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

References

ALDRIDGE, D. (1989) Music, communication and medicine: discussion paper. *Journal of the Royal Society of Medicine*, **82**, 743–746.

ALVIN, D. (1975) *Music Therapy*. London: Hutchinson

FEDER, E. & B. (1981) *The Expressive Arts Therapies*. Englewood Cliffs, New Jersey: Prentice-Hall.

GLOAG, D. (1989) Music and disability: music will benefit disabled people. *British Medical Journal*, **298**, 402–403.

ROSNER, B. S. & MEYER, L. B. (1982) Melodic processes and the perception of music. In *The Psychology of Music* (ed. D. Deutsch). New York, London: Academic Press.

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

in musical improvisation the musical relationship between therapist and patient may be seen as revealing aspects of the patient, which include his or her capacity for establishing, sustaining and developing a relationship with another person. Alternatively, the improvisation may be seen as an adjunct or trigger to a verbal relationship between therapist and patient, in which feelings elicited during the musical activity may be discussed. Improvisation may also be used with patients who have physical disorders, where it provides an opportunity for them to hear their movements in sounds which are given musical meaning by the therapist. The therapist can provide the possibility for extending these movements, by improvising music which invites and motivates the patient to play (and move) in different ways.

Although the studies cited by the authors provide an important theoretical foundation for the use of music in therapy, the profession has evolved well beyond the patient as passive listener, or even music-as-recreation. This is thanks to the pioneering work of figures such as Juliette Alvin, Mary Priestley, Paul Nordoff and Clive Robbins. Kenneth Bruscia's book *Improvisational Models of Music Therapy* (1987, Charles C. Thomas, Springfield, Ill) provides a commanding overview of music therapy.

MERCEDES PAVLICEVIC
Music Therapist and Research Associate
University of Edinburgh
Department of Psychology
Edinburgh EH8 9JZ

Responsibility of the Child and Adolescent Psychiatrist in Multidisciplinary Teams

DEAR SIRS

At a recent meeting of the Wessex Child Psychiatrists the advice contained in the *Psychiatric Bulletin*, (September 1989, **13**, 521) was discussed.

The paragraph containing the sentence "such clinical responsibility must be terminated only by agreement with the child's general practitioner" gave rise to much concern. Our group felt that the need for termination of clinical responsibility should be determined by the consultant. In addition we agreed with many of the points raised in the letter of the Leicester Child Psychiatrists group (*Psychiatric Bulletin*, March 1990, **14**, 175).

We thought that it would have been helpful if the advice had been circulated in draft form by the College for comments by the members before a definitive statement was issued.

W. A. SAUNDERS
Chairman
Wessex Child Psychiatrists

DEAR SIRS

This note is a comment on the two letters that have appeared in the *Psychiatric Bulletin* on the responsibility of child and adolescent psychiatrists in multidisciplinary teams. Issues of medical protection are only one of the many areas where the enlightened practice of child psychiatry (and increasingly other branches of psychiatry and community paediatrics), fit uneasily into the mould developed for the main body of medical practice.

Following detailed discussion with the medical protection agencies guidelines for practice were outlined, and were discussed with the Child Psychiatry Section Executive Committee and other relevant College committees before approval by Council in June 1989.

The letters raised the matter of consultation. Members of the Section must be aware that there are many similar issues being dealt with by their elected Executive Committee. While it is not College policy to circulate draft documents to the total membership, the current officers have instituted a newsletter for the membership. This is intended to inform members of the ongoing issues being considered and to invite comment. It is hoped that members will make use of this opportunity to join in the debate.

A. R. NICOL
Professor of Child Psychiatry
University of Leicester
Department of Psychiatry
Westcotes House
Westcotes Drive
Leicester LE3 0QU

Qualifications for appointments to substantive consultant posts

DEAR SIRS

In his letter (*Psychiatric Bulletin*, January 1990, **14**, 43) Dr Cottrell looked forward to the day when members of Advisory Appointments Committees would finally obtain "... relief from the grim ritual of making no short lists or appointments from a field largely comprised of locum consultants with no senior registrar training of any kind".

Training at the senior registrar (SR) level is important, and I fully support this programme as part of the process of maintaining good standards of clinical practice in the emergent corps of consultants. Nevertheless, as we all know, there are many 'intangible' factors that go into the making of a consultant. Is SR training the only way to acquire these qualities?

One of the 'intangible' factors that distinguish consultants from non-consultant medical staff is experience. The locum consultants to whom Dr Cottrell refers have done, and continue to do, all the things consultants do. Some have been involved in teaching