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EDITED BY LOUISE HOWARD

Comments on Jerusalem syndrome

As the authors of several articles on Jerusalem syndrome (Bar El *et al*, 1991; Witztum & Kalian, 1999), we would like to add our comments to the paper by Bar-El *et al* (2000). If epidemiological data supporting Bar-El *et al*'s typology exist, it is regrettable that they were not presented in their article. To our knowledge, such data have not been found in previous studies (Bar El *et al*, 1991). The psychiatric hospitalisation of tourists in Jerusalem is uncommon (around 50 patients per year, from among almost two million tourists). The condition is much less prominent than problems faced by local services in other major cities (Parshall, 1995; Tannock & Turner, 1995). Contrary to some 'doomsday' predictions, so far, there has been no significant increase in the rate of tourist hospitalisations due to the new millennium. In our view, perhaps Jerusalem syndrome should be regarded as a unique cultural phenomenon because of its overwhelming theatrical characteristics (Witztum & Kalian, 2000). Such dramatic qualities have been reported by various biographers since the establishment of pilgrimage and tourism to the Holy City (Witztum & Kalian, 1999). In view of our accumulated data, Jerusalem should not be regarded as a pathogenic factor, since the morbid ideation of the affected travellers started elsewhere. Jerusalem syndrome should be regarded as an aggravation of a chronic mental illness, and not a transient psychotic episode. The eccentric conduct and bizarre behaviour of these colourful yet mainly psychotic visitors became dramatically overt once they reached the Holy City – a geographical locus containing the *axis mundi* of their religious belief (Turner, 1973).

We would also like to comment on another inaccurate interpretation, relating to Gogol's pilgrimage. It had nothing to do with Jerusalem syndrome. Nikolai Gogol suffered from manic depression, severe hypochondriasis and physical ailments, and he set out to Jerusalem (acts of pilgrimage were widely encouraged in tsarist Russia) hoping to alleviate his long-standing suffering (Witztum *et al*, 2000).

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Effectiveness of intensive treatment in severe mental illness

The criticism of the PRiSM Psychosis Study (Marshall *et al*, 1999; Sashidharan *et al*, 1999) betrays several misconceptions about the nature and philosophy of community mental health teams in the UK. Unlike in the USA, where assertive community treatment (ACT) teams were set up in a desert of community care, any similar teams in the UK have to adjust to working in collaboration with other teams in the area and never aspire to providing a service for an entire catchment area, as Thornicroft *et al* (1999) have emphasised. Both Marshall *et al* and Sashidharan *et al* have failed to note that standard community care has improved enormously in the past 20 years and therefore can compete successfully with formal assertive approaches, including both ACT and intensive case management. Unlike drug/placebo comparisons, in which the effects of placebo are roughly similar whatever the year, complex psychosocial interventions such as those in a mental health service are changing constantly. I can predict with some confidence that the Cochrane review showing such excellent findings with regard to superiority of ACT in randomised controlled trials (Marshall *et al*, 1998) will show steadily decreasing benefits of ACT in future revisions. This is not because ACT has suddenly lost its effectiveness; standard treatments have caught up immensely in the past few years and have done so often by using different approaches to those of the original ACT programmes. The statement of Sashidharan *et al* (1999) that contemporary psychiatric care "continues to be dominated by thinking and practices which have their origin in the last century" is a travesty of the current position and a slur on the reputation and performance of many dedicated community mental health teams across the country. Such teams have cause for congratulation. Even though they are deprived of the resources that are allotted to ACT, particularly the requirement of a case-load of only 8–12 clients per worker, they are undoubtedly effective and may even have a positive effect on reducing suicide and other causes of undetermined death (Tyrer *et al*, 1999). But there is a limit to these benefits and some of those treated assertively may be better cared for in hospital. Sashidharan *et al* find it hard to conceive that intensive case management might increase violence in community settings. Unfortunately, antisocial behaviour in all its forms has been shown to be more prevalent in those with some personality disorders in this type of service than in one in which hospital treatment is given more readily (Gandhi *et al*, 2000) and this could undermine progress towards better community care unless it is acknowledged as a problem.

It is time for the programme of assertive community treatment (PACT) model of

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