Magical thinking is a primitive form of mental activity which, nevertheless, the author contends, is common among mental health professionals. Four examples of magical thinking by inpatient staff members are presented and briefly explored, in order to shed light on our work and ourselves.

Magical thinking refers to the irrational belief that certain thoughts, words, or gestures can in some mystical manner lead to the fulfillment of certain wishes or the warding off of certain evils. One may think that merely imagining an event can cause that event to occur. Young children show this form of thinking as a consequence of their limited understanding of causality. It is common in obsessive-compulsive disorders and achieves its most extreme expression in schizophrenia.¹

Magical thinking is a primitive form of mental activity that is never eradicated completely, no matter how mature the individual.² It is only layered over by more rational thinking, and it reappears readily when one daydreams, creates, regresses, dreams—or when one thinks under stress. Magical thinking may creep into the logical processes whenever one cannot understand, explain, or control reality.

It is my contention that magical thinking is common among mental health professionals. Furthermore, examination of our magical thinking can shed some light on our work and ourselves. I will present four examples of magical thinking by inpatient staff members and will briefly explore the ramifications of each.

The first example of such thinking is the notion that we must never mention any of our discharged patients by name because they will be readmitted pronto. Once our patients are out of sight we must keep them out of mind. Also, it is striking how little we talk about our discharged patients. And our reluctance to

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discuss them seems to be proportional to the severity of their illnesses and the trouble they have caused us. Furthermore, we seek very little follow-up information about our former patients, even though such information is always very interesting and instructive. This reluctance would seem to indicate disinterest, but this is not the case.

Our reluctance to learn about our former patients has two major sources: our own fears of mental illness and our need to defend ourselves against burnout. In the first instance, we hope for the best for our former inpatients, but we fear for the worst because we have so often seen the ravages of severe mental illness. “Forgetting” our former inpatients is a magical attempt to protect them from further devastation. (Our own fear of mental illness can easily be demonstrated if we imagine one of our close relatives being admitted to our own facility for treatment. In such a scenario several possible horrible outcomes will jump to mind.)

In the second instance, our “forgetting” is a form of compartmentalization, which has been identified as a major defense against burnout used by people in the helping professions. Compartmentalization is a healthy and necessary defense in our work with severely ill inpatients. But if we overuse this defense, we tend to completely forget our discharged patients and thus deprive ourselves of an important educational opportunity. To ensure this valuable learning experience on our own unit we have found it necessary to schedule a bimonthly meeting in which we are brought up to date on our former patients by staff members from the two CMHCs that provide after care services to our patients.

The second example of magical thinking by inpatient staff members is the unspoken rule against the unrestrained expression of optimism. All feelings of optimism must be tempered by skepticism and, sometimes, a M*A*S*H-like cynicism. Any optimistic statement regarding the prognosis of a patient must be met immediately by a let's-wait-and-see rejoinder. We feel we must temper our enthusiasm in order to avoid provoking the jealous wrath of the gods of insanity. This is a magical attempt to protect our patients from the terrible crash of sickness that we risk by letting our hopes for them soar too high. The deflation of optimism also serves to prevent the extreme highs and the awful lows that would otherwise follow the inevitable disappointments in our work. Moreover, it contributes to the development of an attitude of detached concern, another important defense against burnout.

A third example of magical thinking is the use of the full moon theory to explain increased admissions and upsurges of agitation and violence in our patients. This theory has many open adherents and perhaps even more secret ones. I suspect that most of us who work with very sick patients have given it some credence at one time or another without ever having investigated its validity. Interestingly, belief in the full moon theory is also common among the police. Perhaps it is not surprising that those who try to contain unfettered aggression would share this belief with those of us who try to contain rampant psychopathology. But how to explain this easy acceptance of a theory that has very little evidence to support it? Uncritical acceptance of this theory seems to be an indication of the feelings of powerlessness and helplessness that threaten to overwhelm us in our work. The full moon “explanation” serves to control these