actually prevented a significant number of suicides or have we just postponed them? Do we at times facilitate suicides in potential patients, for example, by prescribing antidepressants?

Psychiatrists and the rest of the society would be better off if we could confess our helplessness in averting suicides and declare the fact that at the best we might be able to postpone some and only sometimes prevent them.

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Neuroleptic malignant syndrome

SIR: Those who would classify neuroleptic malignant syndrome (NMS) with malignant hyperthermia (MH) and exertional heatstroke (EHS), as differing manifestations of a common thermic stress syndrome with differing trigger factors but shared pathophysiology at a biochemical level, will be disappointed by the report of Rosebush *et al* (*Journal*, November 1991, **159**, 709–712) finding no useful role for dantrolene in the treatment of NMS: dantrolene is the drug of choice in the treatment and prophylaxis of MH and there is some evidence for its efficacy in EHS (Larner, 1992). However, previous reports have acknowledged that the benefits of dantrolene in NMS are at best partial and less consistent than in MH, and the possibility that NMS results, at least in part, from a disorder of muscle-cell calcium homeostasis still remains.

The fullest account of post-mortem muscle pathology in NMS reported a toxic myopathy similar to that seen in MH in the absence of major brain abnormalities, supporting a peripheral mechanism for the hyperpyrexia of NMS (Jones & Dawson, 1989). Furthermore, it has been known for some years that NMS muscle *in vitro* responds to halothane (but not caffeine) with a contracture, as does MH muscle, suggesting a link between the conditions at the pathophysiological level (Caroff *et al*, 1983).

To further elucidate potential similarities in the biochemical mechanisms underlying NMS, MH, and EHS, it would be useful to determine the response of NMS muscle to ryanodine *in vitro*. Ryanodine binds specifically and avidly to the calcium release channel of muscle sarcoplasmic reticulum, the proposed site of the MH defect (Mickelson *et al*, 1988), and ryanodine contracture may therefore be a more specific test for MH (Hopkins *et al*, 1991) and hence for a deregulation of muscle-cell calcium homeostasis.

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SIR: Spivak *et al* (*Journal*, March 1992, **160**, 412–414) report hallucinations induced by physical and psychological stress in three young soldiers and quote the pertinent literature from 1960 onwards. I would like to remind of a similar, but more complex phenomenon observed in the soldier Socrates during the Peloponnesian war (ca. 431 to 404 BC) and reported by Alcibiades (Plato, *The Dinner Party*):

> "At daybreak he became thoughtful. He stood in the same place just thinking, and kept on at it without any sign of giving up. When noon came the men became interested and said to each other 'look, Socrates has been standing there thinking since daybreak'. Later some of the Ionians brought out their bedding after supper – it was in summer time – and slept out in the cool air. They watched him to see whether he would stand there all night. He did! He stood quite still until the sun rose and the dawn came. . . ."

Later, Socrates explained (Plato, *Socrates' Defense*):

> "I have a strange experience. Previously the divine voice which I have become used to, has always stayed with me. It has opposed me even in quite unimportant matters if I was about to take the wrong action. . . . At other occasions it has even stopped me in the middle of a sentence."

I suggest that the term Socrates' symptom should be used for the combination of auditory hallucinations and cataplexia-like symptoms occurring under

stressful situations and in a state of clear consciousness with no evidence of drug abuse.

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SIR: The flood of sexual abuse complaints is placing a heavy burden on our current terminology. 'Childhood sexual abuse' now has to cover three distinct categories of patients, appearing in increasing numbers. There are sexually abused children; sexually abused children who have now grown up; and adults who come forward volunteering for the first time that they were abused in childhood decades ago.

This last group differs significantly in many respects from orthodox child abuse. Key figures are often dead or abroad. Diagnosis is difficult, as other siblings may vehemently deny that abuse took place. Management is complex, particularly as patients often wish to exhume the past and start legal proceedings against their assailant.

We suggest a new name, 'Eureka syndrome', for this rather new illness. This would recognise a curious characteristic of some of these patients – an autochthonous quality to the abuse memory. Two of our last six patients claimed that they had totally repressed all memories of the sexual abuse at the time, and been totally unaware of the history until some chance event brought it back to their minds this year. They were then suddenly confronted with horrifying recollected scenes, which have drastically changed their feelings towards the family member involved.

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SIR: The article by Mendez (*Journal*, March 1992, **160,** 414–416) contains three case reports – patients 1, 6 and 7 – where the syndrome is identical to that I reported eight years ago (MacCallum, 1984). Dr Mendez expresses some interesting viewpoints in the discussion but does not point out the fact that the mothers fail to appreciate their busy daughters as the same persons as their daughters in the tender caring role, yet somehow know that they exist both ways in a personal relationship, but never as intruders.

The publication *The Delusional Misidentification Syndromes* edited by Christodoulou (1986) contains chapters adding further insights, and in which, for instance, Joseph (1986) discusses the basic syndromes including MacCallum's Syndrome. I would expect that with neurophysiological advances, further elucidation of these syndromes will become clearer to clinicians in the years ahead.

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Are non-Western beliefs false?

SIR: I refer to the letter by Singh (*Journal*, February 1992, **160,** 280–281).

While I quite share his views on the evolution of the concept of semen loss and the problem of dealing with self-appointed quacks who perpetuate erroneous views; I am puzzled over his concluding paragraph where he states that ideas related to semen loss appear "to be a variation of the centuries-old false beliefs and ignorance", together with his own interpretation of the term 'culture-bound'.

Singh's assumption of semen-loss beliefs in a myth-orientated native population is predicated on the tenet that views of reality generated by Western scientific discourse are 'true', and since the natives' views do not tally with that of Western science, they automatically become false. His gold standard of reality then posits science to be 'the central truth' which has corrected such erroneous views, that at one time also persisted in the Western world, but thanks to 'development' and 'progress', this has now been dispelled from medical and lay minds simultaneously. This is also to suggest that history follows a progressive linear course, thus the past becomes equated with 'faulty', the present (modern) with 'correct', and science is knowledge while non-science is ignorance.

In my own ongoing research looking at popular ideas of psychological distress among white 'natives', I find a similar theme but in the opposite direction: semen *retention* rather than *loss* seems to be perceived as unhealthy, undesirable and its (semen) regular discharge is therefore physiologically necessary. My sample is a population of contemporary Londoners from the middle and lower social classes attending out-patient clinics for depression and volunteers from our own academic department whose responses did not differ from the clinic population. I wonder if Singh would also consider them to be holding false beliefs?

'Culture-bound' as a term used in transcultural literature stands for phenomena that are found