

the children and screening devices such as the General Health Questionnaire for adults, patients are asked to return the forms to the clinic. They are then allocated an appointment date. While having significantly reduced no-show rates to less than 1%, this device has also enabled "low motivation" or "crisis orientated" referrals, which make up approximately 25% of overall referrals, to be selected out.

Straightforward screening approaches such as these may be particularly important if my observations are reproducible in other clinical settings, as Dr Wood's article suggests that psychiatrists' ability to predict "no-shows" would appear to be extremely poor indeed!

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### *Columbus' egg*

DEAR SIRS

Welcome, Italians, to the world of computer interviewing! Dr Stratta and colleagues encountered great difficulties in applying their computerised general health questionnaire (correspondence *Psychiatric Bulletin*, January 1992, 16, 46–47). Perhaps the reasons for their failure are not hard to see?

Patients' attitudes to a computer interview are greatly affected by the status of the person who introduces them to the computer (a GP had much more success than his nurse: Dove *et al.*, 1983). "Interactive" interviews, where the computer appears to make conversation with the patient, have been shown to be very acceptable, more so than straight questionnaires. Also, patients particularly appreciate being able to conduct the computer interview in privacy at their own speed – it is unfortunate that Dr Calvarese remained present during the Italian interview. Finally, a computer "training session" at the beginning of the procedure is essential. Our *Assessor* and *Elicitor* interviews have now been used on thousands of patients without difficulty: for several minutes at the start of the interview the computer trains the patient on the use of its keys, and checks for his comprehension. If he does not understand, further examples and exercises are repeated.

I am grateful to Dr Stratta and colleagues for reminding us that automating a questionnaire is not a simple procedure.

A. C. CARR

### *Reference*

DOVE, G. A. W. *et al.* (1977) The therapeutic effect of taking a patient's history by computer. *Journal of the Royal College of General Practitioners*, 27, 477–481.

### *Creation of The Royal Free Trust*

DEAR SIRS

We have learnt from recent experience that what is known in Trust jargon as "disaggregation of assets" can be extremely complicated and disruptive to staff. In our case, the creation of The Royal Free Trust resulted in a situation where four parties: the Royal Free Medical School, University of London; the Royal Free Trust; Hampstead Health Authority; the Tavistock and Portman Clinics Special Committee, found themselves engaged in the unravelling of complicated funding arrangements about an academic and research post. The subsequent Trust moves and "disaggregation" caused substantial difficulties, and so I am writing to warn colleagues, whose institutions may have similar arrangements, to take the greatest care over contracts and finances in this area, preferably before the inevitable disruption occurs.

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### *Music therapy*

DEAR SIRS

As a Registered Music Therapist I found the article 'Music Groups for Psychiatric Patients' (Brown & Schofield, *Psychiatric Bulletin*, 1991, 15, 349–350) most encouraging in its humane and creative approach. I too have seen how music may be the one avenue of communication for those who are withdrawn and unhappy and those who are dementing.

There were, however, three points on which I take issue:

- (a) *The comment that music therapy is non-analytical.* Many practitioners do work non-analytically but there are others whose work is based on psychodynamic principles.
- (b) *The comment that music therapy is non-verbal.* My work focuses on counselling techniques in which significant music is used to facilitate the resolution of blocked grief, using a combination of music, familiar and improvised, with verbal interaction to achieve a positive outcome. The use of words is, for some patients, crucial. Music assists in this process, e.g. when a song associated with a lost relationship gives the person "permission" to do emotional griefwork and then talk through, as a cognitive strategy, the reasons why the blockage occurred.
- (c) *The remarks about universal perception of major music as happy, minor music as sad, and the "instinctive" nature of this response.* My recent research on cultural aspects of music therapy

demonstrates that perceptions of emotional content in music are largely culturally determined and should be regarded as learned behaviour.

It showed that:

- (a) For all age groups, it is easy to assess correctly the emotional content intended by the composer at the time of writing if the music is written in a familiar idiom, although there is a significant percentage of people not designated as "patients" whose perceptions differ markedly from the remaining 95% of the populations tested.
- (b) For music written in an unfamiliar idiom correct perception of mood may be more difficult as with a traditional Chinese "Happy Song" which Caucasian persons perceived as sad although to the traditional "owners" of the music, it was happy. Other items were perceived as meaningless although in the country of origin the meaning was clear.

The association of minor keys with sadness is of recent origin. The traditional English Christmas Carol "God rest ye merry gentlemen" is still perceived as of cheerfulness and joy, and yet was written in a minor key with the flattened leading note (7th). Conversely, two 'sad' songs ('The old folks at home' and 'Danny Boy') are written in major keys! Thus that perception of happiness and sadness in music are culturally determined and not instinctive.

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### *Expert opinion on a clinical query*

DEAR SIRs

We request the help of readers in the pharmacological management of a paranoid patient who develops agranulocytosis with old and modern anti-psychotic medication.

#### **Case summary**

Miss F, age 61, was treated for paranoid psychosis 20 years ago in England and needed continuous anti-psychotic medication because of frequent relapses. In Ireland she was prescribed a combination drug of perphenazine and amitriptyline, i.e. 25 m.g. b.d which she continued for eight years.

A routine FBC by her general practitioner in December 1989 detected a low WCC with neutrophils at 40%. On ceasing the medication her WCC returned to normal but the patient became paranoid. At the psychiatric out-patient clinic sulphiride 200 m.g. t.i.d. was prescribed, but once more within

a fortnight she developed neutropaenia; a bone marrow examination a few weeks later was normal.

Thioxanthenes were prescribed and her mental state returned to normal, but once more within weeks neutropaenia had recurred.

We prescribed ECT  $\times$  6 to which Miss F responded but four months later has become paranoid and her life is disrupted. ECT regularly would be an option but she relapses readily and pharmacotherapy does help.

At present we are prescribing minor tranquillisers which does not affect her bone marrow but her paranoia persists. She was seen by a haematologist who confirmed our fears of sensitivity.

Our problem at present is that Miss F is presently paranoid and we cannot prescribe any anti-psychotic medication without endangering her life.

We request urgent help from the readers.

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#### **The Case Report by Bhamjee and Gunning**

This is a surprising and interesting case and one can understand the predicament facing the authors and their patient. Blood dyscrasia associated with perphenazine, and even a thioxanthene (such as Depixol) is not too surprising since occasional blood dyscrasias have been reported with both thioxanthenes and phenothiazines. While these two classes of drug are structurally fairly dissimilar, they are not too dissimilar pharmacologically. The apparent implication of sulphiride, a substituted benzamide, is much more surprising. This agent is structurally quite unlike phenothiazines and thioxanthenes and is pharmacologically much purer, confining its actions almost totally to antagonism at D2 dopamine receptors. There is, to my knowledge, no recorded problem with blood dyscrasias related to this class of antipsychotic. The only property which links these three classes of agent is their dopamine antagonist action and I feel it is most unlikely that this action could have any adverse influence on white blood cell production or turnover.

On the assumption that the patient is not taking any other medication (prescribed or otherwise) during periods when she is paranoid, one must conclude that she is extremely unlucky, indeed possibly unique, in suffering neutropaenia, particularly with sulphiride. On the further assumption that the dyscrasia is not related to dopamine receptor blockade but to some other chemical characteristic of the drugs (although a common factor is impossible to define), one can only suggest a therapeutic trial with other clinically unrelated classes of antipsychotic agents.