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physiological response to these patients' abnormal eating habits or their low body weight.

The data on *treatment* are also highly equivocal. Whilst several reports have described the benefits of antidepressant medication in the treatment of patients with anorexia nervosa, no study has even met the minimal requirements of proper evaluation (Szmukler, 1982). There have also been claims that antidepressant medication helps patients with bulimia (DSMIII). However, the only controlled outcome study found that adequate dosages of mianserin had no specific effect on eating habits or attitudes, or indeed on mental state (Sabine *et al*, 1983). It must be added that it is questionable whether response to antidepressant medication is a legitimate basis for assigning patients to a particular diagnostic category (Murray and Murphy, 1978).

With regard to *family history* of affective disorder, the study of Hudson and colleagues certainly substantiates earlier findings of a high prevalence of affective disorder amongst the relatives of patients with eating disorders. However, the only conclusion that can be drawn from this observation is that a family history of affective disorder predisposes individuals to develop an eating disorder.

In conclusion, an association between eating disorders and disturbances of mood is incontrovertible. However, the balance of evidence weighs against the suggestion that eating disorders are forms of affective disorder.

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PHONEME DISCRIMINATION IN SCHIZOPHRENIA

DEAR SIR,

I read with interest the paper by Drs Kugler and Caudrey (*Journal*, January 1983, **142**, 53–59).

I have, however, found one point puzzling. It was reported in the article that all the patients met Feighner's diagnostic criteria of schizophrenia but, at the same time, the duration of their illness ranged from two months to 27 years. This seems to be contradictory since Feighner's criteria of schizophrenia requires the duration of at least six months.

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Dr Kugler replies:

All patients in this study were initially tested on the basis of hospital diagnoses. Case-note summaries were made at the time of testing and were subsequently examined, using the syndrome checklist of the Present State Examination and Feighner's diagnostic criteria, to confirm diagnoses before the data were analysed. The mental state of the patients in the time between testing and data analysis was also referred to and the minimum duration of illness for any schizophrenic patient at the time of analysis was 18 months. Age, duration of illness, age at onset of the illness and medication data *at the time of testing* are reported in our paper.

I hope this answers Dr Kitamura's query and apologise for the lack of clarity on this point.

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WEEKLY PIMOZIDE VERSUS FLUPHENAZINE DECANOATE IN SCHIZOPHRENIC OUT- AND DAY-PATIENTS

DEAR SIR,

Pimozide has been found to be effective as maintenance treatment in schizophrenics when given four days weekly to in- and day-patients (McCreadie *et al*, 1980) and once weekly to in-patients (McCreadie *et al*, 1982). A preliminary investigation has now been carried out in schizophrenics living in the community.

In a double-blind study, 27 male and female chronic

schizophrenic out- and day-patients received as maintenance therapy either pimozide, given once weekly, or fluphenazine decanoate, given mostly once fortnightly. Plasma pimozide levels suggested in the main satisfactory drug compliance. Over 12 months five patients on pimozide, two of whom showed poor drug compliance, and two on fluphenazine relapsed, as measured by an exacerbation of positive schizophrenic symptoms. A further three patients on pimozide were withdrawn because of side effects, especially restlessness after the weekly dose, but only one on fluphenazine. Although the numbers are too small to warrant statistical analysis, the finding that 8/14 (57 per cent) patients on pimozide and 3/13 (23 per cent) on fluphenazine were withdrawn suggests that once weekly pimozide may not be as useful as fluphenazine decanoate in maintenance treatment of schizophrenic out-patients.

In the pimozide group, parkinsonism lessened over the trial period. Although one patient on pimozide was withdrawn at his own request because of marked oro-facial dyskinesia, in contrast to the previous studies already quoted there was no significant increase in the frequency and severity of tardive dyskinesia in the pimozide group. This may be because the patients in the current study were younger, had received a smaller total amount of neuroleptics over the years, and were given a lower weekly dose of pimozide.

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ANWESENHEIT OR ALLOSCOPY?

DEAR SIR,

Dr Thompson's most interesting article on "*Anwesenheit:* Psychopathology and Clinical Associations" (*Journal,* December 1982, **141**, 628–30) discusses an area of psychopathology which is, in his words, relatively neglected. But by insisting on the German term, *'Anwesenheit'*, he has probably conspired in this process. In the last year I have seen four patients who have spontaneously described this phenomenon, and it is extremely difficult to explore the literature bcause of the lack of an accepted term. I look forward with interest to the categorisation of *Anwesenheit* in the Index Medicus and Medline computer.

In Fish's *Clinical Psychopathology,* (Fish, 1978), the term "sense of presence" is used, under the category of "Hallucinations of individual senses", and it is described as an experience which "most normal people have from time to time . . . . when they are alone". Typically a "dark street" or "dimly lit staircase" is the setting. The paragraph goes on to describe the religious version, as recorded by St. Teresa of Avila, and mentions organic states, schizophrenia and hysteria.

Possibly the association with a central religious experience has further conspired in our neglect. Were psychiatrists to be seen classifying, for example, the mystic sense of God's presence, as a dopamine-dependent disorder of brain function, the hornet's nest of religious fervour so aroused would be mighty indeed.

But there is a popular term at hand, which might rescue us from these complications, namely the "sixth sense". Dr Thompson wishes to avoid "the language of sensation", but *Anwesenheit* apparently denotes an experience *in clear consciousness* whereas in three of his categories (explorers, temporal lobe epilepsy, sleep disturbances) such a state certainly cannot be guaranteed. In my four cases (three with neurotic depression, one a schizophrenic) the words "sense" or "feeling" were always used to describe the experience, and I think we have to accept that it is a disorder of perception. I leave it to the phenomenologists to decide whether it is a true or "pseudo" hallucination of our sixth sense, and to the epidemiologists to establish its prevalence in normal and other populations.

Finally, I would propose the term *alloscopy* to describe this sensation. The Greek root *scopos* means sensing or perceiving as much as actually seeing, and the analogous term autoscopy (or heautoscopy) is already established in the literature to describe "seeing oneself" (Lukianowicz, 1958). The "sensing of another" is an associated experience and should have an associated terminology.

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