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'Psyche' – Spirit as well as Mind?

ANDREW SIMS

Much has been written about the dangers of Cartesian dichotomy for psychiatry, with its equally perilous errors of 'mindless' or 'brainless' psychiatry (Eisenberg, 1986), as well as the nonsense of talking about disease as either 'mental' or 'physical', or with 'somatic' or 'psychological' symptoms. Kendell (1993) has made this point eloquently; this paper further extends the theme. We psychiatrists complain when our medical colleagues cannot get beyond the physical, even when evidence for psychosocial aetiology is quite blatant, but we may be guilty of an equivalent error in almost totally excluding spiritual considerations from the way we understand our patients. This was alluded to in the address to the Royal College of Psychiatrists by our patron (HRH the Prince of Wales, 1991). We ask patients to which religion they ascribe, but we neglect the much more important question of "what does your religion and your faith mean to you?"

Phenomenology – the subjective experience of belief

Some of what little recent work there is bridging the twin universes of religion and psychiatry has missed the point, by enquiring about conformity with the subject's religious background (e.g. Christian, Muslim) rather than exploring subjective experience of belief as a motivating force.

Whereas *descriptive psychopathology* involves "the identification of classes of abnormal mental acts" (Berrios, 1984), *phenomenology* is the study of events, either psychological or physical, without embellishing those events with explanation of cause or function (Sims, 1988*a*). Following Jaspers' (1959) more specific usage, phenomenology involves the observation and categorisation of abnormal psychological events, the subjective experiences of the patient, and his consequent behaviour. An attempt is made to understand the internal event or *phenomenon*, so that the observer can, as far as possible, assess for herself[1] what the patient's experiences must feel like, using empathy as a precise instrument.

Phenomenology, then, directs the practitioner not only to explore how the patient feels inside himself through detailed questioning, but also to use her innate characteristics as a human being, and the experience acquired through learning empathy as a skilled activity, to feel for herself what the subjective experience of the patient must be like.

In Karl Jaspers' *General Psychopathology* (1959), he defines phenomenology between 20 and 30 times, always in terms of *subjective awareness* or the study of experience 'from inside'. The difficulty of phenomenology lies in it being the study of the subjective experience of another person. When this approach to psychiatry is used, the patient's religious beliefs, as part of his total experience, must take on immense significance. No longer can we tolerate the psychiatrist's scepticism or even overt hostility; the clinician has to be humble enough and psychiatrist enough to feel herself 'inside' the experience. As the psychiatrist involves herself in this satisfying but time-consuming exercise, important differences become evident between the self-experience of *magic* from that of *ritual*, or *faith*, in a similar way to the psychopathological differences between *obsession*, *delusion*, and *overvalued idea*.

Not only does self-experience of belief vary between psychiatric diagnoses, but those from differing religious traditions experience symptoms with religious content in different ways. An example is a description of psychotic illnesses in 19 Bratslav Hasidim from Israel (Witztum *et al*, 1990):

> "In order to distinguish between culturally normal and abnormal symptomatology, it was necessary to become acquainted with the behaviour and values of the sect . . . Certain features clearly demarcated our psychotic patients; a process of *change* had occurred, so that whereas previously they had studied and conversed with others, they now became isolated and did not study. They withdrew into a psychotic world of Zaddikim and demons populated by Rabbi Shimon bar Yokai and angels . . . While they justified their behaviour in terms of concentrating on matters of holiness, the degree of self neglect actually transgressed the religiously permissible . . . While those who turned to Bratslav pursued spirituality, our psychotics differed in that spirituality pursued them. They were often frightened by their experiences, terrified of the angels, and would refuse to go out unaccompanied."

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1. Throughout, the patient is referred to as 'he' and the psychiatrist as 'she'.

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One needs to know both about the shared assumptions of the religious group and the unique self-experience of the putatively disordered individual. In the past, talk about religion was a prominent symptom of many mentally ill people resulting in the notion of *religious mania*; too much religion, like genius, was thought to drive you mad. Both hypotheses are, of course, fallacious. George Savage (1886), previously of Bethlem Royal Hospital, wrote:

> "When people talk of religious mania, they often confound two things; first, the cases in which patients are constantly speaking about religious matters, more especially those who are forever repeating texts, or with hand wringing and melancholy aspect, are complaining that their souls are lost; and next, the cases which appear to have been produced by some religious movement. There is a very great distinction to be made between the many cases which exhibit some religious symptoms and the few which are really caused by religion itself . . . As a rule, however, religious insanity, so called, is the symptom, not the cause of the disorder."

The distinction between form and content is relevant. *Form*, in this situation, is the class of subjective experience which may reveal diagnosis, while *content* is determined by the cultural context, in some cases religion. This makes religious mania more readily understood; the form may well be that of mania as part of a major affective disorder, with pressure of talk, flight of ideas, grandiosity, overactivity and so on, while the content, because of the patient's previous predominant interests, is religious.

John Bunyan, in his autobiography *Grace Abounding to the Chief of Sinners* (1666), reveals obsessional thoughts and ruminations which are connected with, but can be clearly separated from, his underlying religious beliefs. For example:

> "33. Now you must know, that before this I had taken much delight in ringing, but my Conscience beginning to be tender, I thought that such a practice was but vain, and therefore forced myself to leave it, yet my mind hanckered, wherefore I should go to the Steeple house, and look on: though I durst not ring. But I thought this did not become Religion neither, yet I forced my self and would look on still; but quickly after, I began to think, How, if one of the bells should fall: then I chose to stand under a main Beam that lay over thwart the Steeple from side to side thinking there I might stand sure; But then I should think again, Should the Bell fall with a swing, it might first hit the Wall, and then rebounding upon me, might kill me for all this Beam; this made me stand in the Steeple door, and now thought I, I am safe enough for if a Bell should then fall, I can slip out behind these thick Walls, and so be preserved not withstanding.
>
> 34. So after this, I would yet go to see them ring, but would not go further than the Steeple door; but then it came into my head, how if the Steeple it self should fall, and this thought, (it may fall for ought I know) would when I stood and looked on, continually so shake my mind, that I durst not stand at the Steeple door any longer, but was forced to fly, for fear it should fall upon my head."

The *obsessional symptom* and the *religious belief* expressed in this passage, although interconnected, can be distinguished phenomenologically.

Prayer

It is generally possible, using psychopathological principles, to make a distinction between symptoms of mental illness and descriptions of religious experience which, although unusual, are not in fact psychiatrically morbid (Sims, 1992). Religious experiences may be evaluated phenomenologically; for example, prayer is a subjective experience of talking to or with God. This can be illustrated by an interesting paper on short intensive psychotherapy for bereavement (Gillett, 1986): "The therapist asked her if she had anything to say to life or to God. She demanded, 'Why did you take him away from me? . . . why? . . . why?' She was very angry." In his biographical account, *Genius and Grace*, of prominent people who had both severe psychological distress and sincere Christian faith, Davies (1992) described how they all acknowledged the fundamental importance of prayer in their lives. In fact, most people, especially when grossly stressed, pray, such as Keenan (1992) when incarcerated in a Beirut basement.

We are often concerned with how our patients make decisions, perhaps neurotically and inappropriately. Do they pray about their actions, and if so, how do they use their praying? We can never know unless we ask them. What does this prayer mean to them in coming to a decision? What is quite often overlooked by those whose daily life does not include prayer is that, subjectively, it is experienced as a two-way communication. Also, it is experienced as "inside my mind"; one does not hear a voice perceptually, and yet it is believed to be valid, and that God can communicate. Such people, who are neither deluded nor hallucinated, hold these beliefs with conviction.

Magic and rituals

Magic or *superstitious* thinking is phenomenologically, or subjectively, different from religious experience. The subjective experience of the supernatural, of the

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belief in God and in God acting, assumes one's own limitations. Magic is quite different. To quote Thomas (1971):

> "The essential difference between the prayers of the churchman and the spells of a magician was that only the latter claimed to work automatically; a prayer had no certainty of success and would not be granted if God chose not to concede it."

Ultimately, the assumption of belief in magic would be that external events are under the individual's control if only the right formula can be found, the right button pressed, and there is no rational association between cause and effect. The magician does not necessarily have any religious beliefs; he might believe that God could be compelled against his will to respond to a powerful enough formula. Magic assumes that the environment can be manipulated.

Ritual may be associated with either religion or magic, or both. Subjectively, it is an elaborate sequence of behaviours, initially based on reason, which emphasises the extreme significance to the individual of the matter in hand.

Cults

Psychiatrists need to remind themselves of the emotional power of religion as a motivating force for action – both creative and destructive. We will return to positive features later, but in the tragedy at Waco, Texas, there was a lethal combination of religious fanaticism and social alienation, of severe individual personal disorder and collective suggestion which was literally inflammatory. These are the public, harmful effects of exclusivist religion, fanaticism, oppression, monolithic absolutism, and fundamentalism. But as every psychiatrist knows, there are also harmful individual effects upon vulnerable people. These also have to be acknowledged, dealt with, and incorporated into our views on religion. There is, of course, a huge danger from those who exploit religion for political purposes.

Galanter (1982, 1989) has studied the consistent psychological aspects of charismatic religious cults and conversions in America. Conversion often occurs from "overly enmeshed families" and when there is psychological distress and substantial chronic disturbance. The adherents often experience psychological advantages upon conversion and during membership of the group, with close emotional ties for those previously isolated, and a feeling of purpose for those who came out of meaninglessness and deprivation.

Aims, goals and values in psychiatry

There is no such thing as 'valueless' psychiatry; all of us, as we practice, carry our values, standards, aims and goals from the rest of life into our psychiatry, and, much more to the point, so do our patients. To quote Paykel (1986):

> "Psychiatry itself raises some ethical issues: the boundaries of free will and responsibility; standards which should guide behaviour in the face of fundamental and ill-governed instincts in relation to love and sexuality, hate and violence; questions of the punishment and care of the transgressor, and the difficult and sometimes impossible distinction between the sick and the bad . . . "

We do not try to impose our own values on our patients: for the young man with a PhD who suffers from schizophrenia and uncomplainingly puts letters in envelopes for a charity, we try to ascertain what are the patient's *own* goals and values. In his rebuttal of Foucault's analysis of mental illness, Matthews (1993) states:

> "The beliefs of paranoid schizophrenics differ from those of other people, not in being delusive, nor in incurring social disapproval, nor in leading to socially unacceptable behaviour, but in that the beliefs, and the affect and behaviour which go with them, are *disabling* to the schizophrenic him- or herself . . . What makes it legitimate to label the schizophrenic 'ill' and to provide him or her with appropriate sorts of help is that the condition makes it impossible or very difficult to achieve the schizophrenic's own aims."

Yet the psychiatrist cannot abrogate her own moral responsibility to evaluate each situation and apply her own values. Fulford (1989) quotes a not unusual case of the conflicting motivation of a severely depressed man who believed that he had cancer of the brain, but presented also a suicidal risk, who insisted that he would not stay in hospital and therefore had to be admitted under the Mental Health Act. What right, what moral obligation even, do we have to compel such a person to come into hospital and receive treatment?

Jenkins (1986) comments on this dilemma for the psychiatrist:

> "Psychiatry, it seems to me, hovers in the potentially creative nonsense area . . . on the fringe of . . . or else very much inside medicine but in a way acting as the very important joker. A joker which upsets the pack by asking things like: how can the techniques, manipulations, mechanics and biochemistry of medicine help souls?"

Psychiatry, quite rightly, tries so hard to show that it has an essential role in physical medicine and in quantitative science that it sometimes appears to be

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ashamed of its parallel need to be concerned with moral questions and spiritual values.

Religion does not feature in the index of most psychiatric textbooks. When referred to at all in hospital, it most often alludes to which denomination, if any, is favoured by the patient, like which supermarket is patronised. In fact, *re-ligio*, from its roots, implies that 'foundation wall' to which one is 'bound' for one's survival, the basis of one's being. Other words with a similar derivation are *lig*ament, *lig*ature and ob*lige*.

There are numerous meanings for the word *spiritual*; the most useful imply what a person lives for, their motivating force; the weakest, a nebulous power beyond description. Here are five aspects of meaning which the psychiatrist should consider:

(a) *Aims and goals*; looking for the meaning in life, what one regards as essential;
(b) *Human solidarity*; the interrelatedness of all, both doctor and patient; consciously and unconsciously-shared aims and beliefs;
(c) *Wholeness* of the person, in which spirit is not separate from body or mind but includes them;
(d) *Moral* aspects; what is seen as good, beautiful, enjoyable, as opposed to what is bad, ugly, hateful;
(e) *Awareness of God*; the connection between God and man.

I suspect that the word *spiritual*, as used by both Jaspers (1959) and Scharfetter (1980) implies all these meanings. It seems that psychiatrists, in their reluctance to use the word, the concept or the implications of *spiritual*, are like a patient with a phantom limb, denying the existence of their handicap.

Why do psychiatrists ignore the spiritual? There could be several explanations:

(a) It is considered unimportant;
(b) It is considered important but irrelevant to psychiatry – like assuming the hospital has a safe water supply;
(c) We feel we know too little about it ourselves to comment, or even to ask questions;
(d) The very terminology is confusing and hence embarrassing; it is not *respectable*;
(e) There may also be an element of denial in which it is easier to ignore this area than explore it as it is too personally challenging.

However, we need to understand our patients, and they often take spiritual issues seriously. It is also an additional force, potentially, both for beneficial development of the individual and for social support.

Sacks (1985) encountered a relevant patient; "charming, intelligent, memoryless Jimmy". Sacks had come to think of him as one who had been 'de-souled' by a disease, but one of the nurses said, "Watch Jimmy in chapel and judge for yourself". Sacks continues:

> "I did, and I was moved, profoundly moved and impressed, because I saw here an intensity and steadiness of attention and concentration that I had never seen before in him or conceived him capable of . . . Fully, intensely, quietly, in the quietude of absolute concentration and attention, he entered and partook of the Holy Communion. He was wholly held, absorbed, by a feeling. There was no forgetting, no Korsakov's then, nor did it seem possible or imaginable that there should be . . . clearly Jimmy found himself, found continuity and reality, in the absoluteness of spiritual attention and act."

In the same way as neurologists in the past did disservice to their patients by only observing and describing left hemisphere lesions, to the detriment of the right hemisphere, so psychiatrists have too often concentrated exclusively upon the mental, and ignored, to the extent of denying its possibility, a spiritual dimension.

A patient with schizophrenia regularly heard a voice commanding him to jump out of the window (Sims & O'Brien, 1979). His simple but devout mother had taught him to resist this impulse by praying to God. His mind was effectively destroyed, but his capacity for spiritual life was still present. Unfortunately, on the final occasion on which he heard this voice he was not quick enough to pray. It is astonishing that we as psychiatrists can be so crass as to neglect this area of life which is clearly important to many of our patients.

Beliefs and practice of the psychiatrist

We all live to some set of standards. The idea of the psychiatrist as totally reflexive, a wall for bouncing the patient's ball of self-discovery, is ill-conceived and, fortunately, outdated.

Religious belief has been a motivator for medical initiative, both overseas and at home. Bravington (1985) records how the Asylum for the Insane at Canton was established by the American Presbyterian Church, and the Lebanon Hospital for the Insane with the support of Sir Thomas Clouston, Director of Edinburgh Morningside Asylum, both in 1898. Nearer home, Cox & Grounds (1991) write about work undertaken with mentally disordered offenders detained in Broadmoor Hospital.

> "A tendency towards sentimental generalizations about human relationships is more easily acquired, perhaps, in

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> the setting of a church or university than in a Maximum Security Hospital . . . The experience of mental disorder itself may involve a kind of suffering and inner abandonment that can barely be comprehended, and echoes the cry, 'my God, my God, why hast thou forsaken me?' . . . A severely psychotic young man . . . looked up and said , 'It's a very remote part of England being mentally ill.'"

Rather belatedly, the Royal College of Psychiatrists has recognised the need to consider spiritual issues, with the College Trainees Committee leading the way by recognising "the need to emphasize the physical, mental and spiritual aspects of healing in the training of doctors in general and psychiatrists in particular. Religious and spiritual factors influence the experience and presentation of illness . . ." (Kehoe *et al*, 1992).

Personal religious experience, although not very unusual, is an area that we as psychiatrists frequently exclude from discussion, and, knowing this, our patients do not talk about it. The great taboo at the start of this century was sex, but it is now the last resort of the burnt out comedian. The unspeakable in the middle of the century was death, and now teaching about bereavement has even come back into undergraduate medical education. What is unmentionable at the end of the century is personal experience of religious faith. Antipathy to religious 'enthusiasm' was rife in the 18th century, as described by MacDonald (1990); such suspicion still continues. Yet spiritual concepts are, for many throughout the world, a perfectly ordinary part of everyday existence.

Gellner (1987) has argued cogently that the psychiatrist cannot escape society thrusting a priestly role upon her. If these expectations do exist, we should quite clearly state that we will not fulfil them. We need to balance the importance of the spiritual in the life of our patients with denying absolutely any sort of priestly role for ourselves as psychiatrists (Sims, 1988*b*).

Religious experience as a factor in medical treatment

In ancient Egypt, a person with mental illness was described as "the man who is between the hands of the gods" (Loza, 1990). The association between an individual's religious beliefs and their psychological abnormalities is neither simple nor unidirectional, but there are some interesting research findings showing the benefits of religious belief and practice. In a 12-year review of all articles appearing in the *American Journal of Psychiatry* and the *Archives of General Psychiatry*, 72% of the religious commitment variables were beneficial to mental health: participation in religious services, social support, prayer and a relationship with God were beneficial in 92% of citations (Larson *et al*, 1992). Similar findings were found in a review of the *Journal of Family Practice* (Craigie *et al*, 1990). In a British epidemiological study, church-going and a vital religion was found to be a protective factor from vulnerability to depression by Brown & Prudo (1981) in North Uist and Lewis.

In a detailed study of suicide rates in different regions of the Netherlands during this century, Kerkhof (1994) considered that over recent decades:

> "the results indicate that differences in suicide rates are associated with the distribution of religious denominations, divorce rates and educational levels . . . the recent decrease of suicide mortality in the Netherlands since 1984 was concurrent with the religious revival among the young . . . This implies that fundamental changes in suicide mortality cannot be expected from improvement in health care facilities alone, but that fundamental changes in the social cohesion of a society are needed as well. This means a revival of religious or other social and cultural values which tie the individual to his society."

Clearly there is a need for further well conducted research in this area. As well as the psychiatric assessment being properly carried out, a phenomenological method should be used that includes exploration of subjective status for the evaluation of religious experience; just listing the denomination is not good enough.

Conclusions

There is a great need to acknowledge, have respect for, and use in treatment, the patient's *own* experience. This is a plea for the Jaspersian phenomenology of self-experience to include our patients' religious experience, both affiliation and belief – not only experience of the transcendental, but also the mundane assumptions, certainties, doubts and aspirations of the everyday believer should be enquired about and understood. The aims, goals and values of our patients should be explored as part of the assessment. The beliefs of the psychiatrist are always relevant and cannot be denied or ignored; the psychiatrist must remain in role as a doctor and never as a priest.

Religious fervour, with or without genuine faith, can be an immense force for evil and destruction, particularly if it takes place in a group. Psychiatrists who deal with victims of trauma are well aware of this. Paradoxically, this is a reason why psychiatrists should know about their patients' religious views.

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Religion can also be a protective factor in recovery and promoting good health. Both its power and its valency needs to be borne in mind. If my religion makes demands on me, it probably proves beneficial to others; if my religion attempts to control the behaviour of others, that is almost certainly harmful to them.

For too long psychiatry has avoided the spiritual realm, perhaps out of ignorance, for fear of trampling on patients' sensibilities. This is understandable, but psychiatrists have neglected it at their patients' peril. We need to evaluate the religious and spiritual experience of our patients in aetiology, diagnosis, prognosis and treatment.

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A. C. P. Sims, FRCPsych, Department of Clinical Medicine, Academic Unit of Psychiatry, Clinical Sciences Building, University of Leeds, Leeds LS9 7TF

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