Nocturnal Hallucinations in Ultra-orthodox Jewish Israeli Men

DAVID GREENBERG AND DANNY BROM

HALLUCINATIONS that occur predominantly at night are reported in 122 out of a sample of 302 ultra-orthodox Jewish Israeli men referred for psychiatric evaluation. Demographic data and the content of a semistructured interview in 302 ultra-orthodox Jewish young men seen over a 10-year period in Jerusalem were evaluated retrospectively by two researchers. Of the 302 subjects, 122 reported hallucinations predominantly at night, 23 reported hallucinations with no diurnal variation, and 157 did not report hallucinations. Most of those with nocturnal hallucinations were in their late teens, were seen only once or twice, were brought in order to receive an evaluation letter for the Army, and had a reported history of serious learning difficulties. The nocturnal hallucinatory experiences were predominantly visual, and the images were frightening figures from daily life or from folklore. Many of the subjects were withdrawn, monosyllabic, reluctant interviewees.

Ultra-orthodox Jewish beliefs include a belief in demons, particularly of dead souls, who visit at night. This cultural group's value on study at Yeshivas away from home places significant pressure on teenage boys with mild or definite subnormality, possibly precipitating the phenomenon at this age in this sex. Although malingering had to be considered as a possible explanation in many cases owing to the circumstances of the evaluation, short-term and long-term follow-up on a limited sample allowed this explanation to be dismissed in a significant number of cases. We suggest therefore that nocturnal hallucinations are a culture-specific phenomenon.

Cultural psychiatry has demonstrated that the presentation of distress varies among cultures and that certain clusters of symptoms are limited to certain societies (Hinton and Kleinman 1993). The latter, known as culture-bound syndromes, were originally described in non-Western societies (Prince and Tcheng-Laroche 1987). Descriptions of psychopathology from a wide range of cultures have revealed that these presentations are less "bound" to one specific culture than was once thought (Levine and Gaw 1995), and the focus of the field has shifted to a broader understanding of the interplay between culture and psychological distress. "Idioms of distress" are the ways people express, experience, and cope with distress as influenced by cultural values (Nichter 1981).

Hallucinations occur in a wide range of conditions, from grief to organic states and posttraumatic stress disorder (PTSD) to psychosis, hysteria, and the use of hallucinogens (Asaad 1990). Although the original meaning

David Greenberg, MRCPsych, is Director of Psychiatric Services, Herzog Hospital, Jerusalem. The Latner Institute, Herzog Hospital, Jerusalem.

Danny Brom, PhD, is Director of Israel Center for the Treatment of Psycho trauma, Latner Institute, Herzog Hospital, Jerusalem.

Address correspondence to Dr. David Greenberg, Herzog Hospital, POB 35300, Jerusalem 91351, Israel.

of the term *hallucination* referred to "ghosts and spirits walking by night" (quoted in Asaad and Shapiro 1986), the accounts of hallucinations in psychiatric texts do not describe a nocturnal predilection, with the exception of the common phenomena of hypnagogic and hypnopompic hallucinations, which are experienced on entering sleep and awakening (Ohayon, Priest, Caulet, and Guilleminault, 1996), and a report on 11 hallucinating, nonpsychotic children, 9 of whom had symptoms around bedtime (Kotsopoulos, Kanigsberg, Cote, and Fiedorowicz 1987).

In the course of 2 decades of mental health work in Jerusalem, Israel, the authors have noted a particular phenomenon—nocturnal hallucinations. Hitherto this symptom has been neither described in detail phenomenologically nor evaluated diagnostically. This symptom has only been noted to date in male members of the ultra-orthodox Jewish population. The following report is based on interviews of 302 consecutive referrals of ultra-orthodox males to a psychiatrist in Jerusalem.

SUBJECTS AND METHODS

The subjects comprised 302 consecutive ultra-orthodox males presenting over a 10-year period for a private psychiatric evaluation for a wide range of complaints. All were systematically assessed using a semistandardized clinical screening interview. If hallucinations were not spontaneously mentioned by the patient or accompanying informant, these were explicitly inquired after. The interviewing psychiatrist avoided asking such leading questions as "Do you see the men mainly at night?" but did ask such clarifying questions as "Do you have fears?" "What do you fear?" "Do you see/hear them?" "When do they appear?" "When do they mainly appear?" "Do they also appear by night/day?" Detailed notes, using a standardized outline, were recorded by the psychiatrist at the time of the interview. As many of the interviewees were withdrawn, reticent, and monosyllabic, verbatim accounts of the clinical interviews were generally available, with a detailed mental state and verbatim report from the accompanying informant.

For the purposes of this study, a research assistant, blind to the topic and hypotheses of the study, extracted data directly from the clinician's notes using a data extraction form to record the following variables:

- Demographic data, including age, marital status and ethnic background
- Personal history, including level of intellectual functioning, family history of mental illness, religious repentance
- Clinical data, including duration of problems, nature and content of delusions and hallucinations
- Number of sessions and request for an evaluation letter for the army.

Owing to the retrospective nature of the investigation, and also the withdrawn state of many of the interviewees, there are missing data in some clinical variables. In addition to the available data we draw upon the clinical impressions of the interviewer in order to describe the phenomena in depth.

RESULTS

Of 302 consecutive ultra-orthodox male referrals, 145 (48%) reported hallucinations, of whom 122 (40.4%) reported experiencing hallucinations solely or predominantly at night. Table 1 presents an overview of the characteristics of the 302 interviewees.

Of the present sample 48% reported hallucinations at the interview. Although this may seem overly common among psychiatric referrals, it should be considered that the ultra-orthodox community is generally reluctant to seek psychiatric care (Greenberg and Witztum 1991) and only does so when forced by extreme distress caused to family members or if the Yeshiva (academy of Talmudic studies) where the young man was registered as a student would no longer allow him to stay because of his disturbed behavior. In both instances, which reflect the use of mental health services by minority cultures, only more se-

TABLE 1
Demographic and Clinical Features of Sample of Ultra-Orthodox Male Psychiatric Referrals with Nocturnal Hallucinations, Nonnocturnal Hallucinations and without Hallucinations (*N* = *302*)

	Nocturnal Hallucinations	Nonnocturnal Hallucinations	No Hallucinations	Test and Probability
Demographic variables				
Sample size	122	23	157	
Age	18.9	22.0	25.1	$F = 17.2^{**}$
SD	5.1	7.0	10.9	
Marital status				
Single	103	16	96	
Married	17	4	50	
Divorced	1	3	9	$\chi^2 = 23.2^{**}$
Number of visits	1.8	4.0	3.5	$F = 4.3^{*}$
SD	1.1	5.1	7.0	
Report requested	108	15	72	
Report not requested	14	8	85	$\chi^2 = 54.6^{**}$
Clinical variables				
Presence of delusions	93	18	41	
Absence of delusions	29	5	116	$\chi^2 = 76.7^{**}$
Delusions at night only	9	0	0	
Delusions at night mainly	27	2	1	
Delusions day and night	55	16	36	
Delusions day only	2	0	3	$\chi^2 = 26.7^{**}$
Visual hallucinations mainly	84	7		
Auditory hallucinations mainly	11	9		$\chi^2 = 18.8^{**}$
History of subnormality	89	12	50	
History of normal development	26	9	90	$\chi^2 = 46.8^{**}$

$^{*}p < .05$.
$^{**}p < .001$.

vere examples of disorder are brought for evaluation (Sue 1977; Sue, Fujino, Hu, Takeuchi, and Zane 1991; Witztum, Greenberg, and Dasberg 1990).

Of the 145 patients reporting hallucinations, 122 reported that they were solely or predominantly nocturnal, 23 experienced them equally night and day, and 157 did not report hallucinations.

The three groups were different in several aspects. The 122 young men who reported predominantly nocturnal hallucinations were significantly younger, more likely to visit only once, and their visit was more often associated with a request for a psychiatric evaluation before receiving an exemption from compulsory army service. Further, they were more likely to have a history of learning difficulties.

Clinical Data

The hallucinations were associated with nighttime rather than sleep and were not usually associated with the moments before or at the end of sleep. They were not reported as nightmares, although the reporting was limited in its detail, and an association has been claimed between nightmares and psychosis (Levin 1998). The images were simple, yet often bizarre, but not part of a complex delusional system of beliefs. Table 2 presents the list of images appearing in the visual hallucinations.

TABLE 2
The Content of Hallucinations

	Nocturnal Hallucinations	Nonnocturnal Hallucinations
1. Feared stereotypes (Arabs, non-Jews, robbers, policemen, soldiers, Sephardi men, terrorists)	38	1
2. Feared neutral figures (relatives, men, faces, friends from Yeshiva, neighbors)	41	4
3. Feared mystical figures (demons, bad spirits)	14	1
4. Dogs	8	2
5. Deceased relatives or friends	5	2
6. Comforting mystical figures	10	1
7. Other images	2	1
Total	118	12

The majority of the hallucinatory images were frightening. Of a total of 130 images, only 11 were comforting. Thirty-nine were figures from daily life of the sort that may appear among the fears of any small children (e.g., robbers), or children in Israel (e.g., Arabs, terrorists), or in the ultra-orthodox community (policemen, soldiers, Sephardi men). In 36 cases the young men were able to identify the figures as biblical or mystical, whether demons and black dogs (a cross between a fear of childhood and a sinister mystical symbol) or positive figures (e.g., the prophet Elijah or Rabbi Nachman of Bratslav) who encouraged them in their studies. In seven cases the onset of symptoms followed the death of a close relative or friend, who would visit them beyond the grave.

Clinical Example. S., age 17, was brought by a friend. S. sat curled over, sighed, and occasionally looked around him fearfully. He did not initiate conversation but answered questions briefly in two or three words: "I am afraid. . . . At night . . . Arabs . . . they want to kill me. . . . I have done nothing. . . . They come at night. . . . They are black. . . . They talk. . . . They make a noise, but I don't understand them. . . . I don't understand Arabic. . . . They want to kill me." His friend described S. as the oldest of 12 children, a slow, poor student, who never got beyond basic texts, which had to be explained to him by a tutor, and he barely retained what he was taught. In the last months he had become fearful, refusing to leave the house.

Owing to the inaccessibility of many of the interviewees, a test of interrater reliability was carried out by selecting 35 files in a random way and letting another judge, who had a similar professional status as the first research assistant, evaluate these files. Interrater reliability on these categorical data was done by calculating the kappa coefficient. The evaluation of the diagnosis of diurnal and nocturnal hallucinations and the presence of a letter for the army were found to be reliable (kappa values = .65 and .82, respectively).

Associated Clinical Features

In all three groups, although particularly among those with nocturnal hallucinations, the young men were reluctant participants at the evaluation. They were led in, often having to be actively brought in. They would sit curled over, with no eye contact. They often seemed frightened and would react with anxiety if a dog barked in the distance. Such cases would not initiate conversation and would only reply to simple concrete questions. Their replies would be monosyllabic or one or two words, and they would often not reply. When the parent or person who accompanied

them was questioned, they seemed to pay no further attention to the interview.

Presenting Complaints

The two main complaints that parents presented were that the young man did not study properly and did not fit into Yeshiva life or that he had "fears" or "imaginings," so he was disturbed in the evenings. The terms *fears* and *imaginings* are general terms of fearfulness that do not necessarily imply that their parents were concerned that they were imagining things. Indeed, it was unusual for parents to focus on the patient's hallucinatory images as a central issue, and they were often unaware of their existence.

Developmental History

The characteristic history of those with nocturnal hallucinations included developmental delays (e.g., walking and talking late, becoming clean and dry late), difficulty in learning reading and writing, inability to read fluently, and never playing with contemporaries but preferring younger children and simpler games. The withdrawn state of many of the subjects precluded relying on the examination as evidence for learning difficulties. A history of such delay and difficulties was significantly more common among those with nocturnal hallucinations (73% of the group).

Insight to the phenomenon was usually absent. Patients believed the images were real and did not believe medication could help. The accompanying parent, however, did not view the experience as culturally normative.

Long-term follow-up was attempted in several ways. First, patient attendance at a community mental health center (CMHC) was tracked. Psychiatric hospitalization is a rarely used resource in the ultra-orthodox community. There is only one CMHC that provides care for the area in which most of the referrals lived. Although it is our experience that the ultra-orthodox population avoids using this resource if possible, it was considered likely that cases that continued to deteriorate would eventually seek help there. All 302 names were sought in the files of the CMHC by the authors, and although 20 files of referrals without nocturnal hallucinations were located, only two files were found of patients with nocturnal hallucinations, one for treatment prior to referral over a 4-year period.

A second means of follow-up was by interviewing a parent or accompanying adult years after the referral. In a sample of files, the parent (seven cases) or the person who originally brought them (six cases) were contacted. Both sources were willing to provide information about the current state of the referral, and all were unwilling to bring the patient for reevaluation. The accounts varied: Some stated the original episode had been brief; others stated that the patient had become much calmer and was able to marry, although in most cases he continued to be restless and in need of family support.

> B., 16, when first seen, was followed for over a year and showed mild improvement. His mother was interviewed 12 years later and reported, "We found a match for him, the girl also has problems. They are married with six children. He still takes medication and occasionally helps caterers at weddings. We support them financially."

> C., 17, was seen once 9 years ago. We contacted his father who said that the fears had been transient. He is a lot better now, although he is still a bit wild. He was married by introduction to a girl abroad, where he lives. He was seen there by psychologists. He worked, but it didn't work out and he now has many debts.

> E., 27, married, was seen twice 9 years ago. The rabbi who brought him reports, "He still has fears and won't go out at night. He does not work and lives by begging."

When the parents were contacted, they were asked if the patient could be reevaluated, but all declined. The reasons given were varied: His spouse knew nothing about him having been seen, the patient himself had no recollection of being seen and would get upset,

they would not like to remind him of that period, and he would refuse.

Three cases with nocturnal hallucinations had been seen in other institutions prior to their private evaluation. Ten further cases were each seen privately for over a year after receiving a letter for the army. Overall, some form of follow-up was available on 27 of the 123 cases with nocturnal hallucinations.

Diagnoses were not easily formulated, as they were often based on one or two interviews with an uncooperative subject. There were some in whom the subnormality seemed to be the main presentation. In others psychosis seemed to dominate the picture, and in still others the two components were equally present. In the presentation of diagnoses in Table 3, we have called this third group propfschizophrenia, a diagnosis described by Kraepelin (1919). Doody, Johnstone, Sanderson, Cunningham Owens, and Muir (1998) found that this combination was associated with more negative symptoms and need for support than patients with schizophrenia alone. Many of the sample presented with symptoms of catatonia (immobility, slow verbal responses, reliance on prompting from others, and passivity) and a history of deficient social interaction and communication. Wing and Shah (2000) reported that catatonic symptoms are often noted in adolescent patients with autistic spectrum disorder, often followed bereavement or pressure at school, and often included visual hallucinations that did not suit any specific diagnosis.

DISCUSSION

In a sample of 302 ultra-orthodox male referrals for a psychiatric evaluation, 122 experienced hallucinations that were predominantly or exclusively nocturnal. The nocturnal hallucinations were mainly visual. Referrals with nocturnal hallucinations were more likely to present with a past history of subnormality. The visual images were all crude, simple images, and there were no examples of them being part of an organized delusional system. For example, one young man reported that men came with sticks to beat him at night, and in the daytime the boys in the Yeshiva were unpleasant to him. Hallucinations were mostly found associated with those who also reported delusions. Referrals were largely uncooperative, and although their replies were usually reported verbatim, they were often frightened or evasive, and the interviewer was wary not to suggest answers.

Malingering is often proposed as an alternative explanation for the complaints of young ultra-orthodox male patients in Israel, as they do not want to serve in the army. The fear of many psychiatrists in Israel is that they are being deceived into writing a letter of recommendation for an exemption from army service for psychiatric reasons (Turner 1997; Witztum, Margolin, Grinshpoon, and Kron 1996). We would like to consider here the different sides of this issue. In favor of malingering as an explanation for the unusual complaint of night hallucinations is the large num-

TABLE 3
Diagnoses

Diagnosis	Nocturnal Hallucinations	Nonnocturnal Hallucinations	No Hallucinations
Subnormality +/– fears	40	3	34
Propfschizophrenia	40	2	0
Schizophrenia/psychosis	33	18	42
Bipolar	0	0	7
Depression	5	0	25
Obsessive-compulsive disorder	0	0	13
Other	3	0	34
Missing	1	0	2
Total	122	23	157

ber (88.5%) who requested a letter and the mean age of the boys that came with this complaint (18.9 years) in comparison to those who came with other complaints (22.0 and 25.1 years). In addition, 54.4% of those with nocturnal hallucinations made only one visit and did not return for treatment. The fact that only very few of the patients subsequently turned to a CMHC could be interpreted as another proof of malingering. Against the malingering hypothesis is that 45.6% of those with nocturnal hallucinations came for more than one session and 11.5% did not request a recommendation letter for the army. Furthermore, the clinical impression is that we are dealing with an authentic problem and that malingering should be considered only in a minority of the cases. As mentioned earlier, for religious and social reasons it is to be expected that psychiatric help in this population is sought only when there is extreme distress and also then very sparingly. The fact that of all of the 302 referrals, only 22 subsequently came to the CMHC shows this clearly. Our conclusion is that the night hallucinations are a real clinical and culturally determined phenomenon, which in a minority of cases may have been misused and presented for purposes of gaining exemption from army service.

> S., 17, described earlier, returned with his cousin a week after a report was sent to the army. He had received increasing doses of chlorpromazine. He reported that the Arabs were coming less often: "They have been killed. . . . New ones are coming. . . . I am frightened. . . . Black Arabs . . . They don't let me sleep." He refused to continue the medication as it made him nauseous, adding, "Let the Arabs take it."
>
> He returned for a third appointment 6 weeks later, having received levomepromazine 300 mg, and said that he was feeling a lot less fearful. The Arabs rarely visited, but he remained fearful that they may visit again.

The two most interesting aspects of these findings are the presentation of nocturnal hallucinations specifically among young men in the Jewish ultra-orthodox community and the absence of such phenomena in female referrals from the same culture.

The Significance of Nighttime in Ultra-Orthodox Judaism

The symbolism among ultra-orthodox Jewish values of the night as a time of fear is apparent in many religious texts. On the line in Psalms 91:5, "You shall not be afraid of the terror by night," traditional medieval Jewish commentaries (Haham, 1989) explain: "This refers to the terror that befalls a person at night; or from evil mishaps such as thieves and highway men, who usually attack at night; or from the demons that roam at night." The third-century Mishna warns: "One who is awake at night, and walks out alone, and thinks about trivia will forfeit his life," and the leading commentary (Bartenura on Mishna, Ethics of the Fathers 3:4) adds: "This is because night is the time of the demons, and one who walks out alone is at risk of robbers and other mishaps." In similar vein, the sixteenth-century Code of Jewish Law states that one who sleeps alone in a house or room will be trapped by Lilith (queen of the demons) and that saintly people require protection from demons at night.

The dangers of the night are alluded to in the daily custom of washing one's hands immediately upon getting up in the morning "to remove the evil spirit" that settles on every person during sleep (Code of Jewish Law, Orach Hayim, 4:12). Similarly the Talmud warns against contact in the morning with someone who may not have washed his hands because of "the danger of demons" (Talmud Berachot 51a). In this vein, the main mystical text, the Kabbala, regards the night as sinister. It is a time with an especial susceptibility to contamination by evil spirits; night time is the time for demons. The demonic nature of night is apparent in the common etymology of the Hebrew word for night, "Laila" (plural: Lailoth), and the name Lilith, the queen of the demons, who became known as a spirit of the night who attacks men who sleep alone, seducing them and causing them to have nocturnal emissions.

Finally, nighttime is associated with death. The Talmud (Brachot, 57:2) states that sleep is one sixtieth death. The blessing re-

cited before sleep by every ultra-orthodox Jewish male captures the fears expressed by our patients: "May it be Thy will that You will lay me down in peace and raise me up in peace. Let not my thoughts, my nightmares and my evil meditations frighten me, and then open my eyes lest I sleep death." Similarly, the first sentence stated immediately upon waking is: "I thank you for restoring my soul in kindness." In addition, according to Jewish tradition, the spirit of the dead continues to inhabit the earth long after death, especially at night (Trachtenberg 1974).

Most of the young men were very withdrawn and uncommunicative, so it was difficult to ask them in detail about their understanding of concepts such as nighttime, demons, and so on. Nevertheless, one young man who was much more communicative and better, if low, functioning stated the following:

> At night I cannot sleep. I think about the things I learnt in Yeshiva. We learnt in the Talmud that there are forces, demons, so I get frightened every time I hear something move. I think they are snakes or scorpions. It is dreadful all night. During the day I am completely fine. I look in the Talmud, and I know the night is the time for forces, mazikim [destructive spirits, a type of demon]. My teacher said not to go out alone at night. You do agree with me that there is such a thing as demons. If a person is wicked, then a snake bites him."

> As a child he was slow in his studies "but" he added, "not the worst." He reads slowly today, aged 23, and is able to spell correctly by dictation, but with very slow child-like handwriting. As a child he was afraid of robbers, animals, and the dark. Aged 13, he was sent away from home, and found studies very hard, and was especially frightened to sleep at night. Some of the boys laughed at him and he heard them saying he was "sick." His parents always told him never to talk of his fears. Aged 21 he was married, and all his wife knows is that he cannot sleep at night, and suffers cramps and diarrhea at night.

A Condition Only Noted in Men

A young man growing up in the ultra-orthodox community will differ from a young girl in certain important ways (Heilman 1992). Ultra-orthodox girls do not study Talmud, generally do not have heavy academic expectations, will not be expected to leave home during adolescence until they marry, and are exempt from army service.

There are four main differences between the sexes that may explain the occurrence of nocturnal hallucinations among male and not female ultra-orthodox psychiatric referrals. First, the overriding importance of study of the Talmud for men will create a continuing and painful sense of failure in a young man with learning difficulties. Second, the exposure to knowledge about the frightening wanderers at night will be on rich soil in a young man whose thinking tends to be concrete and who views himself as a failure. Third, moving away from home to a dormitory will mean there will be no warmth and support for a young man who has difficulty looking after himself and is reliant on his mother or siblings to help him in the simple aspects of daily life. Finally, if the Yeshiva is no longer willing to tolerate the presence of this frightened, withdrawn young man who does not participate in the regular studies, he will be unable to retain the usual indefinite deferment given for Yeshiva study and will face possible mandatory induction for compulsory military service. If not for this possibility, over half of the sample would not have sought help. Even among those who did not want letters were many who hoped that treatment would enable the young man to keep his place at the Yeshiva. It is possible therefore that similar fears may be present among some ultra-orthodox young women, but the circumstances do not demand they are brought for examination. This last explanation is unlikely, however, as a sample of women, albeit smaller, was seen during this period with no examples of nocturnal hallucinations.

The contents of the nocturnal hallucinations may be understood as a combination of fears resembling the fears of childhood, fears based on culturally consistent spirits and the souls of the departed. In a study of 20 hallucinating nonpsychotic children evaluated at the Maudsley Hospital, London, the images

of the hallucinations included childhood fears such as skeletons and ghosts in three cases and recently deceased people in three cases (Garralda 1984a).

The diagnoses given to the present sample include subnormality and/or psychosis in nearly all the cases. Nevertheless, the generally good prognosis in contrast to their dramatic presentation suggests that included in the sample are grief reactions, depression and anxiety, and chronic adjustment difficulties, in many cases secondary to life-long learning difficulties (Hollins and Esterhuyzen 1997). Follow-up of the cases that includes repeated interviews is necessary to enable differentiation among the various diagnoses and to gain understanding of the course of nocturnal hallucinations. Garralda's study of children with nonpsychotic hallucinations found they were no more likely to develop psychosis than a control group over a 17-year follow-up (Garralda 1984b).

Despite the cultural consistency of a belief in nocturnal forces, the relatives and friends of our sample viewed their fears as pathological (Al-Issa 1995). Further, neither rabbis nor family recognized nocturnal hallucinations as a local cultural phenomenon, so it cannot be viewed as a culture-bound syndrome, although the combination of social pressures and religious-cultural beliefs may be understood as the precipitants of nocturnal hallucinations, an idiom of distress among ultra-orthodox Jewish young men.

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