necessity, and so on. Although all these areas are compatible with a research interest, that interest should arise out of a personal commitment and involvement with the subject. Unwilling researchers are unlikely to produce good results. It is therefore improbable that they will enhance the reputation of psychiatry as a serious scientific subject.

Moreover, the current situation is often difficult for those trainees who desire to obtain research experience. Registrars are rarely given the support and advice necessary to obtain a higher research degree as a result of their work. In many jobs no encouragement is given to find time for research. Finally, trainees are frequently advised to aim for the maximum number of publications for the purposes of enhancing the curriculum vitae. Although the brevity of an "e = mc2" may elude psychiatry for some time, qualities of conciseness, precision and economy of words are virtues which should not be ignored. The uncertainties of our subject should not be further amplified by superfluous publication.

SIMON HALSTEAD

St Lawrences Hospital
Caterham, Surrey CR3 5YA

Madness in opera

DEAR SIRS

I read with some interest Dr Jones' article on the Psychiatry of Opera (*Psychiatric Bulletin*, May 1990, **14**, 306–307). I was rather surprised to see that he failed to mention the representation of madness in opera. I would suggest that the study of how different composers depicted madness in opera reflect on the current attitudes of the day.

Mental illness as represented by opera can be divided into three basic periods: the first is 'The Mad Scene', followed by the shunning of mental illness in opera. The third period is the rise of the psychoanalytical opera.

The Mad Scene – The first classical 'Mad Scene' appears in Handel's (1685–1759) 'Orlando' (1733). King Orlando goes mad in Arcadia for the love of a shepherdess. He returns to the sane world when she returns his love. DSM-III-R would probably classify this as a brief reactive psychosis. This type of madness was acceptable when removed to a distant/pastoral setting. This type of illness tended to be confided to regal sufferers. The great master of 'The Mad Scene' during early 19th century opera was unequivocally Gaetano Donizetti (1797–1848). The best example of his considerable output is Lucia di Lammermoor (1835). Lucia, in a state of madness on her wedding night, murders her new husband. After a stunning coloratura aria, still in her blood-stained wedding dress, she dies. Her free spirit is represented by an obligato flute. The point of this is clear: through madness Lucia discovers freedom, not merely from her unwanted husband but from life itself. Thus madness relates to heaven, freedom and liberty. Of course, at this time the great humanitarian movement in psychiatry was gaining momentum. In England the first patients to be removed from physical restraint were in York in 1796.

The rise of physical illness – During the middle of the 19th century, opera composers steered away from madness. They preferred to use physical illness as a symbol of purity. TB was used as a common method of escape to death, e.g. La Traviata (1853). Was this because insanity was too real and close to home for many of these composers? Wagner never really dealt with mental illness in any of his works. I suspect this was because it offended his Germanic view of purity. His patron, Ludwig II of Bavaria, was clearly psychotic and probably committed suicide in 1886. Verdi (1813–1901) made a few poor attempts of portraying mental illness on the opera stage. This was mainly evident in his early works, e.g. Nabucco (1843). These attempts were dramatic devices, poorly represented musically. He clearly found madness a difficult subject to write about, finding it was a little too close to home. He was never able to start his great project of an opera based on King Lear; he found the subject too stressful.

The Psychoanalytical Opera – During the latter part of the 19th and early 20th century one starts to see a change in the psychological treatments in opera; Greek legends as a metaphor for the emotional human condition were often used. This parallels the rise of the European psychoanalytical schools. The best example of this is Richard Strauss's (1864–1949) Elektra (1909). He deals with them in a tense and strongly sexual way. This idea was taken up by Stravinsky (1888–1980) in Oedipus Rex (1929). In 1925 Alban Berg (1885–1935) finished Wozzeck, an opera influenced by the horror of the first world war. This opera presents madness in a very different light, Wozzeck's insanity is not a release to a better world but a descent to hell. In effect we have witnessed a change in the representation of madness. Initially madness equalled beauty and freedom, it then metamorphosed into a living hell.

I am hopeful that this area of interest will awaken further study and thought.

NEIL BRENER

Gordon Hospital
London SW1V 2RH

DEAR SIRS

Dr Brener in responding to my introductory article on the psychiatry of opera (*Psychiatric Bulletin*, May 1990, **14**, 306–307) seems to have missed the point that my article was an introduction to a series of articles which he has partly pre-empted. I would agree, at a general level, with his representation of

mental illness in opera being broken down, historically, into a series more or less as contained periods. However, the introduction that I wrote was intended to put over the particular angle on the approach some producers have to opera, and of which, as a critic to a national newspaper, I approve. So many critics operate like pinball machines since one never really knows until their articles are in print which pocket the ball will fall into. I have strong views about the implications for opera in the 20th century with regard to the new and challenging theatricality of the producer's opera. My opinions and my overview of the various forms of madness that occur in opera will become apparent as my series unfolds over the next few months in the *Psychiatric Bulletin*. I hope then Dr Brener will see that I have not missed the point.

MARK JONES

St Bartholomew's Hospital
West Smithfield
London EC1A 7BE

Music therapy – indications

DEAR SIRS

I am writing in response to the interesting article by Drs Dunne and Schipperheijn (*Psychiatric Bulletin*, May 1990, **14**, 285–286). The authors describe historical aspects and some indications for music therapy.

Music therapy has a broad spectrum of indications, including disorders of general and psychosomatic medicine, and psychiatry. Unusually, it is a treatment without contraindication which is virtually free of side effects (Rosner & Meyer, 1982). Frenzied rhythmic music may induce agitation and irritability but such 'side effects' are subject to wide individual differences and are often idiosyncratic.

It may be useful to distinguish between active, receptive, and group music therapy (Alvin, 1975).

Active music therapy, in a setting with a therapist or within a group, enables individuals to achieve feelings of control, and can increase abilities in communication (Aldridge, 1989). It can foster spontaneity and creativity, enhance self esteem or enable affective discharge. Examples of active music therapy include singing or playing with the Orff instrumentarium (tamborine, bells, percussion). This kind of music therapy is most helpful in disorders with a disturbance of communication as in autism, mental handicap or mute psychoses.

Passive or receptive music therapy may enhance interest in the surroundings, may generate affective relaxation, and may increase phantasy. Examples are the use of records and tapes in a possible combination with methods of biofeedback. Hearing music may have desirable effects in many psychiatric disorders, e.g. disorders leading to anxiety or in inhibited patients.

Both forms can be performed as group music therapy, thus enhancing social activity and communication, for example community singing and instrumental improvisations as well as the perception of music within the framework of a therapeutic group. The group setting is especially important in personality disorders and anxiety states such as social phobia and social withdrawal, and in shy and emotionally restricted patients (Feder & Feder, 1981).

Music therapy may also support other therapies, for example relaxation therapies, guided phantasy, body-centred group therapies and physiotherapeutic techniques. Music therapy can play an important role in the rehabilitation of chronic organic diseases such as multiple sclerosis, Parkinsonism, strokes, etc (Gloag, 1989). My own experiences also suggest a supportive effect of receptive music therapy in autogenic training (the autosuggestive influencing of body functions).

MICHAEL LANGENBACH

University Hospital Nottingham
Queen's Medical Centre,
Nottingham NG7 2UH

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DEAR SIRS

It is unfortunate that in their article entitled 'Music Therapy' (*Psychiatric Bulletin*, May 1990, **14**, 285–286) the authors fail to distinguish between the therapeutic benefits of listening to music, and the active engagements of patients in musical activities in music therapy sessions. By focusing exclusively on the former, where they appropriately report on a wide range of patients who may benefit from listening to specially selected music, the authors inadvertently create the impression that this is the whole story. Indeed, the title suggests nothing to the contrary.

Music therapists in Britain place a strong emphasis on engaging patients in musical activities, structured or improvised, in group or individual sessions. The significance of the musical activity depends upon the therapist's theoretical orientations. The activity may be considered to be an end in itself; for example