designated course of psychotherapy of a particular kind. However, from the moment of referral, to selection, engagement, working through, and finally termination of treatment, these clients represent a progressively filtered and highly selected subgroup. While they may, in a rather self-fulfilling way, fit the Western template of suitable candidates for psychotherapy, they would not allow one to determine whether more or fewer non-Western people, compared with Western subjects, generally respond to 'Western' psychotherapy. From a 'new' cross-cultural point of view, it may paradoxically be of great interest to study the characteristics of the reject or dropout cases, and find out in what other ways they can be engaged in a mutually agreed form of healing, or to whom they go for alternative forms of help and why. Unfortunately, these subjects seem to be ignored in 'cross-cultural' research on psychotherapy.

The thesis that 'Western' psychotherapy is (not) applicable for non-Western people therefore involves two intrinsically complex factors, non-Western people and 'Western' psychotherapy, and is difficult to test empirically. Psychotherapy has been said to lie in the realms of rhetoric and hermeneutics. Its credibility is enhanced by invoking the prestige of Western science but, paradoxically, is not scientifically ascertainable (Frank, 1988). If psychotherapists seriously want to study the question of cross-cultural application, they would have to move beyond value-laden personal experience and single case reports to examine, preferably with inter-disciplinary efforts and culturally relevant models, specific dimensions of psychotherapy in relation to specific subgroups of non-Western people. However, the justification for such an endeavour may deplorably be questioned by many therapists themselves and the required cross-cultural methods and instruments are far from being developed at this stage. Until then, discussion on the question of cross-cultural applicability of psychotherapy seems to be mainly an emotional one.

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Psychological outcome of abortion

SIR: In an era when the expression of strident and polemical viewpoints concerning all aspects of abortion has become the norm, cool-headed attempts at evaluating the psychological outcome for the women concerned are greatly needed. As such, the paper by Zolese & Blacker (*Journal*, June 1992, **160**, 742–749) is to be welcomed.

We feel, however, that the authors could have done more to highlight the difficulties in conducting research in this area, particularly regarding the choice of control subjects.

When the goal is simply to identify a population at risk of psychological dysfunction it is sufficient to compare recipients of abortion with non-pregnant women of similar age. To isolate the effects, both mental and physical, of therapeutic abortion is rather more difficult, as there is no comparison group where confounding factors are small.

A relevant question here is "what are the psychological consequences of *denying* an abortion?". Thus one comparison group might be women whose request for a termination is refused. Although in a country where termination of pregnancy is widely available this group might be more or less psychologically disturbed, the comparison seems a worthwhile one since this group would represent the only possible alternative outcome of an unwanted pregnancy. The interested reader is referred to an earlier review (Handy, 1982) for a fuller discussion of these issues.

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'Socrates' symptom'

SIR: Förstl (*Journal*, June 1992, **160**, 868–869) reminds us of Socrates' experiences and behaviour and suggests the term 'Socrates' symptom' for the combination of auditory hallucination and cataplexia-like symptoms occurring in stressful situations. Although being a soldier in a time of war is certainly stressful, Socrates seems the least likely person to become disturbed by this, as he was renowned as a man indifferent to physical pain and hardship (Xenophon, *Symposium*) and indeed accepted his own death 'philosophically'.

I would like to suggest that Socrates' 'symptoms', on the contrary, are a consequence of dissociative phenomena occurring during intense and prolonged introspection. Introspection seems to be an important factor in Spivak *et al*'s original cases (*Journal*, March 1992, **160,** 412–414) as each was alone and thoughtful as well as being distressed and under pressure. In trance states and under hypnosis hallucinations readily occur. A possible objection to this explanation is the high level of arousal suffered by Spivak *et al*'s cases: this is no obstruction to trance-like states, as demonstrated by the work of Milton Erikson, who at times induced such states at the same time as increasing arousal.

Introspection by Jean Paul Sartre's hero in *Nausea* results in derealisation, distortion of time sense and visual illusions. This altered perception of the environment leads on to adoption of a different personal philosophy. It is of interest that two major philosophers described such states, and both regarded them as sources of inspiration rather than a pathological response to stress. Most individuals are vulnerable to such experiences (or should I say 'capable of such experiences'?), but to a variable degree.

It seems the outcome has sometimes been very positive and sometimes rather unsettling.

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Clozapine in the community

SIR: The pharmacology and clinical efficacy of clozapine are extensively described by the contributors to your recent review of the drug (*Journal*, May 1992, **160,** (suppl. 17)). In contrast, the difficulties and implications of widespread prescription outside of research settings, and in particular to patients living in the community, are given scant attention. In view of the increasing use of the drug this would appear to be an essential area for debate.

To service a small group of patients in the community on clozapine could well require the services of an almost full-time nurse to ensure the following precautions are undertaken.

(a) Blood samples must be taken regularly in a patient group who find it notoriously difficult to attend regular appointments.
(b) Adequate time must be allowed for these samples to be posted to the Clozaril Patient Monitoring Service, analysed, and the result to be sent to the pharmacy dispensing the drug. If no result is obtained, no tablets are dispensed. It is therefore essential that coordination of these events occurs and that accurate reporting systems are in place.
(c) There is close liaison with the pharmacy and also with the doctor to ensure that these steps run smoothly and so that any notifiable change in blood sample results can be brought to the attention of the relevant people immediately.
(d) Patients should receive their prescribed medication following the results of blood tests, which for this patient group may mean that it has to be delivered to their homes in the community.

It may therefore be necessary to redeploy mainstream staff, in order to set up a special clozapine service in every district.

As well as having regular blood tests, patients on clozapine, and their carers, need to know that any episodes of infection are potentially lethal. Firm integrated working relationships should be established with local general practitioners, so that any episodes of physical illness are picked up, and all concerned need to given clear guidelines about what action they should take. Even with such precautions there will be significantly increased risks to patients who are vague or unreliable, or to those who do not have carers in close contact.

In some centres, community practitioners are not registered to prescribe clozapine because they have patients placed in settings which do not have staff cover 24 hours a day seven days a week, and they do not have access to hospital beds. If this cautious approach is justified and accepted, it is likely to have important implications for patients on clozapine. They may remain incarcerated in hospital because of a lack of adequately staffed accommodation.

At the Maudsley hospital, a considerable proportion of pharmacy time is already taken up with administering clozapine prescriptions. Is there enough evidence at this stage of justify the extra staff time and concentration of resources in order to provide the required level of intensive input in the early stages of clozapine prescription? We need to be clear that any such investment is worthwhile in terms of being clinically effective, cost effective (Honigfeld & Patin, 1990), and in providing a better quality of life for patients (Meltzer *et al*, 1990), and that tying up such resources will not result in more people having to stay in hospital.