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An Integrative Bio-Psycho-Musical Assessment Model for the Treatment of Musicians: Part II—Intake and Assessment

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Abstract

This is the second of a two-part series addressing the comprehensive bio-psycho-musical needs of musicians. An assessment that is inclusive of music medicine and music psychotherapy practices is included. The presented integrative bio-psycho-musical assessment is based on the authors' co-directorship of a center for music and medicine and their extensive study of musicians' medical and psychosocial presentations.

Keywords

musicians' injuries, performance arts medicine, musicians' wellness, music medicine

The Intention of Music

Music, as an avenue for expression, has its own neurological pathway in the brain and its own culturally contextual meaning within each musician patient's varying perspective and history (Loewy, 2000). As the music psychotherapist engages through music with the patient, extensive psychological impact is generated. The therapist may be anything but neutral. He or she can use the music *intentionally*, based on the patient's therapeutic goals. But intrinsic to participating with the client in playing music especially during the assessment intake, the music therapist may offer the patient extensive psychological self-reflection. In their duet, the choice of one piece of music or harmony or rhythm over another may reflect at times on the inner life of the music psychotherapist while simultaneously generating emotional response from the client. There are extensive historical references generated in people by a particular song or sound. Patient response to a certain melody or lyric or rhythm can be evocative. All of this reflects on the remarkably activist role of the music psychotherapist and, as well, on his or her need to be profoundly disciplined in integrating into the therapeutic work insight into his or her influence on the patient psyche and within the clinical relationship. Countertransference is an important part of this work and it has been found to be quite prevalent during the assessment period (Loewy, 2000).

So, while these issues concerning clinician neutrality and countertransference (Scheiby, 2005) may be relevant across multiple domains of health care delivery, in unique ways these issues resonate particularly deeply in music psychotherapy. Entry-level trained music therapists easily can be underprepared to realize the psychological material and countertransference that they bring to the interpersonally intense clinical relationship with patients. Entry-level training may, in general, be acceptable for the clinicians who practice more conventional music therapy—and do so with non-musician clinical populations. But in treating musicians using music *psycho*therapy, there is heightened demand on music psychotherapists to explore, monitor, and control for their inner material and countertransferences and for the effect that it has on all levels of the psychotherapeutic relationship.

Music psychotherapy includes the identification of themes (music/emotional) in a clinical context. Through repetition of what is known (review, orientation) and/or the development of what is unfamiliar (creative, improvisational), the music psychotherapeutic relationship provides insight and a mechanism for constructing meaning and understanding action. This construction may occur via exploration and integration of sounds and silences through vocalization, song, and/or verbalization and through the use of musical instruments (Loewy & Scheiby, 2001).

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Mental Health Needs of the Musician Patient

At The Louis Armstrong Center for Music and Medicine, where medical, psychiatric, holistic/integrative, and music psychotherapy services attend to the comprehensive health needs of performing artist patients, we have found that there is a disproportionate calling for mental health care. In an attempt to be as effective as possible, we learn from the mixed experiences in general of physicians, psychiatrists, psychotherapists, holistic practitioners, and music therapists to be exceedingly attentive to the psychological lives that we bring to our healing arts and to the powerful clinical relationship as well. In addition, while remaining broad in our medical perspective, nevertheless we focus heavily on the emotional needs of the patient audience.

Musicians and performing artists apparently face sizeable psychiatric challenges (Pruette, 2004). Depression, anxiety, substance abuse, sleep disturbance and distortion of the sleep-wake cycle, stress intolerance, trauma and hardship, heightened emotional sensitivity, dramatic personality styles, bipolar disorder, and relationship problems seem to be common in our relatively young patient population.

In addition, other factors as well seem to have a tendency to fuel the high prevalence of emotional problems that are representative of our patient population.

The False Self

Most human beings live with some level of disintegration between the true or inner self and the false or public face we choose, consciously and unconsciously. This schism can drive conflict that interferes with optimal emotional health and happiness. While each of us wrestles with these opposing selves to some degree or another, performing artists as a population seem to face it to an extreme. The split is accentuated because the emphasis is so great for musicians on stage to maintain performer personae. Add to this the vulnerability that may come genuinely from being naturally expressive in public, and the end result can be a psychological disharmony that performing artists face more intensely than the average person.

Finally, once the public face dominates the emotional life of the artist, valuation potentially shifts from internal to external sources, bringing with it substantial psychological distress. Once the artist finds self-worth primarily from audience approval rather than from internal satisfaction, he or she may never feel intrinsically or personally content, as the concert hall can never be large enough to supply enough accolade to fill the artist's need for self-love and integration of his or her inner and outer lives. The resulting tension can be destructive and often is the presenting material for clinical attention in our music and medicine center.

In the mix of people, perspectives, and pursuits that make society as a whole work best and most interestingly, the artist makes a critical contribution to the collective even while his or her individual, socially beneficial behavior does not necessarily foster his or her own competitive advantage/survival in the conventional world. Therefore, we who are the fittest for survival in that logical and competitive society, even if that comes at the cost of our lack of creative expression and emotion, have a collective responsibility to subsidize the survival needs of the artist so that we all can gain from the artist's creative contribution to the collective. As a society, we gain far more than it costs us to subsidize the survival needs of artists. Such logic fuels the engine that drives The Louis Armstrong Center for Music and Medicine. It motivates us to prepare ourselves to treat the broad needs, including the overrepresentation of emotional challenges, of the performing artist population and to accept such patients irrespective of their ability to pay.

Intake Assessment

In examining the mission of The Louis Armstrong Center for Music and Medicine, in reflecting on how we establish its scope of practice, in exploring its emphasis on appreciating psychodynamic material and the therapeutic power of the clinician-patient relationship, and in emphasizing the substantial emotional health needs of performing artists, we begin to understand the core structure and function of The Center. Focus is on a bio-psycho-musical model of care, with integrated delivery of medical, psychiatric, holistic, and music psychotherapy treatment. While attention is head to toe, there is heightened attention to psychosocial concerns. We take significant time with each patient so as to be comprehensive in our orientation and to nurture the therapeutic relationship. We remain acutely aware of the limitations of our knowledge and abilities, so we refer as needed to a select group of specialists committed to serving musicians and performing artists. Yet, at the same time, we strive to avoid compartmentalizing patients by body parts or organ systems or disease states. Finally, we monitor closely what we bring by psychology and personality to the clinical relationship so it can flourish as a therapeutic process, regardless of the specific health issues that a particular patient might have. The intake assessment is an important first step for acquiring health data relevant to the presenting case and for framing the start of the therapeutic relationship.

Like any intake form, we request to be given detailed information on chief complaints, their course, and how they fit into the patient's broader health history and context. This involves medical, psychiatric, and music material and how such material fits together. It is an extensive back and forth conversation. The art is to hear what the patient says and does not say. Careful attention is necessary to ''read between the lines'' successfully. Yet, at the same time, we work to avoid reaching conclusions prematurely about the client. So, as a rule, we ask the patient for clear confirmation of data presented and of our clinical suspicions rather than relying on innuendo. As the clinician, we are sanctioned to ask probing and personal questions that no one else, culturally, is allowed to ask. But we still must create, from minute one, a safe environment so that the patient feels secure in being so revealing. And at the same time, in quest of relevant medical information and diagnostic insight, we provoke patients strategically with calculated questions,

interpretations, and statements. In these moments of patient reactive discomfort, we stand to gain access to genuine material that can clarify diagnostic considerations and can resolve inconsistencies or holes in the patient's clinical narrative.

This complex exchange can mirror the interplay of two soloist musicians learning about and testing each other while simultaneously exploring how to jam together, to make one from two.

There is more to the intake assessment. Current and past medications need listing, including positive and adverse reactions. Supplements used should be recorded. Experience with any past psychiatric care or psychotherapy is important to learn. Response to the therapy and to the therapist, reasons for it helping or failing, material remaining inadequately addressed, and willingness to try more is all valuable information to collect.

Family medical, psychiatric, and artistic history is relevant. Social history receives significant attention in our intake. Living situation and conditions, employment and financial health, avocational interests and life passions, obstacles and stressors, relationships and support, details of a typical day, and various life goals all prove to be essential components, ultimately, to developing individualized diagnostic insights and to building personalized treatment plans that maximize the likelihood of achieving optimally, not just adequately, in life, health, and art.

The music psychotherapist takes a detailed history of the patient's performance track record: instruments, training, titles, years performing, percentage of time practicing and performing, solo versus group time, medical/psychological/functional challenges to performance, details of performance in behavioral and psychological terms, and goals/obstacles/strengths/needs related to perfecting performance. From such background information, a case formulation can develop to outline the direction for music psychotherapy and for strategy to optimize performance.

As we state frequently to Center for Music and Medicine patients in need, the best that we clinicians can do is to help you help yourself. Toward that end, in the intake assessment we like to learn how, despite challenges and limitations, the patient has succeeded overall and has developed effective methods for self-help and self-care. Also of relevance is exploration of that which has failed to help this patient and that which actually undermines his or her own health and success. Such a discussion inquires as well into health practices (conventional and alternative) pursued by the patient in the past and present.

Finally, in furthering the therapeutic relationship, it is key to investigate patient expectations for the intake and ongoing care at The Louis Armstrong Center for Music and Medicine. This involves an explicit discussion so that no unresolved mismatch evolves between patient and provider perspectives.

Physical, psychiatric, and musical examination follows as the "objective" (through the eyes of the clinician) section of a complete intake. This is often a particularly sophisticated musical, voice, sound, and language exchange between the patient and the music psychotherapist. Based on all inputs, and arising out of clinical conferencing about the case between all involved caregivers of The Center, a comprehensive and integrated assessment of the case—all facets—is developed, with a corresponding treatment plan that tries to address all relevant material while also being appealing to the patient.

On one hand, the intake encounter described here is familiar to most clinicians. Yet, when applied in the context of The Louis Armstrong Center for Music and Medicine, it offers a potent first step in delivering care that pursues optimal practice. The intake assessment, properly completed, emerges from our commitment to provide comprehensive bio-psycho-musical care that requires provider excellence, that recognizes clinician limits yet avoids compartmentalizing treatment, that emphasizes the power of the therapeutic relationship in any and all clinical situations, and that mandates provider awareness of their psychodynamic material that influences the patient, the therapeutic relationship, and the totality of care.

Conclusion

At The Louis Armstrong Center for Music and Medicine, the art of integration occurs not by accident or by providence. The deliberate and conscientious effort to design The Center and study how music and medicine can affect patient care begins with a comprehensive assessment. The assessment found in the appendix is the culmination of such efforts.

It is our hope that this assessment will serve as a pilot for health care professionals who have the delicate yet astute privilege of treating the musician or performing artist. The growth and development of this unique subspecialty provide promising opportunities to those who seek to recognize and study the integrative capacity and influence of music in medicine and medicine in music.

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Appendix
Bio-Psycho-Music & Medicine Assessment: The Louis Armstrong Center for Music and Medicine

1. Medical, psych/musical chief complaints:

   Present illness:

2. Medical, psych/music, and functional history:

3. Current medications and supplements/herbal medicines:

4. History of medications and supplements/herbal medicines:

5. Allergies/adverse events (specify):

   Medications, other:

6. Other clinicians involved in care:

7. Family history of medical/psychiatric illness:

8. Social history
   Living situation/conditions:

   Employment/avocations status:

   Financial health:

   Relationships:

   Typical day (stress index: 1 = *least*, 5 = *most*):

   1 2 3 4 5

   Goals—long term/short term:

   Passions/obstacles/stressors:

9. Performance arts
   Title and number of years performing:

   Percentage of time performing:

   Practice amount and time per day:

   Solo/group music time:

   Details of performance Hx (behavior and psychology):

   Goals/obstacles/needs related to optimal performance:

   Medical/psychological/functional challenges to performance:

10. Common ailments include (circle all that apply):

    drugs / alcohol / general anxiety / depression / insomnia / chronic fatigue / personality style, narcissistic / performance anxiety / respiratory/breathing challenges / hearing ability / vocal care / trauma / repetitive use injuries / cigarette smoking / exercise / nutritional challenges

11. Self-help, self-care, and complementary/alternative practices:

12. Patient expectations for the intake encounter at The Louis Armstrong Center for Music and Medicine:

13. Instruments/themes:

14. Description of music (individual/collaborative):

15. Description of music (structured & improvised):

16. Significant elements:

17. Plan of care

    Interest in: Individual Group

    Best time of day:

    Morning Afternoon Evening

    Hour preference:

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Bios

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