

schizophrenic out- and day-patients received as maintenance therapy either pimozone, given once weekly, or fluphenazine decanoate, given mostly once fortnightly. Plasma pimozone levels suggested in the main satisfactory drug compliance. Over 12 months five patients on pimozone, 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 A further three patients on pimozone were withdrawn because of side effects, especially restlessness after the weekly dose, but only one on fluphenazine.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analysis, the finding that 8/14 (57 per cent) patients on pimozone and 3/13 (23 per cent) on fluphenazine were withdrawn suggests that once weekly pimozone may not be as useful as fluphenazine decanoate in maintenance treatment of schizophrenic out-patients.

In the pimozone group, parkinsonism lessened over the trial period. Although one patient on pimozone was withdrawn at his own request because of marked orofacial dyskinesia, in contrast to the previous studies already quoted there was no significant increase in the frequency and severity of tardive dyskinesia in the pimozone 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 pimozone.

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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 because 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 autoscopia (or heautoscopia) 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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