

Music groups for psychiatric patients

MÁIRÍN BROWN, Occupational Therapist; and ANN SCHOFIELD, Senior Registrar,
St Stephen's Hospital, Sarsfieldscourt, Glanmire, County Cork, Ireland

Music therapy is a non-analytic therapy concerned with the creative process in which an attempt is made to reach the emotions of the patient without recourse to verbal means. It should in theory be suitable for chronic psychotic patients and all whose verbal ability is minimal. The ability to appreciate music may persist despite psychotic disintegration and provides one way, maybe the only way, into a patient's inner life. Music is one aspect of the aesthetic or creative experience that neurotic patients often lack and for this group music may provide a broader view of emotional life than their own more narrow previous experience.

A certain amount of musical ability appears to be present in everyone. For those who are not tone deaf a minor key sounds sad and a major key sounds happy and this perception seems 'instinctive'. A sense of rhythm also seems inherent with a fast rhythm conveying excitement and a slow rhythm calmness, even to those who are deaf or tone deaf. Similarly, loud sounds may convey strength and soft sounds fragility, while a rising pitch conveys beginning or opening and a falling pitch, closing or ending. With varying combinations of key, rhythm, pitch, volume and quality of sound, and especially where the composer uses contrasting variations, many ideas and feelings may be expressed and evoked. Thus patients need no formal musical ability to participate and benefit from a music group.

In the latter half of 1989 we started a music group in this hospital and the article by Dunne & Schipperheijn (1990) has prompted us to write this report on our experience in the hope that it might encourage others. We have no music therapist and are unlikely to get one in the foreseeable future. We have found few references to music therapy with psychiatric patients, although a number of reports deal with the use of music for the physically disabled or mentally handicapped (Dunne & Schipperheijn, 1990; Frampton, 1986; Gloag, 1989). Nevertheless we believe that a certain amount of work in this area can be done by those who are interested and willing to experiment.

Music groups

Aims of music groups

We now run two music groups, one with chronic long-stay patients who have minimal or no

communication abilities, and a second one with the slowest of the chronic long-stay patients who are being rehabilitated in the occupational therapy department.

For the first, regressed, group the aim of music therapy is to provide an aesthetic experience through novelty, enjoyment and the achievement of discovering something new and outside the usual everyday experience. It is hoped to provide a means of non-verbal communication and stimulate old music-linked memories. Another aim is to achieve greater physical self-awareness, re-affirm body image and right-left orientation and improve posture. Gross motor movements are rehearsed with the aim of replacing motor mannerisms with more appropriate actions. Relaxation is practised. There is scope too for reinforcing reading skills and listening and concentration are encouraged. Non-sexual physical contact and eye contact are attempted, both of which are frequently lacking in these patients. Finally, exploration, activation and control of feelings through music is sought.

In addition, for the second, more motivated, group of patients, we have tried to provide some musical education, to encourage more advanced motor movement such as dancing, to develop sequential thinking through developing sequences of movement and verbal learning of songs, and to increase awareness of and affiliation with others.

Equipment

We started with a radio-cassette, the loan of an electric keyboard, percussion instruments (tambourines, triangles, castanets, bells), song books and a tape with the songs recorded so that patients can 'sing along' and a small library of music tapes – classical, jazz, folk and pop. We later acquired the *Irish Times* newspaper-RTE music education programme (Grant, 1989) for primary school children. This consists of five demonstration tapes and a manual.

Structure of music group

Sessions are flexible. We stop when the patients want to stop and change the subject matter when interest appears to lag. Patients can come and go as they please so that they can avoid over-stimulation. The therapists participate in the group as much as

possible to provide modelling and to avoid the patients feeling they are being 'watched'. We have found a minimum of two therapists necessary. Patients are encouraged not to smoke.

Content of music group

The contents of the music group are the same for both groups of patients but the standard of achievement we aim for is lower with the more regressed patient group.

(a) *Gross motor movement*

For the very regressed patients this may be the only time they are encouraged to do anything other than sit, lie or make a shuffling walk. Exercises are done with the group or in pairs. Marching, clapping, movements on command, 'hand jiving', dancing (waltzing) and rehearsed sequences of movement are used according to ability.

(b) *Percussion instruments*

This gives the patients experience of different instruments, tambourines being the most popular, possibly because several different sounds can be elicited at once. Patients gain experience in the creation of differing qualities and volumes of sound and forms of rhythm. We have found that syncopated popular classical music is best for this section.

(c) *Singing*

Patients are encouraged to read the songs from the song book and encouraged to learn the songs, which are old familiar ones, as well as perform individually. If possible a 'choir' is formed and breathing and vocal exercises are sometimes added.

(d) *Education*

The tapes are designed for five-year-olds and upwards but we find that only some of the patients are up to this standard. Nevertheless most are quite happy to listen to a five minute section of the tape each week. This is followed by a quiz or some attempt at discussion of the contents.

(e) *Listening and relaxation*

At the end of each session patients are asked to relax and concentrate on a specially chosen piece of music, usually classical, as this is the type of music that is least well known by these patients.

Findings

Nearly all patients look forward to the music group, many turning up before the starting time, and some

joining who have not been invited, which has led to problems of overcrowding. For some patients it is the only group they will tolerate attending. Patients have become less restless and concentration and listening ability appear to have improved while participation has gradually increased. The highlight for one therapist was when one patient, whom she had not heard speak previously, spoke out in front of the whole group. Another patient listened to the group from a neighbouring room. When he eventually agreed to join the group he could repeat the contents of the previous week's group accurately.

We have recently acquired more instruments (glockenspiel, electric keyboard, kazoo, maracas, tulip wood block, chicken shakes, drum) and we have encouraged other staff to become involved in running similar groups.

Comment

We hope to liaise with musicians working in the catchment area of the hospital, enlarge our repertoire of songs on tape, encourage patients to make their own instruments and obtain a better sound system and thus expand the activities and scope of the music groups.

It is hoped that the increased ability to listen and concentrate and the greater awareness of emotions may be generalised to other areas of the patients' lives. Research is needed in this area. In Maslow's hierarchy of drives the aim of rehabilitation must be to fulfil the lower drives first but this should not preclude some attempt to fulfil the higher drives as well (Maslow, 1970). It may be that in acquiring some satisfaction of the higher drives the patient is facilitated in fulfilling lower drives more competently.

We believe that it is possible for those not trained in music therapy, but with experience in psychiatry, to introduce music to psychiatric patients in a methodical manner to their benefit, and our article describes one way in which this may be done. We hope this will be of help to those who, like us, have no music therapist to call on.

References

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