

Spirituality, music and psychiatry

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Introduction

Now the Spirit of the Lord had departed from Saul, and an evil spirit from the Lord tormented him. Saul's attendants said to him, 'Let our Lord command his servants here to search for someone who can play the harp. He will play when the evil spirit from God comes upon you, and you will feel better'. So Saul said to his attendants, 'Find someone who plays well and bring him to me. One of his servants answered, 'I have seen a son of Jesse of Bethlehem who knows how to play the harp. He is a brave man and a warrior. He speaks well and is a fine looking man. And the Lord is with him.... (So) David came to Saul and entered his service.... Whenever the spirit from God came upon Saul, David would take his harp and play. Then relief would come to Saul; he would feel better, and the evil spirit would leave him (1Samuel 16: 14-18,21,23).

The link between mental illness, spirituality and music stretches back a long way, although music is not always the healing agent. Plato, describing music in the third century BC has this to say.

'There is a tradition or story, which has somehow crept about the world, that Dionysus was robbed of his wits by his stepmother Hera, and that out of revenge he inspired Bacchic furies and dancing madresses in others; for which reason he gave men wine. Such traditions concerning the Gods I leave to those who think that they may be safely uttered; I only know that no animal at birth is mature or perfect in intelligence; and in the intermediate period, in which has not yet acquired his own proper sense, he rages and roars without rhyme or reason; and when he has once got on his legs he jumps about without rhyme or reason; and this, as you will remember, has been already said by us to be the origin of music and gymnastic'¹.

Such a potential in music both to soothe and to arouse makes it a very powerful medium. In our own time, Brian Keenan, sane but in solitary confinement whilst held hostage in Beirut, describes a powerful experience of music that he had when the noise of the heating pipe running through his cell one night took on a musical quality'

'And I listened entranced in the dark to the music that was coming from this pipe. I knew that there was no music and yet I heard it. And flowing out melodiously was all the music that I had ever loved or half remembered. All at once, all simultaneously playing especially for me. It seemed as if I sat alone in a great concert hall in which this music was being played for me alone'².

Becoming terrified by the incessant music, he decides to dance, to yield to it: 'Slowly, slowly at first then going with the music, faster I danced and faster until I went beyond, and beyond the music's hold on me... I danced and danced until the music had to keep up with me. I was a dancing dervish. I was the master of this music and I danced and danced... I felt myself alive and unfearful'.

This quality of music to enable one to 'feel alive' is the basis for music therapy, an arts therapy with which many of you are probably familiar, in which patients are encouraged to improvise their own musical sounds. I will give some clinical vignettes below. But before that, Rainer Maria Rilke's poem, 'An die Musik'.

Since training as a music therapist nearly fourteen years ago, this poem has become inspirational for my work because its powerful imagery encapsulates for me very succinctly the process of music therapy and, with surprising clarity, describes something of the qualities of the experiences that my patients and I have together. It is reproduced here in the translation by Stephen Mitchell:

'To Music'

Music: breath of statues. Perhaps:
silence of paintings. You language where all language
ends. You time
standing vertically on the motion of mortal hearts.

Feelings for whom? O you the transformation
of feelings into what? - : into audible landscape.
You stranger: music. You heart-space
grown out of us. The deepest space in us,
which, rising above us, forces its way out, -
holy departure:
when the innermost point in us stands
outside, as the most practiced distance, as the other
side of the air
pure,
boundless,
no longer habitable.

Rainer Maria Rilke³

For me, Rilke articulates the sense that I have when improvising of being in touch with something that is very transitory and ephemeral. Because of this quality of being somehow out of time and yet, paradoxically profoundly connected with time, because of the nature of rhythm, music is perhaps able more than other art forms to be expressive of something that is quintessentially human.

Music, perhaps more than any of the other art forms, is more abstract because it is not referential. It does not represent something else. Sounds stand for themselves. They may remind me of something else, but they are not directly translatable into something else. Derek Cooke, for instance, makes the claim that '...music is, properly speaking, a language of the emotions, akin to speech... It is, let us repeat, the supreme expression of universal emotions, in an entirely personal way, by the great composers.'⁴

I find this idea unsatisfactory, for two reasons, firstly because language, by definition, must be translatable and therefore referential and, as I have already said, I find this not to be the case. Secondly, music has to do with feeling but not necessarily with emotion. If I hear a piece of music, I may feel sad, happy, or even patriotic. Some music is designed to be programmatic and sometimes musically depicts a scene in sound (Beethoven's Pastoral Symphony, for instance, contains such references). But I would argue that more commonly what I experience has to do with being conscious of 'slowness' or 'quietness' or 'jerkiness'. In other words, my response is concerned with internal states of 'feelingfulness'.

Over the period of ten years that I was working as a music therapist in psychiatry I became more and more convinced of the importance of providing opportunities for such rich experiences for those who are mentally ill. Music therapy afforded such opportunities. Over that time, I developed a growing sense of the important contribution that music therapy has to offer the mental health patient. Eventually, I came to understand it as a form of spiritual care. But in order to understand how I reached that position, let me first describe for you what happens in a music therapy session.

Clinical Vignettes

Six people meet together in a room. The room has a circle of six chairs and at the side of the circle is a mat spread with assorted percussion and simple wind instruments. Each of us takes up an instrument and starts to play. It is difficult to play together at first and there is anxiety about how to start. We discuss this as a group. It is agreed to try again. Each person chooses an instrument and starts to play. At first all the parts are disparate. There is no common musical thread, no shared pulse, no sense of the parts being linked at all. After a few minutes, the different parts take up the same pulse. The music builds in a crescendo and then dies away again, gradually slowing down and stopping. At the end of the piece, six minutes in all, there is silence. No one speaks. Then someone says:

'It was quite loud, wasn't it? (There is universal laughter).

'Shall we cut a disc?' (More laughter).

'What did it sound like?' (We listen to the tape).

'It sounds different when you hear it, doesn't it?'

'Yes; more like real music!' (More laughter).

'What shall we call it?'

Various names are proposed. Eventually, someone suggests: 'Puerto-Bernobongo!' There is mutual consent to this name, which contains reference to the place and instrumentation, and is in itself the kind of mishmash of ideas that often happens in psychosis.

This is an extract from a session from an open group for patients in an acute ward of a psychiatric hospital where I worked for several years. I chose it as an illustration because it captured what I came to think of as a peak moment in my clinical work and one on which I reflected often as an example of something important. Why I came to consider it in terms of spiritual care I will discuss below but let us first consider two another clinical vignettes.

On a ward caring for those chronically ill with schizophrenia, a weekly group meets. The group's average attendance is 1! Once again, the room, a side-room off the ward, is set out with an array of easy-to-play percussion instruments. I arrive half an hour before the group is due to start and spend at least ten minutes of that time inviting patients on the ward to attend. Initially there was a referral system but that seemed not to work. Personally inviting patients from week to week seems a much more effective referral strategy. Most people say no most of the time and the average attendance figure of 1 reflects the fact that no one comes at all some weeks. But it also means that some weeks, three, four or even five people attend and it is then possible to be a group. This is such a week.

The group of four patients and I assemble in the room. I start with a brief introduction. 'It's now 1.45 and we have 45 minutes until 2.30pm. If you would like to play an instrument, then please do. If you would like to sit and listen or just to sit and be quiet, then that's fine. If you would like to say something, then that's fine, too'.

We sit in silence for a while and then each person chooses an instrument - a xylophone, a cymbal, Indian bells. At first, each instrument's line is separate, isolated, even. Then gradually, the parts come together, as if each becomes aware of the other in a different sort of way. After a minute or two, the parts seem to accommodate each other, sharing a pulse. I have the sense of a group of oscilloscopes, all on completely different wavelengths, which gradually find not the same but a compatible frequency. For a while, there is a connection, even a closeness about the parts. We are truly 'playing together'. And then, gradually, the parts limp out of sync. again. Another minute or so and it happens again, the parts gradually coming into focus with each other again. And

then, very suddenly, the loudest player, on the cymbals, stops abruptly. 'Have you ever seen a shark?' he says.

A third and final vignette: Roger is 31 and has a diagnosis of schizophrenia. He has been an in-patient since the age of 18. Sustaining a conversation with him is difficult as his thoughts seem to race ahead and sometimes one sentence seems to be a collision of several. Thus, there is very little sense of continuity. This session came after attending a once-weekly individual music therapy session for three years. Roger had developed a ritual of playing all the instruments in the room in a certain order, in a similar fashion, each week. After he had played all the percussion instruments in the room he would come and sit next to me at the piano.

After completing the weekly round of the other instruments in the room, Roger sits down next to me and plays a few notes on the piano. I play an answering phrase. He plays another phrase. I answer. He plays again, and I respond. He plays a glissando (*running his finger up along several notes in a ripple*). I do the same, but down instead of up. He beams at me. He plays and I then play with him, making the piece into a jazzy/blues rag. The piece lasts about three minutes in all. It comes to a joint conclusion, and, after a moment of silence, he beams at me'.

I have chosen each of these clinical illustrations because all of them were in some way 'significant moments', peak times when something important seemed to be happening. Reflecting on these and other such important moments in my work over the years, I concluded that their significance lay in the fact that in some way they lifted those involved to another place, a place beyond their immediate environment, in a way which was hard to describe in words, precisely because of its other-worldly nature. The more I reflected, the more I began to wonder about whether in fact what was happening could be classed as an experience of the spiritual.

What is spirituality?

Spirituality is one of those slippery words, often defined by what it is not rather than what it is.

'...The state or quality of being dedicated to God, religion, or spiritual things or values, especially as contrasted with material or temporal ones'.⁵

Within the Christian tradition, the definition has evolved over the centuries. There are those who are concerned that it has recently become so woolly that it has lost its meaning altogether. 'Spirituality may indicate stoic attitudes, occult phenomena, the practice of so-called mind control, yoga discipline, escapist fantasies, interior journeys, an appreciation of eastern religions, multifarious pious exercises, superstitious imaginations, intensive journals, dynamic muscle tension, assorted dietary regimens, meditation, jogging, cults, monastic rigours, mortification of the flesh, wilderness sojourns, political resistance, contemplation, abstinence, hospitality, a vocation of poverty, non-violence, silence, the efforts of prayer, obedience, generosity, exhibiting stigmata, entering solitude, or, I suppose, among these and many other things, squatting on top of a pillar'.⁶

For those concerned primarily with safeguarding Christian spirituality, this debate is clearly important, but for us I would suggest that it is not relevant for our particular purposes. Our purpose, as those concerned with the primary care of the mentally ill, is to address their spiritual needs and there, I suggest, Christian theological reflection may be of some assistance. For what Christianity has always valued (and I am not in any way claiming that it is unique in this) is the central connection of humanity and divinity. In other words (in its saner moments, at least) it has rejected the dualism that believes spirit (or soul) and body are two warring and opposing elements, but rather seeks to unite them as one whole.

'So God created man in his own image, in the image of God he created him; male and female he created them'. (Genesis 1:27)

As the theologian John Macquarrie, a Christian existentialist, says, 'surely there is some link between the humanity of God and humanity as we know it on earth. If so, then our ordinary everyday humanity must afford on the finite level some clue, however distant, to the being of God'.⁷

I am not suggesting that we should necessarily be in the business of telling our patients how and where to find God. In our multicultural society, such a forcing of our theology and religious beliefs on other people, particularly our patients, would clearly be wholly inappropriate. Indeed we must guard against using our position of power in such a way. (In research as yet unpublished, Jennifer Eeles, a psychiatric nurse, analysed how nursing staff assessed the religious beliefs of their patients. She found that nurses with strong religious beliefs were more likely to deem a patient's religious beliefs to be pathological and symptomatic of their mental illness if such beliefs contradicted the nurse's own theology.)

Nevertheless, we are aware that in a general sense giving patients access to spiritual care is crucial and that in order to do so we need to articulate what that means.

What is spiritual about music therapy?

As part of my own research I conducted a survey of music therapists working in mental health settings in the South-East of England. I asked them whether they felt that their work had a spiritual component and, if so, whether this was connected to the therapist's own religious experience.

All focussed on the process rather than the outcome of therapy and stressed that it was what they offered rather than what they or the client achieved. What emerged was that many felt their work to have a spiritual component because it presented clients with an opportunity to explore those aspects of themselves which were deeply concerned with their humanity; in particular, their capacities for creativity, expressiveness and relatedness.

'I always think of it as being in a room with someone else, trying to relate and express themselves'.

'It's about helping people to take themselves more seriously, especially creative, vital things'.

'Connecting with people - society, I suppose. But isn't it dreadful that we have to make that society?'

'I think that the joining of people together: I would call that spiritual'.

'Well, I think that the expression of things that can't necessarily be spoken or understood in concrete words - that's the way that spirituality gets expressed at its best'.

For those in whom such capacities are impaired by the negative symptoms of schizophrenia, clearly developing the capacities for creativity, expressiveness and relatedness is of key significance. Music therapy offers one possible arena for exploring and developing such capacities, as I hope was illustrated by the clinical vignettes that I gave earlier. It is in developing such capacities as make a person unique and individual, I would suggest, that a person's spiritual self is able to grow. Such a process is a difficult task for the psychiatric patient, especially if he suffers from schizophrenia. The kind of experiences that I described above may be rare. But what I as a therapist am trying to nurture in the patient is potential, a point that was echoed by the other music therapists that I interviewed. This emphasis on working with potential is crucially important. As Macquarrie puts it (p.2), 'we could say that we are all becoming human, in the sense that we are discovering and, it may be hoped, realizing what the potentials of a human existence are. Yet, it is true that we already are human, because these potentialities

already belong to us. This holds in the case even of someone who is slipping back from an existence worthy to be called human, for even he has not lost the potentialities’.

Conclusion

What I have outlined is a very personal and specific theory of the role that music therapy has to play in the spiritual care of those with mental illness. I would see other arts therapies as having similar roles. I have suggested that the process of music therapy enables those involved to develop those capacities for creativity, self-expression and relatedness, which touch the heart of what it means to be alive and that such a process is deeply spiritual. I have suggested that our definition of spiritual care needs to transcend faith boundaries and be wide enough to embrace a multitude of disciplines.

I would like to conclude with some more poetry, an extract from T. S. Eliot.⁸

‘...But to apprehend
The point of intersection of the timeless
With time, is an occupation for the saint –

For most of us, there is only the unattended
Moment, the moment in and out of time,
The distraction fit, lost in a shaft of sunlight,
The wild thyme unseen, or the winter lightning
Or the waterfall, or music heard so deeply
That it is not heard at all, but you are the music
While the music lasts. These are only hints and guesses,
Hints followed by guesses...’

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