studies traumatic experiences are documented and quantified within limits, addressing concerns about the 'reality' of self-reports. Critics of MPD often ignore the larger scientific investigation of dissociation, now encompassing hundreds of published studies.

Although sharp differences of opinion will no doubt continue, I appreciate Piper's willingness to move the debate away from the question of its existence, and onto the larger questions of what MPD is, and how we should approach it clinically.

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A spiritual dimension to mental illness

SIR: Sims' belief in the need to recognise patients' religious experiences (*BJP*, October 1994, **165**, 441–446) presents a challenge. My experience in the UK was of an almost complete silence on this intensely personal issue. In Zimbabwe I have found that the spiritual resonates clearly through everyday life. Patients and staff, and even government ministers, will raise spiritual concerns in relation to mental illness. Many Shona patients and their families see a spiritual dimension to mental illness and often seek spiritual remedies. These spiritual issues are not addressed in Zimbabwe by formal Western psychiatry, any more than in the UK; there is often tension or conflict between these spiritual and biomedical positions.

Sims encourages us to evaluate the role of religious or spiritual experience in the treatment of our patients. There is a lack of spiritual care or nurture offered generally by psychiatrists and their colleagues, particularly to those individuals with long-term disabilities. By this I mean the provision of suitable and accessible opportunities for spiritual or religious expression analogous to the provision of adequate diet or accommodation, not just as alternative treatment modalities. Some patients may have specific needs for spiritual counsel or intervention as part of a truly holistic management approach. Sims rightly warns of the dangers of adopting a priestly role. However, this should perhaps encourage us to work more closely with those who do have such a role – the local clergy, church counsellors, and hospital chaplains. At the same time, it may not always be inappropriate to act as a spiritual guide to individual patients in much the same way as a therapist guides clients through psychotherapy.

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A HUNDRED YEARS AGO

Insanity and Crime

A case was heard recently at the Central Criminal Court which illustrates very well the mode of procedure in the case of a person of unsound mind who is charged with crime. The counsel for the defence said he desired the issue to be tried whether the defendant was of sound mind and fit to plead to the indictment. The jury was accordingly sworn to try this issue. Counsel then stated that the defendant was 67 years of age. His mind had been affected for a considerable time. Some twelve months ago steps were taken with a view of having him certified as a person of unsound mind, and his son was advised that that was a proper course to take. Unfortunately, the counsel added, the son did not act upon the advice given, but had his father looked after in the hope that the state of his mind would improve, but it did not improve. Medical evidence was given to the effect that the defendant was of unsound mind, and Dr. Savage stated that as long ago as January, 1894, eight months before the charge was made against the defendant, he had been prepared to certify him as of weak mind, and had advised that he should be made a ward of the Court of Chancery. The jury found that the defendant was insane, and unfit to plead to the indictment; and the Recorder said that the defendant would be detained during the Queen's pleasure. The case has a useful moral for the public. Had his friends acted upon the medical advice given to them, the crime would never have been committed, and this unfortunate man would not have had to have spent his declining years in Broadmoor.

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