such as rest, relaxation, comfortable laziness, and play, on creativity and wisdom" (Tornstam, 1992, p. 323).

Tornstam first published his theory in Swedish, and then in English in 1989. In this first paper published in English, he takes the theory of disengagement and examines it from a meta-perspective and suggests "that what social gerontologists describe in negative terms and label "disengagement" is in reality often a positive development towards gero-transcendence" (Tornstam, 1989, p. 55). Tornstam believes "since disengagement is a natural process, it is associated with satisfaction and inner harmony" (Tornstam, 1989, p. 55). Tornstam discusses aging from a Zen Buddhism perspective, bringing in Jungian and Eriksonian concepts.

Through a survey 912 Danish men and women, Tornstam (1994) suggests that a high degree of transcendence is related to high degrees of life and social activity satisfaction, but that social activity actually becomes less important as gerotranscendence increases. Tornstam conducted a number of qualitative (1996b, 1997b, 1999b) and quantitative (1994, 1997a, 1997c, 1999a) studies. He presented the full outline in his 1997b study, which he later revised (2005):

The Cosmic Dimension
- **Time and childhood.** Changes in the definitions of time and the return of childhood. The transcendence of boarders between past and present occurs. Childhood comes to life—sometimes interpreted in a new reconciling way.
- **Connection to earlier generations.** Attachment increases. A change in perspective from link to chain ensues. The important is not the individual life (link), but rather the stream of life (chain).
- **Life and death.** The fear of death disappears and a new comprehension of life and death results.
- **Mystery in life.** The mystery dimension in life is accepted.
- **Rejoicing.** From grand events to subtle experiences. The joy of experiencing the macrocosm through the microcosm materializes, not infrequently related to experiences in nature.

The Dimension of the Self
A THEORY OF ELDER MUSIC THERAPY AS INTEGRAL AGING

- **Self-confrontation.** The discovery of hidden aspects of the self—both good and bad—occurs.
- **Decrease of self-centeredness.** Removal of the self from the center of one’s universe may eventuate. However, if self-esteem from the beginning is low, it may instead rather be a question of struggling to establish a level of confidence that feels appropriate.
- **Development of body-transcendence.** Taking care of the body continues, but the individual is not obsessed with it.
- **Self-transcendence.** A shift may occur from egoism to altruism. This may be a special matter for men.
- **Ego-integrity.** The individual realizes that the pieces of life’s jigsaw puzzle form a wholeness. This may be a delicate state, demanding tranquility and solitude.

The Dimension of Social and Personal Relationships

- **Changed meaning and importance of relations.** One becomes more selective and less interested in superficial relations, exhibiting an increasing need for periods of solitude.
- **Role playing.** An understanding of the difference between self and role takes place, sometimes with an urge to abandon roles. A new comforting understanding of the necessity of roles in life often results.
- **Emancipated innocence.** Innocence enhances maturity. A new capacity to transcend needless social conventions.
- **Modern asceticism.** An understanding of the petrifying gravity of wealth and the freedom of asceticism develops. Having enough for a modern definition of the necessities of life, but not more.
- **Everyday wisdom.** The reluctance to superficially separate right from wrong, and thus withholding from judgments and giving advice is discerned. Transcendence of the right-wrong duality ensues, and is accompanied by an increased broad-mindedness and tolerance ensues. (p. 188-189)

Tornstam’s theory of gerotranscendence appears to be the first theory to address the importance of spirituality in the aging process. While there continues to be a significant number of theories that ignore the spiritual dimension, over the last few decades, discussion on the topic of aging and spirituality has increased.

Aging and Spirituality

When I began this project, I had abandoned the idea of exploring spirituality. As my research progressed, it became clear to me that spirituality must be discussed, not only in relationship to aging, but in relationship to music (this will occur in the Chapter 4). The idea of spirituality is not as clear-cut as examining theories of aging and reviewing studies seeking to
understand the use of music by the elderly to improve their quality of life. Spirituality is, by nature, subjective, and much more difficult to measure experimentally (Atchley, 2008; Boswell & Boswell-Ford, 2010). I may see a hawk flying in the sky and be completely in awe. Another person seeing that same hawk may only think of how that hawk kills his chickens. Yet another person may not even see the hawk.

While some individuals use religion and spirituality interchangeably, they are distinct from one another. I tend to think of religion as the dogmas and specific constructs of a particular belief system, i.e., Christianity, Judaism, Islam, etc. Religion relates to outward characteristics: attending services, following specific protocols, etc. (as in Boswell & Boswell-Ford, 2010). Spirituality, on the other hand, is what gives meaning to one's life, and it is an inner process. I believe that we can be spirituality connected to anything that gives our lives meaning (see Atchley, 1997). I think spirituality involves conscious attention. Many people attend religious services out of obligation, go through the motions, and then return to their day-to-day lives without having been touched on a spiritual level. Religious practices can be a part of the way one expresses their spirituality, but I believe a person can consider themselves religious and not be connected to anything spiritual or experience meaning in his life. Atchley (1997) describes spiritual movement as:

Movement from simple imitative and dependent religious thought and behavior; toward a personal cognitive picture of spiritual issues that integrates both inner and outer life experiences of spirituality; toward subtle, contemplative understanding of the common ground of both inner and outer life experiences; toward becoming one with the ultimate ground of all being. (p. 125)

Many people tend to think of spirituality in predominantly positive terms; however, I believe that we can be spirituality connected to something that is not necessarily good for us. For example, if a person continually engages in detrimental behavior, there is, no doubt, a
psychological explanation, and I believe there is also a spiritual connection. What is lacking in the person's life that drives her to perpetuate detrimental behavior? What need is not being met? What meaning is the person trying to find in his life?

Other aspects of the spiritual vs. religious dynamic are the experiences of the transpersonal and transcendent or mystical (as in Atchley, 1997). Atchley (1997) defines transcendence as "dwelling in mindfulness and nonpersonal consciousness\(^5\), which provides natural integration to all of one's life" (p. 130). I believe these experiences are part of the spiritual experience. I do not believe it is possible to experience spirituality without having experiences of the transpersonal or transcendent/mystical. Perhaps a better word to use is "numinous," i.e., supernatural or mysterious, filled with a sense of the presence of divinity, appealing to the higher emotions or to the aesthetic sense (Merriam-Webster, 2012). Atchley says that spirituality "is about becoming rooted in being, about nurturing and living in a connection with the sacred, however labeled . . . about developing a perspective about life that transcends the purely self-centered" (Atchley, 2006, p. 23).

The overall consensus in the literature that I reviewed regarding aging and spirituality is that as people age, spirituality becomes more important (Atchley, 2006; Carstensen, Fung, & Charles, 2003; Erickson, 1980; Koenig, 1995), and they move toward a more inner relationship with their religion of choice (Atchley, 1997; Boswell & Boswell-Ford, 2010). Both of these phenomena may be attributed to elders using religious beliefs and/or spirituality as coping mechanisms, as well as a diminished ability to participate in religious activities outside the home due to declining health (Moberg, 2001a; Koenig, 1995). As Atchley (1997) comments, "Aging does not inevitably bring spiritual development, but aging does alter the conditions of life in

\(^5\) Atchley (1997) defines "nonpersonal consciousness" as a "region of consciousness that transcends thought and is qualitatively different from ego-centered consciousness, in which the personal self and its agendas are experienced as the center of human awareness" (p. 133).
ways that can heighten awareness of spiritual needs and that can stimulate spiritual development"
(p. 129).

Some people who had abandoned their previous religious affiliation may be drawn back
to that religion, pursue another religious affiliation, or engage in practices from the religion of
their youth, but not attend services; whereas, individuals who never had any religious affiliation
may find themselves being drawn to a specific spiritual path (Atchley, 1997; Vaillant, 2002).
Atchley, (2008) contends that spirituality as a coping mechanism "seems to work best for people
who have been using this strategy for years" (p. 15). Moody (2003) questions if later life opens
"up greater possibilities of moving to a higher stage of faith, or does late-life habituation make
such a move less likely unless there has been previous internalization of spiritual orientation
earlier in life?" (p. 423). Atchley's (1995) theory of continuity suggests that individuals who
have engaged in spiritual or religious practices will continue to do so, and those for whom
spiritual and/or religious practices have not been important would not be expected to begin to
engage in those practices.

Polls dating from the 1930s up through the early 1990s support the findings of these
researchers; however, a more current poll (The Pew Forum on Religion and Public Life, 2010)
indicates younger generations, particularly the 18-29 age bracket, are less likely to be affiliated
with a particular faith tradition. In fact, 25% of people in this age group have no religious
affiliation. Does this mean as this age group ages, they will be less likely to turn to religion as
they move into their elder years?

Individuals on a spiritual journey may find themselves asking such questions as:

Is this all there is? What does it all mean? How do I fit into the picture? What will
happen to me when I die? How can I leave a legacy for future generations? How can I
give back to a world that has nurtured me? Do I need to get even with a world that hasn't
nurtured me? (Atchley, 2006, p. 22)
According to Atchley (1997), "learning to accept the self with all its frailties requires rising above personal desires and standards to a more transcendent viewpoint, and learning to witness the personal self without evaluating it is a skill that most definitely supports spiritual development" (p. 130).

Moody (2003) cautions against viewing conscious aging (as an aspect of spiritual growth and development) as a magical way of avoiding the fact that we age, become frail, and require help from our friends and loved ones. To age consciously is a strategy to promote mental well-being; however, it cannot save us from experiencing the losses that occur as we age.

Tornstam (1999a), Moberg (2001b), and Huber (2003), among others, support the use of reminiscence and life review as means to assist with spiritual development and reconciling, honoring, and incorporating the past, present, and future. Schachter-Shalomi and Miller (1995) refer to this process as "harvesting life," which is part of a process he refers to as sage-ing. He believes that as elders begin to develop tools for inner growth (e.g., meditation, journal writing, and life review), they can "come to terms with their mortality, harvest the wisdom of their years, and transmit a legacy to future generations" (p. 12).

Conclusion

In this chapter, I have discussed the foundational theories of aging, which have spawned newer theories such as Tornstam's theory of gerotranscendence. Even more recently, the need to examine spirituality as part of the aging process has gained prominence (Atchley, 2006; Huber, 2003; Moberg, 2001a; Moody, 2003). As Achenbaum (2009) has pointed out, these early theories are rooted in our Cartesian duality, e.g., activity theory vs. disengagement theory, aging as a disease process (i.e., pathological aging) vs. a normal process, etc. This dualistic thinking
continues to permeate our culture; however, with the increased interest in the spiritual aspects of aging, we can begin to integrate these varying theories.

This exploration has led me to begin thinking in terms of *integral* aging. This phrase suggests an integration of the many aspects of aging, the coming together of various parts to form a whole. Individuals experience aging individually. Terms such as "positive," "successful," and "conscious" aging imply a judgment, suggesting that if one is not aging positively, one is aging negatively; if one is not aging successfully, one is aging unsuccessfully; or, if one is not aging consciously, one is aging unconsciously. Many of these theories leave no room for individuals with physical and mental impairments. Rowe and Kahn's (1987, 1997) theory of successful aging clearly suggests that to age successfully, one must be in good physical and mental health. I am uncomfortable with this kind of theory as the basis for developing our music therapy interventions when working with elderly individuals. I prefer to perceive each person's "parts" (physical, mental, emotional, social and spiritual) integrated within a whole individual.

Gerotranscendence suggests that developing spiritually is a possibility regardless of one's past experience of aging; whereas, Atchley (1995) and Moody (2003) suggest this does not ordinarily occur. I believe, as has been suggested by Moberg (2001a), Koenig (1995), and Schachter-Shalomi and Miller (1995), that assisting individuals to develop spiritually can help them to tolerate, and even transform their perspectives of the aging process.
As mentioned previously, when I was first considering topics for this thesis, I wanted to explore the spiritual aspects of music. This desire came from my work in hospice as I began to experience a change in my own spirituality, and as I witnessed how music appeared to relieve anxiety for individuals facing their own mortality. One of my ideas was to examine the claims of Hazrat Inayat Khan, a Sufi master, regarding the effect of the various elements of music on the mind and body to lead one to greater spiritual connectedness. Another option was, because of its spiritual overtones, to take the theory of gerotranscendence and apply it to existing models of music therapy. These were abandoned in favor of the suggestion that I develop a theory of music therapy.

After some preliminary research, I felt that developing a philosophy of elder music therapy would be more appropriate since philosophy informs and influences theory; however, I am not totally convinced that developing a specific philosophy of elder music therapy is what is needed in the profession. I hope what I have proposed will, at a minimum, provide a starting place for further philosophical discussions regarding aging, music, music therapy, and spirituality. If nothing else, the research process for this thesis has caused me to evaluate my own approach to my patients, and for that, I am grateful. Additionally, the process of researching this topic has brought me around full circle to my interest in music and spirituality.

I believe that any philosophy is a work in progress. As one learns more, experiences more, and questions more, that philosophical perspective changes. If it does not, then I would wonder if that philosophy has not now become a dogma, which is typically less malleable. I agree with Bright (1997): "none of us has all the answers but, by being alert to challenges
outside our own speciality, we can call upon others to give help as necessary," and even more importantly, "if we ignore every profession but our own, we risk making mistakes and thereby diminishing the wholeness of the individual" (p. 2). I began this process because I believe it is important for music therapists who work with the elderly to become more familiar with the field of gerontology and the various theories to better serve their clients.


Salas's (1990) exploration of the aesthetic aspects of music in music therapy could be considered as part of the spiritual connection with music, and while not addressing spirituality in particular, Wärja (1994) explored the transpersonal journey of one individual through music psychotherapy. Goldman (1988) discussed the ability of music to lead to personal and planetary transformation.

Bright (1997) devoted an entire chapter to spirituality and aging in her book *Wholeness in Later Life*, but included no material regarding music or music therapy and spirituality. Crowe (2004) discussed music therapy and spirituality as part of her theory of music therapy, referring to the spirit as one of four areas of human functioning. Both Crowe's theory of music and soulmaking (2004) and Kenny's "field of play" theory (1989) have been influenced by the writings of the philosopher Ken Wilber who attempts to embrace truths from the world's psychological, spiritual, scientific, and philosophical traditions.
From a Philosophy of Elder Music Therapy to a Theory of Elder Music Therapy

The task of developing a philosophy is at once exciting and overwhelming. The first realization I came to when reviewing the theories of aging is that, aside from Joan Erikson’s supplemental chapters, all of the theorists whose work I reviewed had not yet entered old age. Just as a 10-year child has no understanding of what it will be like to become a teenager, those of us who have not reached old age, cannot possibly understand what it is like to be old. I do not presume to know what it is like to be elderly, nor do I wish to presume that I know exactly how music therapy can assist elderly individuals in their developmental process; however, music therapy is becoming widely used in nursing homes and hospice care. And because of the increased interest in music therapy for the elderly, it is important that music therapists examine their own music therapy philosophies and theories regarding elderly populations. Young music therapists, as well as those in their middle years, must take time to reflect on their own beliefs about and stereotypes of aging and how these might be affecting their interactions with their elderly clients.

While the available research shows that music therapists are interested in using music therapy to meet the needs of individuals with dementia and other conditions, there is an obvious lack of research supporting the efficacy of music therapy for elderly individuals who continue to live independently. Even though many independent elderly individuals have rich social lives, others, who continue to live independently, may experience isolation due to the loss of friends and family through death because they are not as able to attend functions, and/or are too independent to ask for help or companionship.

As a first step, I think it is important to understand our feelings, beliefs, and stereotypes about aging. Our culture typically dismisses the elderly. Government funding is severely
lacking for programs to assist the elderly to live independently. Because of our mobile society, the children of elderly individuals often live in other cities or states and are not available to look in on their parents on a daily or regular basis.

We are beginning to see more interest in developing community music therapy programs. This is a step in the right direction. I believe that we need to examine these programs to make sure that they are meeting the needs of the individuals they are meant to serve. How are the programs conducted? Do we lead, or do we invite participants to co-facilitate these programs? Do we view ourselves as the expert, or do we remind ourselves that we are also learners? Yes, we have a certain expertise; however, if we engage with our clients from the place of learner or even servant, I believe we are more open to creative possibilities in developing programs and specific interventions that meet the expressed and relevant needs of elders.

Do we think of old age as a time of uselessness, decline, frailty, and disease? Or do we see it as another phase along the developmental continuum? Do we seek advice from elderly individuals, respecting their lived experiences? Or do we come from the point of view that because we have more energy and vitality, we have more to give? As clinicians and musicians, we not only create a therapeutic dynamic with our clients, we create a "musical space," which Kenny (1989) describes as sacred space. We must be aware of this sacred space we are creating with our clients because, as with any sacred space, consciousness is altered, individual boundaries are loosened, and the clients themselves are more vulnerable. Depending upon individual circumstances, an elderly person may already be feeling vulnerable. When they engage in music interventions, they may feel even more vulnerable. So we must tread lightly, intuitively, and with compassion. I believe that this type of evaluation must be ongoing and
include not only our music therapy competencies, but also our beliefs about aging and spirituality.

If I begin to form a philosophy based on the concept of integral aging as introduced in the previous chapter, what does that mean? In my first draft of this section, I had decided to begin with Crowe's (2004) four areas of human functioning: body, mind, emotion, and spirit. I do not agree with Crowe's categorization of psychological development within the emotion function, nor do I agree that emotion and feeling should be part of the same function. Emotion is a behavioral response to autonomic and hormonal responses to a given situation, whereas, feelings accompany these physiological responses (Carlson, 2007). For lack of a better model, I decided upon four functions, which I label physical, cognitive, psychosocial, and spiritual. Instead of referring to them as functions, I think "sphere" better describes my image of how these domains operate. I also believe each of these spheres are on a continuum, but they are not completely distinct continuums. The relative position of one sphere on its continuum can affect the relative position of another sphere on its continuum. They are inter-related, weaving in and out, one continuum becoming more dominant depending on the other continua. For example, when the body is weakened, the other spheres may begin to compensate, or they may become less functional depending on the particular relationship of those spheres within the individual person. We may become more engaged cognitively or begin a creative project that does not require as much physical effort, or we may withdraw into ourselves either as a process of healing or as a process of detrimental disengagement.

Originally I thought of the spiritual sphere interacting with the other spheres equally. What I now propose is that the spiritual sphere acts as an umbrella over the other three spheres. Or it might be perceived as encasing the other three spheres. The reason for this shift is that I
think the spiritual sphere oversees quality of life and well-being. I believe that a person can be in ill health, and also experience a satisfying quality of life if he has a rich spiritual life, i.e., if he is able to experience meaning is his life in spite of, or even because of his current health status. When an individual experiences isolation, her spiritual practice may assist in creating another type of connection that can sustain her through periods of social deprivation. Conversely, a person may be the model of physical health, but be detached from any spiritual connection, having few experiences of meaning or joy. The image of Scrooge in Dickens' *A Christmas Carol* comes to mind as an example of this.

The previous discussion provides a description of integral aging that can be used to elaborate upon a theory of elder music therapy. I have attempted to provide a visual representation of integral aging (Fig. 1), which I perceive as being three-dimensional. The three spheres within the spiritual container interact with each other and the spiritual casing creates an integrated whole. The arrows could actually be considered more as spirals, weaving in and around each of the dimensions.

Unfortunately a linear discussion does not easily lend itself to this three-dimensional, constantly interacting and integrative model. I will discuss each of the three inner spheres, and conclude with a discussion of the spiritual sphere. However, since these spheres do not operate independently, the discussion of each sphere will reflect this. Furthermore, each of these spheres operates on its own continuum as well as in relationship with the other functions.
Figure 1: Two-dimensional model of integral aging
Physical

There can be no doubt that the body slows down as we age. We can acquire various conditions or diseases that complicate the aging process. But even if we do not, cartilage wears down, eyesight fades, muscle tone relaxes, hearing loss occurs, wrinkles form, hair turns gray or white, etc. I think we have a tendency to see the aging body first and forget that the personality is still vital. I have heard from a number of aging people that they look in the mirror and have difficulty reconciling the aging face they see in the mirror with the energetic, alive person living inside the body. I am beginning to have these experiences myself as I near my sixth decade. I see the wrinkles forming around my mouth and on my neck, and think, "How can this be? I don't feel like I'm getting older." Even though I try to ignore the physical signs of aging, I am forced to slow down whether I like it or not. For example, I have had to take more frequent breaks while typing this thesis because my hands cannot tolerate typing for hours on end as they did when I was younger! The paradox is that in some ways, I am physically healthier than I was in my twenties. These experiences can create ambiguity, possibly creating confusion about what it means to move into old age.

How does thinking about the decline of our human bodies inform a theory of elder music therapy? First we need to be mindful of our clients' physical limitations, as any trained music therapist knows from his first geriatric placement as a student. But, what if we subscribe to an activity theory of aging or a successful aging perspective? Our goals for our clients will center on maintaining or increasing range of motion, improving heart rate and lung capacity, etc. We will attempt to perpetuate the activity level of the middle years. If we are coming from the perspective of disengagement theory, we may ignore physical needs entirely. Even a gerotranscendent perspective may lead us to pay less attention to the body's capabilities.
Regardless of what our particular theory of interest might be, they become irrelevant when we focus on the client's perspective. What does the client want to accomplish? What if the client does not know or is fearful of what is happening to them? What if her decisions are as a result of declines or deficits in other areas of her life? Where do we begin?

If we come from an integral aging perspective, then these issues will not be treated as separate categories. This harkens back to a problem Rowe and Kahn (1997) encountered in their model of successful aging. They had no explanation for why people continue to practice unhealthy behaviors even when they know that those behaviors are not good for them. What if we come from a perspective of acknowledging that the body is not functioning like it used to and assist our clients in processing their feelings about these losses so that they can begin to generate their own plan for how they want to experience their bodies? I think that viewing the body as an integral part of the whole human being provides a more realistic approach. Music therapists can assist individuals with exploring their feelings of loss in non-threatening ways through music interventions such as improvisation and song writing. The music and the supportive involvement of the music therapist can assist them in coming to new perspectives of their physical experiences.

Hazrat Inayat Khan was an Indian Sufi master and a trained classical Indian musician who is credited with bringing Sufism to the West. He lived from 1882 to 1927. His lectures to students in Europe and the United States have been written down and published in a number of books. The information described here is from *The Mysticism of Sound and Music* (Khan, 1991). Khan taught that the breath that comes through the voice of one person can touch another person through any of the five senses: sight, hearing, smell, taste, and touch. He suggested that we experience sound through every pore of our bodies and that it permeates our whole being.
Depending on the sound that is produced, it can slow or quicken blood circulation, waken or soothe the nervous system, or arouse or calm the passions. He believed we must have the right knowledge of sound and use it wisely. This is somewhat similar to the medical practices of the Renaissance period when music was used as a remedy for various illnesses as well as for preventive medicinal purposes, and healers were required to know how to choose the correct musical qualities for medical treatments (Carapetyan, 1948). Khan (1991) stated, "Health is a perfect condition of rhythm and tone. And what is music? Music is rhythm and tone. When the health is out of order it means that the music is out of order" (p. 103). Music therapists may be able to assist clients in discovering what rhythms and tones are out of order, particularly if they seek additional training and knowledge of various sound vibrational techniques. Toning, chanting, and the use of Tibetan singing bowls are music experiences that require minimal physical activity, and could address the decrease in physical function as well as deficits occurring in the other spheres.

Clearly music therapists must come to terms with their own physical appearance and abilities before being able to assist their clients in understanding the bodily changes they are experiencing. This extends into the religious realm because some religions suggest that the body is evil. While I am not saying that a person should not have this belief, the music therapist needs to be aware of this belief system so that he does not inadvertently offend the client or develop interventions that will be ineffective.

Cognitive

Decline in cognitive function is most evident in individuals with dementia. As mentioned above, there has been considerable research regarding the benefits of music therapy for individuals with dementia. I believe it would be more beneficial for our clients with dementia if
we viewed them from a position of wellness on the cognitive continuum and within the integral aging model. From that perspective we can then ask, "What areas can be strengthened to compensate for diminished mental function?" Because it has been found to activate a number of areas of the brain (Levitin, 2006), music can be particularly effective in engaging with individuals with dementia.

For this same reason, music is applicable in the lives of the well-elderly. As noted in Chapter 2, individuals who engage in music groups primarily do so to keep up their music skills. It is generally known that learning to play an instrument is a suggested activity for maintaining or improving cognitive skills (Gomes, 2005).

As in the discussion of the physical sphere, how we assist individuals in managing the cognitive sphere will depend on our theoretical approach. Those leaning toward activity theory will seek to maintain or improve cognitive function without considering if this is appropriate. On the other end of the spectrum, a music therapist who leans toward disengagement theory may not even see a need for therapeutic intervention. From a gerotranscendent perspective, the music therapist may believe in stimulating cognitive function, but primarily for the purpose of assisting the client in progressing toward transcendence. Integral aging suggests we look at the whole picture and include the client in the assessment, goal-setting, and treatment processes as much as possible depending on the individual's current level of cognitive functioning.

Loss of cognitive function can lead to feelings of frustration and fear in elderly individuals. As with declines in physical function, music therapy interventions can be used to assist individuals to explore their feelings and generate ideas for compensating for the loss or improving cognitive skills. If individuals continue to have adequate physical functioning, active movement can be included as part of the music interventions. Perhaps a person has always
wanted to learn to dance. Assisting the individual in fulfilling this desire, not only enhances the physical continuum, it promotes the cognitive (learning something new), psychosocial (improved self-esteem, shared experiences with other individuals), and spiritual (improved quality of life) spheres.

**Psychosocial**

I believe, as Tornstam (2005) and Joan Erikson (1997) suggest, that psychological development continues to occur into old age. And, as Tornstam suggests, I believe that people become more selective in their relationships and social activities as they age. Unfortunately there have not been many gerontologists who continue to write about aging into their eighties and nineties. Joan Erikson provides us with a picture of the experience of psychological development into the nineties. She speaks of the losses that occur in old age, but she also speaks of transcendence. The fact that she was writing into her early nineties and reviewing her husband's previous work demonstrates that psychological development continues into old age.

The Bonny Method of Guided Imagery in Music (GIM) is a music therapy modality well-suited toward psychological development. It "is a process that involves a client who is willing and able to explore his/her inner process through carefully selected music in an altered state of consciousness with a trained [GIM] therapist" (Ventre, 2002, p. 29). GIM "supports the integration of mind, body, and spirit and teaches a new way of using the creativity inherent in us all" (Ventre, 2002, p 35). This method of music therapy fits well with the concept of integral aging, allowing the client to explore all four areas of functioning.

In this realm of the psychosocial sphere, we must consider how mental illness or trauma might affect psychological development and social interaction. Individuals with mental illness are underserved, stereotyped, misunderstood, and isolated in our society, in much the same way
the elderly are underserved, stereotyped, misunderstood, and isolated, but to a much greater degree. One subset of this population is soldiers who return from combat. In hospice we are beginning to see an increase in the number of veterans who are suffering from un-treated post-traumatic stress disorder. Individuals with mental illness often spend the last few years of their lives in nursing homes. There are a number of policy issues that must be addressed, which is beyond the scope of this thesis; however, I believe that advocacy for the elderly and disenfranchised must be part of a philosophy and theory of elder music therapy. Do we speak up for the elderly (and others who are disenfranchised) when we see that they are being disrespected or taken advantage of? Do we contact our state and federal legislators, encouraging them to work toward improved social services for the elderly?

In meeting the needs of the mentally ill or those affected by war, abuse, random acts of violence or other traumatic events, we can apply this model of integral aging by engaging the other three spheres to support the cognitive sphere. We can look at the other spheres to draw on their strengths to support the individual's overall functioning. Many times people with mental illness do not engage in sufficient physical activity. Music therapy can be used to help increase physical as well as cognitive engagement. I believe the condition of the person's spiritual sphere plays a significant role in psychosocial well-being. Spiritual practices are believed to be helpful to those suffering from mental illness or trauma (Koenig, 1995), and music therapy can assist in promoting spiritual engagement. As these the other spheres are strengthened, the music therapist can begin to develop music interventions to address the mental health issues. Perhaps these issues are beyond the scope of the music therapist's training. In which case the music therapist can refer the patient to or collaborate with a mental health practitioner while continuing to help the individual strengthen the physical, cognitive, and spiritual spheres.
For elderly individuals who are considered mentally healthy, community music programs can not only assist in maintaining cognitive functioning, as described above, but can maintain psychosocial functioning by providing a venue for interaction on an emotional and social level, and physical functioning through breath control, physical dexterity, and eye-hand coordination. Learning to play an instrument in a group setting can also provide psychosocial benefits. If, from a gerotranscendent perspective, the individual is leaning toward a more contemplative lifestyle, he can engage in private sessions to learn an instrument or co-develop interventions with the therapist that support his lifestyle.

**Spiritual**

As mentioned above, I believe the spiritual sphere plays a significant role in overall well-being. A person can face extremely difficult situations if he has a strong spiritual connection. For some people, their spirituality is supported by an organized religious practice. Others find spiritual connections in nature, books, art, music, other people, animals, etc. I believe that in the process of aging, the spiritual sphere is the only area of our lives that does not deteriorate with age. In spite of declines in the other spheres, or even perhaps as a result of these declines, I believe our spirituality can grow, expand, enlarge, and deepen. Even if someone is non-verbal, there is an energetic presence between the music therapist and that person. A gentle touch can be a spiritual experience.

In this sphere, music seems to be particularly well-suited. As far as I am aware, there is no religion or spiritual practice that does not utilize music or sound. It is important that we support a person's spiritual practice regardless of our own beliefs. Because I believe we are all connected and that there is truth in every religion, I can support that individual in his own faith tradition. I can sing the hymns or spiritual songs from that person's faith tradition with a belief
that supports the individual and does not negate my own spiritual practice. I can be present for individuals who have committed serious criminal acts in a compassionate manner because of my experience with Jungian analysis and the belief that we are all capable of heinous crimes. But for the circumstances of my upbringing, and that I have been blessed with relative health and sanity, I might be the one who committed those heinous crimes.

Within the spiritual sphere is where we find compassion and understanding for our fellow beings. It is where we can allow ourselves to transcend the physical plane and become aware of something greater than ourselves. Drum circles, GIM, toning, chanting, and Tibetan singing bowls can be effective interventions to assist individuals in accessing these spiritual realms. The singing of spiritual songs and hymns from the person's faith tradition can open up his receptiveness to consider spiritual concepts, engage in a spiritual and life review, relieve physical or psychological stress, or provide comfort and peace.

This is the sphere that can help us when we are experiencing difficulties in one or more of the other spheres. When the body does not work like it used to, when we have trouble breathing, when we are suffering from mental health issues, low self-esteem, and regret, or when our memories begin to fail us, we can reach out to music. Music therapists can assist their clients in exploring the type of interventions that provide relief from pain and suffering, and can lead the individual into a more transcendent realm. It is in the area of spirituality that we can connect with our creativity, intuition, and inspiration. It is here where there is no right or wrong; there is just being, being in the moment to allow the rhythms, timbres, melodies, and harmonies wash over us like a cleansing tide.

Few gerontologists have considered the spiritual realm when developing theories of aging. Perhaps it is the spiritual connection that wreaks havoc with ideas of aging. What I mean
by this is that we see individuals who do all the "wrong" things (e.g., drink, smoke, eat fatty foods, engage in dangerous activities, etc.), yet, they live long lives. We question how this can be so. Perhaps their spiritual connection, the meaning they find in life, is what accounts for their longevity.

**Conclusion**

This chapter described a theory of elder music therapy as integral aging that considers all aspects of an individual. The physical, cognitive, psychosocial, and spiritual spheres exist on their individual continua, while interacting and intertwining with each other. The spiritual sphere encases the three other spheres. I believe this model can assist us in viewing aging from a more holistic perspective.

By using this model of integral aging, we can address a variety of areas within each of the four spheres. Rowe and Kahn (1997) advocate that the number one cause of death in the United States, cardiovascular disease, could be ameliorated by diet and exercise. Even though people know this to be true, they do not diet or exercise. Rowe and Kahn acknowledge this is a problem, but they do not address this issue. A model of integral aging suggests these concerns can be addressed through other avenues. For one person there may be a spiritual issue at the root of his decision (conscious or unconscious) to avoid healthy diet and exercise. Another person could be experiencing low self-esteem or suffering from a mental health issue that prevents adequate self-care.

A significant benefit of using a model of integral aging is that people with physical, cognitive, psychosocial, and spiritual disabilities and/or conditions can achieve a sense of well-being and quality of life in one or more of the other spheres. In successful aging, continuity and activity theories, and even in gerotranscendence theory, there are unaddressed assumptions that if
you are not following the pattern as proposed by the theory, it can be assumed by you and others that you are not aging well. This is not a helpful perspective when attempting to assist individuals in their aging processes.

Integral aging looks at the entire individual human being. It provides options for individuals to decide how they want to age. It provides options for health care practitioners to incorporate all aspects of the individual into the health care plan. Integral aging can be used across the spectrum of ages and physical, cognitive, psychological, and spiritual domains to ask, "Where am I on the spectrum of this continuum? Where do I want to be? Where is my client on this continuum and where does he or she want to be?" The integral aging model creates a partnership.
The two most important implications for any person working with the elderly is that health care professionals need to engage in ongoing examination of their beliefs and stereotypes around aging, and in their own spiritual beliefs. Because of the added dimension of music and the musical space created between the music therapist and the client, music therapists must be particularly aware of these issues.

Our beliefs about aging can affect our interactions with our clients, especially when we are unaware of them. These unconscious beliefs can affect our decisions regarding assessment, developing a plan of care, and the selection of appropriate interventions. We can unwittingly discriminate against our clients in subtle, but hurtful ways. I, myself, am still learning how to put myself in the shoes of my aging clients when I am not elderly myself. We must attempt to do this if we are going to be effective music therapists.

As with one's overall aging beliefs, it is important for music therapists to explore their own understanding of spirituality. We need to be careful not to force our own beliefs on to our clients. Our clients may not have any definite spiritual beliefs or practices, or they may have very definite, and even rigid, belief systems. I believe it is extremely important for music therapists working in hospice or with individuals suffering from emotional pain to be in regular evaluation of their spiritual beliefs. As a music therapist working in hospice, I am frequently challenged by the suffering some patients experience. Some patients linger for months and months. I find myself frequently asking, "Why?" in these situations. Other patients suffer emotionally, unable to forgive themselves for acts committed for which it is not possible to make amends. At times, it is almost unbearable to witness this suffering. It is important that I have my
own support system, and that I spend time being with the unanswerable questions. I do not know why some people experience what is called a "good" death and others must go through excruciating turmoil. And I have to be okay with that. I have to be in a place where I can be fully present with that person, open to any intuitive guidance that may come my way. I think this is true for any music therapist working in any setting.

One of the areas with the most potential for music therapists working with elders is the opportunity to use music therapy interventions to promote life review and reminiscence. These interventions have been found to help elderly individuals process their past, assess their current situation, and plan for the future (Tornstam, 1999a; Moberg, 2001b; Huber, 2003). They are also helpful in what Schachter-Shalomi and Miller (1995) call harvesting life. We can assist in creating music memory audio recordings related to different stages of the person's life. The client can select music related to major life events, and these can be recorded live, with the client reminiscing during the song, or after the song is completed. Reminiscence can occur in the presence of other family members so that they might share in those memories with their loved one as well as learning more about their loved one's life. Music therapists can assist in the creation of digital photo albums with client-selected music.

Supporting individuals with music from their faith tradition provides a supportive presence and encourages clients to talk about their spirituality. We can take training in spiritual care so that we might provide prayer as needed and engage in ongoing spiritual assessment. There are several spiritual assessments available from Internet sources for use with clients that could also be used to explore our own spiritual and well-being states. In her doctoral dissertation, Kagin (2010) examines music therapists' spiritual practices in relationship to their clinical practices, and provides a spiritual assessment scale in the appendix section of her
dissertation. We can collaborate with spiritual care practitioners within our organizations or communities. I work quite closely with the hospice chaplains: making joint visits and providing spiritual music for communion or other spiritual activities.

For individuals without a religious affiliation, music therapists can provide interventions that offer meaningful experiences, such as song-writing or learning to play an instrument. We can combine other modalities to provide opportunities for exploration: creating a collage of nature pictures or collaborating with art, dance, or drama therapists to explore other creative modalities that may lead to developing meaningful experiences.

Music therapists who are trained in GIM can provide opportunities for clients to explore their psychological lives with symbolism that arises from the altered level of consciousness while listening to music. Other imagery experiences might include the patient drawing while pre-recorded music is playing in the background, or the music therapist might lead the client in a guided meditation voiced over pre-recorded music.

Family members may want to engage in active music making with their loved ones, engaging in music improvisation on specific topics such as family gatherings or the celebration of a family event. A digital photo album could be constructed with family members improvising or writing music for the album. These experiences can bring family members together in a non-threatening way to demonstrate to the client that they have a support system.

Music therapists can be instrumental in starting community music programs that, ideally, bring together the old and the young. In this way, young people can be involved with elders in a way that broadens their understanding of aging and connects them with elderly individuals within their community. This is another non-intrusive way to increase elders' support systems.
Elders can meet new people through community music programs. Some of them may be former music teachers or musicians and can conduct or facilitate music groups themselves.

Community music groups also provide an avenue for music therapists to begin advocating for programs for the elderly. Music therapists can align themselves with organizations that provide services for the aging such as the Office for the Aging, local senior citizen centers, and county-sponsored Veteran's Services offices. Other possibilities include local service organizations such as Kiwanis or Rotary Clubs that might have programs that assist the elderly. Music therapists might want to consider volunteering at the local soup kitchen where elderly individuals on a budget or who are homeless might come for food, or volunteering with organizations such as Compeer, Inc., which matches individuals with mental health issues to appropriate volunteers.

I believe utilizing a model of integral aging opens up a different way of experiencing the aging process, and a different way for music therapists to think about aging for themselves and their clients. I think it allows us to be more open to ideas and possibilities when assessing our clients and planning our sessions, and gives us the freedom to collaborate with other disciplines to provide optimal experiences for our clients.
CHAPTER 6

FINAL WORDS

This development and writing of this thesis has been a journey. Reviewing the literature regarding theories of aging, music and spirituality, the use of music for improving the quality of life, and stumbling across a variety of related topics has made a change in the way I perceive my own aging process, my work as a music therapist, and my place in my community. The process has encouraged me to think about looking into how to establish a community music program for elderly individuals. It has also shown me the need to obtain training in spiritual care.

It has reminded me to be with my patients as a learner: to learn more about their history, and to learn more about how music can help them meet whatever goals they may have for the remaining weeks or months of their lives. This process has accelerated a process that began when I started my internship in hospice several years ago, that of reconnecting with my spirituality, and reminding me that we are all connected and that we are all spiritual beings.

This journey has increased my awareness regarding the importance of advocacy for the elderly. I believe music therapists must be agents of change. Can we separate our involvement with our clients from being involved in public policy and how those policies affect our clients who reside in nursing homes, low-income housing, and those who are disenfranchised? I do not have to go to Washington, D.C. and protest on the steps of the capitol building. But I can contact my members of congress. I can work on a local level to increase awareness of the various issues affecting elderly individuals.

And finally, I believe this model of integral aging can be applied in any setting. It is not just about what happens to us as we grow old. I believe it can be applied in all settings with all populations. I believe that if we begin to apply concepts of wholeness and health to our clients
rather than concepts of brokenness and illness, this could change the way we see our clients, ourselves, and the world around us. Based on the undergraduate music therapy training I received, I believe that music therapists are more likely to have this perspective than many other therapies and health care professions. In one of my very first music therapy classes, I was given an assessment template that included a section for discussing the client's strengths. As a profession, we can have a powerful impact on the overall philosophy of healthcare because of our more holistic approach.

I believe we are all connected to each other, to other animal beings, to our planet, and to the entire universe. We are connected by the collective unconscious (Jung, 1959). We are connected in our daily interactions, therapeutically and non-therapeutically, by transference and countertransference. If we are connected to a universal source, then we have access to ways of being and living we have not yet fully explored. We can be more effective music therapists, friends, co-workers, parents, children, lovers, if we remain open to all that was, is and is yet to come.

I close with a quote from Joan Erickson cited earlier in this thesis:

I am persuaded that only by doing and making do we become. Transcendence need not be limited solely to experiences of withdrawal. In touching, we make contact with one another and with our planet. Transcendence may be a regaining of lost skills, including play, activity, joy, and song, and, above all, a major leap above and beyond the fear of death. It provides an opening forward into the unknown with a trusting leap. Oddly enough, this all demands of us an honest and steadfast humility. (Erikson, 1997, p. 127)
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