

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.

Pimozide (a diphenylbutylpiperidine) or haloperidol (a butyrophenone) are obvious candidates, and in neither cases has blood dyscrasia been reported as a problem. Regular blood samples over the first few weeks of treatment with any such agent would seem to be prudent.

I wish them well with the case, and cannot help thinking of the well-publicised problem of neutropaenia with clozapine, the exact mechanism of which has so far eluded the manufacturers. If there were to be a surface receptor action shared by all anti-psychotic drugs and possessed in large measure by clozapine, which is unrelated to dopamine receptor blockade, then the implications for a new approach to antipsychotic drug design could be intriguing.

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*Philic disorders: are there such things as positive neuroses?*

DEAR SIRS

This is a brief self-revelatory piece written to put forward an idea and to find out if colleagues have had similar experiences.

I am a male married caucasian psychiatrist in my late 30s. Almost two years ago I developed a "philia" ("an intense, senselessly persistent and disproportionately pleasurable preoccupation with an activity or pursuit"). The disorder had a very acute onset, arising during the course of a televised penalty shoot-out during the 1990 World Cup. My wife insisted my son and I watch the football. Previously antipathetic to soccer, I then developed a lively and pleasurable interest in all things soccerial. This included attendance at most of Stoke City's home matches, Sunday afternoons in front of the TV

watching 'The Match', reading *When Saturday Comes* on train journeys, a trip to Wembley, getting up early on Sundays to help with a kids soccer team etc. etc. For several months I had a tendency to go off to sleep thinking about the game (rather than work – I believe this to be a pathognomonic feature of the philic disorder). During my summer holiday I went to a French second division match.

The disorder was intense for the whole season but has gradually improved and become less financially disabling since. Why did it arise? A cardiologist friend believed that my previous antipathy to the game was a subconscious rejection of my working-class origins. I had in fact a strong family history of chronic active soccerphilia (a father who was a Blackburn Rovers season ticket holder for 30 years). A 10-year-old son who was more than willing to share the interest with me was an important maintaining factor, as was a wife who was tolerant of this aberration. My working life was particularly hectic at the time and a source of temporary escape was most welcome. I wondered if I was alone in having experienced such an acute philia but, on making enquiries, discovered that I was not. The commonest object of an acute philic disorder I have encountered is windsurfing (n = 2, a general surgeon and a gynaecologist). Given that this is a post-Freudian pursuit I refrained from interpreting it. I would be interested to know if *Bulletin* readers have experienced similar disorders. Of particular interest is whether this is a sex-linked or culture bound phenomenon. Also, would selective 5-HT uptake inhibitors reduce its severity? If not, then what is the most helpful therapy? Finally, will Stoke City make it to the final of the Autoglass Trophy and get to Wembley for the first time since 1972?

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