Child psychiatry

DEAR SIRS

I write in response to Sebastian Kraemer's letter (*Bulletin*, October 1988).

Dr Kraemer asserts in his second sentence that "child psychiatry is by its very nature a multi-disciplinary craft". This seems to me to be the accepted wisdom in child and adolescent psychiatry, but I am unaware of any evidence to support this assertion.

If the assertion of the multi-disciplinary nature of child and adolescent psychiatry is accepted, it follows that the practice of child and adolescent psychiatry should be carried out in multi-disciplinary teams. Of course this has enormous implications which have been debated to some extent but which seem to have been accepted by the profession without supporting evidence.

I would welcome a return to a public debate within the profession on this issue.

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Music therapy and mental health

DEAR SIRS

The use of music in psychiatry is nothing new, with a history stretching back to early Arabic–Hebraic medical traditions. What is becoming a late 20th century phenomenon is the specific application of music therapy in mental health services. Music therapists are beginning to explore music's functions above those of a general cultural, entertaining, relaxing and aesthetic nature.

Within Great Britain a music therapist is a professional musician who has undergone further post-graduate training in music therapy. Once qualified a music therapist can apply for membership of the professional association and work within the Whitley Council's established career and grading structure. Much emphasis is placed on active music-making, with clients being encouraged to create or listen to live music, music of a wide range of styles and traditions. Much use is made of free improvisation as a personal and self-expressive articulation of feelings, music being able to arouse deep emotional responses in us all. Tuned and un-tuned percussion is widely used, including instruments of African or Eastern origin. There is no typical session but a common pattern is a warm-up period – possibly involving listening to sounds, exploring instruments or group rhythmic individual/group issues explored musically. The session may then conclude with some form of summing-up and closure. Individual and group sessions take place with the music therapist adapting the music and style of leadership in relation to the needs of different clients and contexts. Musical skill is not a referral pre-requisite. Referrals are made across the whole age range and work occurs in the acute, rehabilitation and long-term areas.

One of the most commonly stated attributes of music therapy is its socialising nature. Inter-personal dynamics can be explored in an environment and within structures where the pressure is very much off verbal expression. Although there is no clear psychodynamic meaning of music, several therapists do relate aspects of musical processes to psychoanalytical theory. Several music therapists have undergone a personal analysis themselves or are involved in some form of individual or group psychotherapy. Other therapists may model their work on an eclectic or humanistic approach.

Recent research is developing ways of evaluating the effects of the work. Odell (1988), in her work with the elderly mentally ill at Fulbourn Hospital, Cambridge, compared levels of engagement between a verbal group and a music therapy group. Her results, although not significant, indicated higher levels of engagement in the music group. There was a significant increase when the results of regular weekly music therapy were compared with intermittent sessions. Since 1984 a series of projects has been set up in Bristol with funding from the Emperor Fine Arts Ltd, London. The aim of these projects is to discover how music therapy can be beneficial to people suffering from schizophrenia in particular. A project at Glenside Hospital, Bristol (1986) highlighted such specific effects as a high level of attendance, a high percentage of 'on-task' behaviour and increases in attention. More general effects such as a reduction in the level of tension as manifested in body posture were observed. As with Odell's work, the engagement and motivational aspects of music were highlighted in this project. The setting-up of a half-week post at this hospital resulted from this project's very basic conclusions.

In addition to further quantitative results, more qualitative data are emerging from a project at a smaller Bristol day hospital facility (Bunt, Pike & Wren, 1987). An initial questionnaire clearly indicated music therapy's contribution to changes in mood with a very high proportion of positive as compared to negative comments from both clients and staff. The work has also been the focus of two third-year psychology projects from Bristol University, when details of the social interactions and comparisons of musical and verbal content of the groups have been analysed. We are presently exploring further evaluation methods including client self-reporting. As this work continues we are finding out more about general effects and the detailed processes of the therapy. Eventually music therapy may be at the stage when it will have its own methodology and be