PSYCHIATRIC MUSIC THERAPY

Origins and Development

Florence Tyson

CREATIVE ARTS REHABILITATION CENTER

Creative Arts Rehabilitation Center
New York

Library of Congress Cataloging in Publication Data
Tyson, Florence.
Psychiatric music therapy—origins and development.
Bibliography: p. 73
includes indexes.
1. Music therapy. I. Title. (DNLM: Music therapy. WM 450.5.M8 T 994p)
ML 3920.T95 616.89'1654 81-69631
ISBN 0-9606876-0-2 AACR2
ISBN 0-9606876-1-0 (pbk.)

Fred Weidner & Son Printers, Inc.
New York
Cover Design: Communigraphics, New York

Table of Contents

Music Therapy in Hospitals

Music therapy is a hospital-developed practice; it evolved particularly in psychiatric hospitals, which have borne the major responsibility for the care of the mentally-ill in the United States for more than two hundred years.

From the outset, conditions in institutions for the mentally-ill were abysmal. One of the earliest indications of the abuses suffered by patients is that walls were finally built around the first general hospital in this country in 1760 to *protect the patients* from the gaping public, who came to bait and enrage them. The Pennsylvania Hospital began to charge a fee in order to limit the number of sightseers and, finally, banned the public completely by 1800 (Deutsch, 1949).

America was not spared the inquisition of ignorance originating in medieval beliefs in demonology. Some of the people persecuted as Salem's witches were in fact victims of a rare hereditary disease, Huntington's Chorea, brought over on the Mayflower by an affected family. This neurological disease causes movements of groups of muscles, and these movements were interpreted by the trials of persecution as possession by the devil (Stone, 1966).

Ironically, wars have been a major influence both in bringing mental illness to the fore, and in creating the means of attacking the problem. The Civil War helped establish the field of neurology, which advanced knowledge pertaining to diseases of the brain. During World War I, much resistance to psychiatry as an integral part of medical treatment was overcome. World War II spurred the devising of large-scale screening techniques, which are today applicable in other areas, as well as the establishment of the practice of group therapy; it also led to the greater use of music in hospitals.

Applications of music gradually evolved along four main lines:

1) *In Functional Occupational Therapy (FOT)*—During World War I, it was noted that many military patients recovered the use of wounded limbs sooner as the result of physical activities, especially during long hospital confinements. The purpose of FOT was to increase the functions of muscle power, joint mobility and coordination of movements. Re-training and coordination by special exercises were also necessary in the case of severe burns, and of nerve destruction

and disease. Music was prescribed as exercise for most of the joints and muscles of the body (through instrumental playing), and to increase the use of the lungs and larynx (through singing and blowing)—practices current to the present time.

2) *As an adjunct to psychiatric treatment*—Music was seen to have the following attributes in the treatment of mental illness (Gilman and Paperte, 1952):
   a) Ability to command attention and increase its span;
   b) Power of diversion and substitution;
   c) Capacity to modify the mood;
   d) Capacity to stimulate pictorially and intellectually;
   e) Capacity to relieve internal tensions;
   f) Capacity to facilitate self-expression;
   g) Capacity to stimulate resocialization.

Empirically-derived assumptions (Altshuler, 1944), (Altshuler and Shebesta, 1941), (Blackwell and Neal, 1946), (Coriat, 1945), (Isham, 1945), (LaMaster, 1946, 1947), (Robinault, 1949), (Simon et al, 1951) upon which its use has been based in most neuropsychiatric hospitals are:

   a) That rhythmic stimuli set up muscular tensions which seek immediate release through physical activity and which help, therefore, to pull the patient out of his morbid preoccupations and direct his attention toward things and events around him;
   b) That the moods created by different types of music stimulate emotional responsivity;
   c) That music awakens real or fantasied associations and memories and, in this way, facilitates the expression of repressed, unconscious material.

Authors such as Eby (1943), Hevner (1937), Simon (1945) and Van de Wall (1926, 1946) describe the ways in which music enhances and facilitates individual and group therapeutic activities. Some stress the socializing effect of music through vocal and dance groups; some emphasize the positive effect of mood change and physical release even with severe, chronic cases; still others see the development of musical skills alone as capable of giving new and stabilizing dimensions to the patient's life.

3) *As a direct aid to anesthesia*—When the phonograph was introduced into the general wards of veteran's hospitals during World War I, it was noticed that music not only entertained the patients; it also helped to relax them. Doctors introduced the phonograph into the operating room as a psychological aid at first. It was soon found that, as the patient relaxed while listening to the music, he could be anesthetized more easily and did not require the same amount of medication. In dentistry, too, its use was found to lessen the amount of anesthetic required, and to generally eliminate the administering of drugs for pre-medication.

4) *As a psychological stimulus in the total hospital environment*—Music was found to be especially effective as an accompaniment to meals,

calisthenics and remedial exercises; to increase the endurance and efficiency of work projects in the Occupational Therapy shop; to diminish anxiety and relax patients in the administering of certain shock therapies, e.g., when used in conjunction with hydro-therapy and electroshock therapy, Altshuler (1956) reported "synergistic facilitation"; to divert patients during time-consuming physical therapy and deep X-ray therapy treatment. Of course, music was indispensable as entertainment—at the bedside, in the ward and the assembly hall, or outdoors. In hospitals for the chronically ill, maximum enjoyment was obtained from listening to fellow-patients performing.

By the 1930's, the aim of the music program was to modify patient's moods, as well as destructive or immoderate physical activity, usually on the open ward. In this phase, the structural requirements of the group music activity provided the controlling framework within which the patient was helped to participate. With the introduction of the tranquilizing drugs in the 1950's, it became possible to utilize therapeutic approaches in greater depth to meet patients' psychological needs. By the 1960's, the two most commonly shared goals reported by practicing music therapists were: 1) The establishment or re-establishment of interpersonal relationships; 2) The bringing about of self-esteem through self-actualization (Gaston, 1968).

Before World War II, the U.S. Army provided for music by tables of organization which assigned a musician to small units. Until 1942, a band was provided for each regiment. During the war, however, music was discouraged, and only divisions and Armies were supplied with bands. Soldiers were not permitted to take musical instruments overseas during 1942 and 1943; nevertheless, many small varieties were secreted among organizational equipment—usually the mess (Ainlay, 1948).

When wounded men began to fill our hospitals, doctors were faced with the prevalence of functional disorders. They soon learned that music was not only a morale-booster; it was even more helpful as an adjunct to the recovery process. Music then became a part of the Army's Reconditioning Program; music utilized for physical reconditioning, educational reconditioning, and occupational therapy of the reconditioning program was administered under direct supervision of medical officers. (In general, audio-reception for recreational purposes was provided through the American Red Cross and other civilian agencies.) This was the first official recognition given to music as a specialized means to be used in military hospitals to help the sick and injured. For the first time, bands were authorized, not for marching purposes or military ceremonies, but for general hospitals. Shortly before World War II ended, music technicians were assigned to general and regional military hospitals to work directly with patients (Ainlay, 1948). This program exposed musicians and administrators to the potentialities of music in the hospital setting; it helped to increase the understanding of the functional uses of music, and led to the establishment of the music therapy profession.

In non-military institutions, the purposes, organization and control of music programs varied considerably from hospital to hospital (Van de Wall, 1948). In the mid-1940's, no criteria existed for the selection of the hospital music worker, or for the structure of a hospital music program.

Well-trained musicians and music teachers were not necessarily suited for hospital work: some fled the wards as too depressing; others were too upset by the manifestations of illness; still others were too frustrated by inconsistencies and set-backs in patient response, including learning and performance capabilities. Activities evolved from two extremes of the musical spectrum: from *individual teaching* at a patient's bedside, and from *performing* to large groups in ward and auditorium programs. Emphasis gradually shifted in each extreme—from the *individual* to the *group*, and from *passive* to *active*.

Group music provided one of the earliest and safest group experiences for the most seriously-ill mental patients; it furnished non-verbal persuasion not only to act, but to act together. Patients who could not enjoy any other form of common action beyond the bare fact of being near each other, could still sing or dance together. Even with increasing complexity of the activity, the feeling of belonging or "taking part" remained constant. According to Hughes (1948), group music necessitates a subordination of the individual to the group, a merging of individual desires in a common effort which is non-competitive and non-threatening. This subordination of self to the common musical good, in most cases, brings an automatic reward in the form of greater musical pleasure, and satisfaction and pride in group accomplishment.

In state mental hospitals, particularly, full-scale music programs were conducted on the ward and in large groups, in an effort to reach as many patients as possible. In this situation, the music itself produced involuntary responses such as clapping hands, sudden smiling, humming, singing or dancing, which often provided the opening wedge toward contact with reality and resocialization. Altshuler (1948) noted that many disturbed or confused patients responded to music either by tapping the foot, swaying the body, or nodding the head. When tempos were changed, corresponding changes were observed in these "thalmic reflexes." He, therefore, sought to strengthen this temporary contact through the "Iso" principle, which engaged the patient at his level of mood and tempo, and the ward at its level of volume and rhythm. Such applications of music have demonstrated the unique quality of music not only as non-verbal stimulus and modifier but, especially, its power to reach through the barriers of the withdrawn, isolated schizophrenic patient.

Through these applications, many patients were rendered accessible to other therapies for the first time. Group singing, square dancing and rhythm band (Shatin et al, 1961) activities assisted in arresting deterioration among chronic and senile patients; when utilized as tension-discharging stimuli on the wards, they helped improve interaction between patients and hospital staff (Lee, 1956).

In mental hospitals, we also learned of the patients' overwhelming need for satisfying experiences — in performance and in interpersonal relationships. These needs could best be met in a more selective way through small groups and individual sessions. Satisfying participation in musical activity for the patient depended upon the degree of his interest, the direct experience of successful learning and evidence of accomplishment, and the quality of his relationship with the music therapist.

From the point of view of the music therapist, the following factors

appeared to contribute to the development of positive relationships with patients (Tyson, 1959): the degree to which each patient is perceived and considered individually, as a person whose feelings and sense of dignity are genuinely respected; the acceptance of each patient as s/he is, with whatever eccentric behavior s/he may present; the capacity of the music therapist for empathic response; the therapist's sensitivity and alertness to perceive and comprehend the slightest effort to communicate on the part of each patient; the extent to which the therapist participates dynamically in establishing communication, along with the use of music; the depth of the music therapist's conviction that the patient can learn and grow; the successful adaptation of musical concepts and materials to each patient's level of capacity.

Above all, we learned of the widespread motivational deficit which existed among patients suffering from a variety of illnesses, but particularly those with psychiatric disorders. Whether or not it was a consequence of constitutional breakdown, or a reflection of economic or cultural deprivation, this deficit very often existed prior to hospitalization. It existed, as well, among patients with musical aptitude or previous musical training.

The large-scale programs of music activities, then, were a means of stimulating response that might be kinesthetic, emotional, intellectual and associative, whether positive or negative. A function of the music therapist was to reinforce positive response in order to awaken or restore interest in music. This interest was then utilized as motivation for new learning and relationships, and reintegrating the patient into the social community. Where the interest was already expressed, the music-learning situation was usually regarded by the patient as a normal, non-threatening one in which he was willing to participate. Here the music therapist might function on deeper levels to achieve diagnostic, supportive and rehabilitative goals, depending upon a particular institution's philosophy and scope of practice. For example, the performance of music involves choices of instruments, choices of songs or musical selections, and choices of tone colors which may have diagnostic significance (Gaston, 1955).

A fully-developed hospital music program included the following activities: instrumental and vocal groups such as orchestra, band "combos," chamber music, chorus, rhythm band; ward community singing, music-listening and appreciation; ward and auditorium concerts; musical quiz, variety and talent shows; the staging of Broadway-type musicals; individual music study, including creative music-writing; folk and square dancing; religious choir; holiday pageants; maintenance and repair of musical instruments; construction of simple instruments; special ward and radio programs; programming music for public address system broadcasts; maintenance of a representative library of sheet music, records and books. Patients were encouraged toward maximum, appropriate participation in as flexible and informal a setting as possible. Sessions were usually no longer than forty-five minutes, and their musical content reflected the patients' preferences and interests.

Musical activity was regarded at first as a strictly recreational pursuit, and the major forms employed were instruction, performance and entertainment. Most often, the program was administered under the hospital's

Recreation Department, a practice which corresponded to prevailing custodial concepts of inpatient hospital care. In a further development, music was employed under the broadest interpretation of the meaning of therapy, which included the application of *educational* methods. Although not necessarily medically-prescribed, such methods were designed to counteract or terminate destructive processes and conditions favoring them. Through these procedures, the patient was seen as learning to collaborate with the various efforts of the staff to improve his condition by the use of his own physical and mental powers (Van de Wall, 1948). This shift in emphasis coincided with the growing trend toward *rehabilitation* and, in many cases, resulted in the transfer in administration of the music program to the Occupational Therapy Department.

The period after World War II experienced the cumulative impact of advances in social psychiatry, chemotherapy, and other related fields. At the same time, greater public interest and support resulted in increased state and federal appropriations for mental health services. These advances brought about a minor revolution in the management of mental patients; they made possible a dynamic shift in practice from traditional custodial care to the manipulation of the total environment for maximum therapeutic effectiveness.

In the mid-1950's, the effects of the tranquilizing drugs gave new emphasis and increased consideration to the usefulness of music therapy and, indeed, of all the creative arts therapies. For the first time, acute disturbed behavior among psychotics was modified to a large degree, which facilitated more normal interaction from patient-to-patient and from patient-to-hospital employee. Through improved social relationships, many previously inaccessible patients were able to take on deeper involvement with their immediate environment. (One of the important original uses of music as a mood-modifier has been largely eliminated since this time.) Hospitals began to mobilize all possible activities, music included, into full schedules designed to encourage growth processes and resocialization. The Activities Program developed at the Austin Riggs Center at this time, typified the growing belief in activity as a vital component of rehabilitation and recovery (Erickson, 1976).

But there was an even greater change which resulted from widespread use of the tranquilizing agents—a change implicit in their power to control acute states of anxiety and hyperactivity. It was now possible to return great numbers of patients to their homes and to general hospitals in their communities where they could be maintained on continued treatment at outpatient facilities. It was also possible to avoid hospitalization in many cases. These possibilities have become realities with startling rapidity. For example, during the past twenty years, the population in New York State mental hospitals has decreased from 93,000 to 24,000 and the downward trend continues.

Concurrently, these changes were reflected in hospital music programs. The broader applications became increasingly useful, whereas the high rate of turn-over, particularly among new admissions, precluded any meaningful continuity in working with individuals. This was frustrating for patients with strong motivation toward music and, for music therapists, represented lost opportunities of possible consequence in patients' rehabilitation.