the columns

correspondence

Religion, psychiatry and professional boundaries

We were alarmed to read the editorial on religion and mental health (Koenig, 2008). Some of the assertions are highly contentious, and we believe some of the recommendations for clinical practice are inappropriate. The invited commentary by the (former) President of the Royal College of Psychiatrists (Hollins, 2008) is cautious, but none the less seems to endorse Koenig's point of view. In doing so, Hollins lends certain credibility to Koenig's recommendations. Closer integration of religion and psychiatric practice is a key aspiration of an element within the Spirituality and Psychiatry Special Interest Group of the College. We believe that there is an urgent need for a serious debate on the implications of such attempts to shift the boundaries of psychiatry and the other mental health professions.

Koenig uses some statistics that are questionable. For example, the World Chrisitian Database may say that 1.4% of the British population are atheist, but the British Humanist Association website cites recent figures from the national census, a Home Office survey and a Market and Opinion Research International (MORI) poll ranging from 15.5% to 36% (www.humanism.org.uk/site/cms/contentChapterView.asp?chapter=309). However, it is Koenig's fundamental argument that is seriously flawed.

Koenig uses the rhetorical ploy of suggesting that religion is denigrated and under attack by psychiatrists. He states that psychiatry has traditionally regarded religion and spirituality as intrinsically pathological. We have been involved in mental healthcare in the UK since 1978 and none of us has ever known this to be suggested by a mental health professional. Koenig further states that there is a widespread psychiatric prejudice against religious faith and that psychiatrists commonly do not understand the role of religion in service users' lives. However, the research that he cites can be interpreted as suggesting that psychiatrists, by and large, believe that religion can be both helpful and problematic to service users and that they enquire about religious matters when these are relevant. As the salience of religious issues will vary between service users, this seems to us to be the appropriate approach.

Our major concern about Koenig's paper is his suggestions for practice. No one could seriously challenge some of his assertions, for example that we should always respect people's religious or spiritual beliefs and that we should sometimes make referrals to or consult with appropriate priests or religious elders. However, these are well-established parts of routine practice. They are within the limits of existing codes of professional behaviour. Some of his other suggestions, however, constitute serious breaches of professional boundaries, for example:

- Psychiatrists should routinely take a detailed 'spiritual history', even from non-believers; Koening recommends that when the person resists this, the clinician should return to the task later. This seems to us to be intrusive and excessive. The insistence that even non-believers have a spiritual life shows a lack of respect for those who find meaning within beliefs that reject the transcendent and the supernatural.
- Some spiritual or religious beliefs should be supported and others challenged. This involves the application of the clinician's values, which is incompatible with the maintenance of an appropriate degree of therapeutic neutrality. It is unnecessary and inappropriate for clinicians to take a position on highly sensitive matters of personal conviction, such as the existence and nature of evil, the meaning of unanswered prayer and doctrinal intolerance of homosexuality.
- It is sometimes appropriate to pray with service users even when service user and psychiatrist do not share a faith. The introduction of a completely non-clinical activity carries a grave danger of blurring of therapeutic boundaries and creates ambiguity over the nature of the relationship.

We have personal experience of dealing with the adverse consequences of religious breaches of therapeutic boundaries. For the most part, these have been well-intentioned but ill-advised; for example, individuals who want to pray with psychiatrists at one point in their treatment can become persistently distressed over having done so when their mental state changes. We have encountered more worrying breaches of boundaries where clinicians have proselytised in the consulting room. Occasionally, we have encountered frankly narcissistic practice, where clinicians have been emboldened by the certainties of a charismatic faith and take the position that their personal beliefs and practices cannot be challenged because they are supported by a higher authority than secular professional ethics.

The problem with blurring the boundaries by inviting an apparently benign spirituality into the consulting room is that it makes it more difficult to prevent these abuses. Having moved the old boundary it is then very difficult to set a new one.

Psychiatrists will always have to understand service users who are of different gender, class, ethnicity, political beliefs and religious faith. Understanding their lives, the contexts they exist in and the resources that give them strength is a key skill in psychiatric practice (Poole & Higgo, 2006). Religion can be an important source of comfort and healing, though it can also be a source of distress. Of course, it can be intertwined with psychotic symptoms. Spiritual matters, however, exist in a different domain from psychiatric practice. There are others in our communities who have a proper role in helping individuals spiritually and who can be an important source of advice to us. Quite apart from the obvious dangers inherent in confusing these roles, it is completely unnecessary to do so.

Psychiatry has done much to improve the lot of people with a mental illness, though it has also been guilty of some major historical errors. Our professional roles and professionalism are under sustained attack from a variety of sources (Poole & Bhugra, 2008). In order to resist these attacks, we need to be clear about our important and distinctive roles in helping those with a mental illness. Psychiatrists are essentially applied bio-psychosocial scientists, who work within a clear set of humanitarian values and ethical principles in order to get alongside


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service users and facilitate their recovery from a mental illness. Psychiatry does not hold all the answers and other professions, agencies and individuals have different distinctive roles. Within psychiatry, we have to struggle with the internal threat of crude biological reductionism. Equally, if we break the boundaries of our legitimate expertise and become generic healers, we will have lost all usefulness and legitimacy.

Declaration of interest

The authors have a range of personal convictions including atheist, Buddhist, Methodist, Roman Catholic and non-denominational faith.

HOLLINS, S. (2008) Understanding religious beliefs is our business. Invited commentary on . . . Religion and mental health. *Psychiatric Bulletin*, **32**, 204.

KOENIG, H.G. (2008) Religion and mental health: what should psychiatrists do? *Psychiatric Bulletin*, **32**, 201–203.

POOLE, R. & BHUGRA, D. (2008) Should psychiatry exist? *International Journal of Social Psychiatry*, **54**, 195–196.

POOLE, R. & HIGGO, R. (2006) *Psychiatric Interviewing and Assessment*. Cambridge University Press.

***Rob Poole** Consultant General Adult Psychiatrist, North East Wales NHS Trust, Pwll Glâs Centre, Pwll Glâs Road, Mold, Flintshire CH7 1RA, email: rob.poole@new-tr.wales.nhs.uk, **Robert Higgo** Consultant General Adult Psychiatrist, Merseycare NHS Trust, Liverpool, **Gill Strong** Community Mental Health Team Manager, North East Wales NHS Trust, **Gordon Kennedy** Community Mental Health Team Manager, North East Wales NHS Trust, **Sue Ruben** Consultant General Adult Psychiatrist, North East Wales NHS Trust, Flintshire, **Richard Barnes** Consultant Old Age Psychiatrist, Merseycare NHS Trust, Liverpool, **Peter Lepping** Consultant General Adult Psychiatrist, North East Wales NHS Trust, Wrexham, **Paul Mitchell** Psychotherapist in Private Practice, North Wales.

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Koenig (2008) discusses important principles for working therapeutically with the spiritual dimensions for our service users' well-being. However, several points need highlighting.

Of course one should respect religious beliefs. As an old age psychiatrist in London seeing people at home, I have to be aware of what to do if offered coffee in a Muslim home during Ramadan, who looks after the *mandir* in Hindu households and of the dates and social impact of Jewish holidays. I have had to respond to letters from Catholic priests 'she needs a psychiatrist, not an exorcist' and avoid sending Muslims appointments for midday on Friday. In a multi-faith society there is much to learn to avoid pitfalls which could be interpreted as lack of respect.

Most of us have little experience of taking a spiritual history as distinct from asking about religion. Neither Koenig nor Hollins (2008) direct us to Sarah Eagger's guidance on the College website saying just how to do this (www.rcpsych.ac.uk/PDF/DrSEaggeGuide.pdf).

We cannot work with mental health trained chaplains in our area; there aren't any. Recent guidance (Department of Health, 2003) details specific provision for mental health. However, the first stage of implementation is related to numbers of beds. In this age of community care and bed reductions, this is unrealistic. If the first stage has to be implemented before the community-focused second stage, we still have a long wait for an essential service.

DEPARTMENT OF HEALTH (2003) *NHS Chaplaincy: Meeting the Religious and Spiritual Needs of Patients and Staff*. Department of Health (http://www.parliament.uk/deposits/depositedpapers/2008/DEP2008-0777.pdf).

HOLLINS, S. (2008) Understanding religious beliefs is our business. Invited commentary on . . . Religion and mental health. *Psychiatric Bulletin*, **32**, 204.

KOENIG, H.G. (2008) Religion and mental health: what should psychiatrists do? *Psychiatric Bulletin*, **32**, 201–203.

Claire Hilton Consultant Psychiatrist, Mental Health Services for Older Adults, Northwick Park Hospital, Harrow HA1 3UJ, email: claire.hilton@nhs.net

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I was amazed and alarmed to read Koenig's article on religion and mental health (Koenig, 2008), and the President's lukewarm support of the article (Hollins, 2008), as it presents no scientific evidence that any of the suggested working practices improve patient care. The few figures it uses are not supported by other studies. Koenig claims that only 1.4% of the British population are atheists. His source is the World Christian Database, hardly an unbiased source of information. This low figure has no face validity to anyone working in this country. A recent study (Huber & Klein, 2008) funded by the conservative Bertelsmann Institute looked at religious beliefs in 18 countries (eight of them European) across both high-income and low- and middle-income countries. It used a very broad definition of religion and spirituality focusing on Pollack's work on the belief in the transcendence as the core of substantial spirituality (Pollack, 2000). In other words, it looks for the belief in something spiritual that may or may not be related to formal religion. They professionally polled tens of thousands of people in the 18 countries making it by far the largest and most comprehensive study into the subject so far.

Their findings confirms Britain to be among the least spiritual countries of the 18 examined, across a wide range of factors including prayer, church attendance, personal religious experience, religious reflection, pantheistic influence, etc. It finds that across European Christians more than 10% of those who formally belong to a church do not believe in anything spiritual at all. This makes census data potentially quite unreliable when it comes to assessing people's real religious believes. In Britain, 19% of those polled were classed to be highly religious, 43% as religious and 38% as non-religious using a broad definition of spirituality; 55% of Britons consider prayer to be non-significant for their lives and only 33% have personal religious experiences.

Far from religion being pervasive throughout the majority of society, in Britain at least the opposite seems to be the case. Moreover, there is already a well-organised provision of support for people who follow organised religion in all hospitals with easy access to religious elders and prayer rooms. However, no provision exists for non-believers who look at questions of meaning of life and morality in a non-spiritual way. It is this group that is disadvantaged rather than those who follow organised religion. It follows that rather than insisting on getting a 'spiritual history' of each service user we should show respect to those who can discuss the meaning of life without spirituality and find a solution to identify and facilitate their needs in an increasingly secular society.

HOLLINS, S. (2008) Understanding religious beliefs is our business. Invited commentary on . . . Religion and mental health. *Psychiatric Bulletin*, **32**, 204.

HUBER, S. & KLEIN, C. (2008) Kurzbericht zu einzelnen Ergebnissen der internationalen Durchführung des Religionsmonitors der Bertelsmann-Stiftung. *Religionsmonitor* (http://www.bertelsmann-stiftung.de/bst/de/media/xcms_bst_dms_23399_23400_2.pdf).

KOENIG, H.G. (2008) Religion and mental health: what should psychiatrists do? *Psychiatric Bulletin*, **32**, 201–203.

POLLACK, D. (2000) What is religion? In *The Religious Dimension in History Lessons in European Schools: an Interdisciplinary Research Project* (ed. W. Schreiber) [*Was ist Religion?* In *Die religioese Dimension im Geschichtsunterricht ans Europas Schulen: Ein interdisziplinaeres Forschungsprojekt* (ed. W. Schreiber)], pp. 55–81. Ars Una.

Peter Lepping Consultant Psychiatrist and Associate Medical Director, North Wales NHS Trust, Technology Park, Croesnewydd Road, Wrexham LL13 7YP, email: peter.lepping@new-tr.wales.nhs.uk

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Koenig's attention to the topic of religion and psychiatry is welcome (Koenig, 2008). That the minority of psychiatrists have a religious affiliation is evidently beyond the scope of any intervention or policy. However, I worry that the studies quoted do not accurately reflect the situation. Although they confirm that religion is

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more important to service users than their psychiatrists, this does not tell us what happens in practice.

The real question which we should be asking is to service users themselves and how *they* feel religion has been accounted for in treatment. I worry that the answers might be even more demoralising.

Taking a spiritual history is both an easy and important task to be undertaken by any professional. It can substantially help a service user feel understood and hence engaged in treatment. The Spirituality Special Interest Group provides several tools which should surely become routine practice for all mental health professionals, at the very least in screening (www.rcpsych.ac.uk/PDF/DrSEaggeGuide.pdf).

The suggestion of prayer with service users is a troubling one with the potential to lead to transgression of boundaries through sharing such an intimate act. It leads to duplicity of the psychiatrist's role, erosion of the purpose of treatment and in my mind is best avoided.

Declaration of interest

P.C. is an atheist.

KOENIG, H.G. (2008) Religion and mental health: what should psychiatrists do? *Psychiatric Bulletin*, **32**, 201–203.

Peter Carter Consultant Psychiatrist, North East London Foundation Trust, South Forest Centre, 21 Thorne Close, Leytonstone, London E11 4HU, email: Peter.carter@nelmht.nhs.uk

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Medication for side-effects under the Mental Health Act

The need to authorise the use of hyoscine to counter hypersalivation caused by antipsychotics has been recently debated by Woochit & Husain (2008). They question the logic of the Mental Health Act Commission in suggesting that authorisation needs to be sought on Forms 38 or 39 for detained individuals to receive such medication. They propose a corollary of the Commission's position that all medication used for possible side-effects should similarly be specified, such as senna for constipation and metformin for diabetes.

The Mental Health Act 1983 nowhere defines 'medication for mental disorder' in relation to its consent to treatment powers and the courts have never ruled on the question, although the case of *B v. Croydon Health Authority* [1995] is often cited as a precedent for the contention that a treatment ancillary to the administration of medication for mental disorder can fall within section 58 of the Act (Jones, 2006) and therefore requires certification. It is a long accepted practice, for example, that antimuscarinic drugs should be named on the legal forms. Of course this approach could be taken to absurd lengths, meaning that a statutory second opinion might be required to administer a laxative or an indigestion tablet to an incapacitated detained individual.

The Mental Health Act Commission seeks to ensure that forms should provide a clear indication of the limits of any authorisation, both for clinical teams and for the service user, while remaining practical. We therefore seek to distinguish between ancillary treatments that are an essential adjunct to the core treatment, without which the latter could not be reasonably given, and treatments of more widespread physical complaints that may or may not be related to the core treatment.

Hyoscine is a good example of how this distinction should work in practice. Idiopathic sialorrhoea is exceptionally rare. Where it occurs with antipsychotics, in particular but not exclusively with clozapine, it can be said to be almost certainly one of the side-effects of that drug and nothing else. Contrast this with, for example, constipation or indigestion: both are known to be side-effects of psychotropic medication, but are also common intermittent or chronic problems in the general population, often with no exact known cause. From such pragmatic distinctions we have drawn up a list of ancillary treatments requiring certification including, for example, antimuscarinics used in parkinsonism and other motor effects of antipsychotics and hyoscine used for hypersalivation but excluding laxatives, indigestion remedies, or antidiabetics (Mental Health Act Commission, 2002). Our guidance is under review and we would welcome comments and responses to the correspondence address below.

JONES, R. (2006) *Mental Health Act Manual* (10th edn). Sweet & Maxwell.

MENTAL HEALTH ACT COMMISSSION (2002) *Guidance for Commissioners on Consent to Treatment and Section 58 of the Mental Health Act 1983*. MHAC.

WOOCHIT, V. & HUSAIN, S. (2008) Does hyoscine need to be 'legally' prescribed? *Psychiatric Bulletin*, **32**, 196–197.

B v. Croydon Health Authority [1995] 1 All E.R. 683, CA.

***Mat Kinton** Senior Policy Analyst, Mental Health Act Commission, 56 Hounds Gate, Nottingham NG5 4AU, email: mat.kinton@mhac.org.uk, **Keith Dudleston, Peter Jefferys, Satnam Singh Palia, Claire Royston, Simon Wood** Lead Second Opinion Appointed Doctors, Mental Health Act Commission, Nottingham

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Discharge delays

Many elderly psychiatric wards are currently experiencing problems with delayed discharges (Hanif & Rathod, 2008). It is interesting to note that mental health patients were initially included in the Community Care Act 2003. They were only excluded in a late House of Lords amendment after lobbying by mental health groups, particularly MIND.

As with New Ways of Working, we reap what we sow.

HANIF, I. & RATHOD, B. (2008) Delays in discharging elderly psychiatric in-patients. *Psychiatric Bulletin*, **32**, 211–213.

David Tullett Consultant Old Age Psychiatrist, Rochford Hospital, Union Lane, Rochford, Essex SS4 1RB, email: david.tullett@southessex-trust.nhs.uk

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Depot risperidone, hyperprolactinaemia and prolactin-associated side-effects

Hyperprolactinaemia is a significant adverse effect of antipsychotic treatment and is particularly associated with dopamine-blocking agents like risperidone. Hyperprolactinaemia may cause menstrual disturbance, galactorrhoea, impotence and reduced libido. These problems impair the quality of life and contribute to non-adherence to medication (Maguire, 2002). Chronic hyperprolactinaemia has been associated with osteoporosis (Naidoo *et al*, 2003).

Depot risperidone is an injectable, slow-release formulation whose prolactin-inducing properties may differ from oral risperidone. Only one previous trial assessed hyperprolactinaemia associated with the use of depot risperidone in routine clinical care (Bushe & Shaw, 2007).

In a pilot study in Renfrewshire, Scotland, we identified 37 individuals who were taking depot risperidone. Twelve individuals had medical conditions or took other drugs that may have influenced the level of prolactin and thus were excluded from our study. The remaining 25 individuals had the level of prolactin measured and they completed a questionnaire about prolactin-related side-effects. Ten individuals refused to take part in the study and it was completed by 15 participants (9 men and 6 women, mean age 48 years, mean duration of treatment with depot risperidone 15.4 months).

In 12 participants the level of prolactin has risen, with 3 individuals having levels more than four times the upper limit of

normal. Only 4 participants with hyperprolactinaemia complained of any prolactin-related symptoms. One person complained of prolactin-related symptoms despite having a normal prolactin level.

The prevalence of hyperprolactinaemia in this study was 80% compared with 53% reported by Bushe & Shaw (2007).

Most individuals taking depot risperidone will have hyperprolactinaemia and reported symptoms are an unreliable guide to prolactin levels. Further study is required to inform decisions about the clinical management of this patient group.

Declaration of interest

None.

BUSHE, C. & SHAW, M. (2007) Prevalence of hyperprolactinaemia in a naturalistic cohort of schizophrenia and bipolar outpatients during treatment with typical and atypical antipsychotics. *Journal of Psychopharmacology*, **21**, 768–773.

MAGUIRE, G. A. (2002) Prolactin elevation with antipsychotic medication: mechanisms of action and clinical consequences. *Journal of Clinical Psychiatry*, **63** (suppl. 4), 56–62.

NAIDOO, U., GOFF, D. C. & KLIBANSKI, A. (2003) Hyperprolactinemia and bone mineral density: the potential impact of antipsychotic agents. *Psychoneuroendocrinology*, **28**, 97–108.

***Selwyn McIlhinney** Consultant Psychiatrist, Whangarei Hospital, Whangarei, Northland, New Zealand, email: smcilhinney1@waitrose.com, **Michael Smith** Consultant Psychiatrist, Dykebar Hospital, Paisley, UK

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'I wish to speak to a psychiatrist, please': psychiatric vocabulary in phrase books

Phrase books play an important role for many tourists and travellers in helping to manage everyday situations. Whether or not individuals with mental health problems can express their needs in local languages using the vocabulary found in commonly available phrase books has not been assessed.

We wished to ascertain whether the expression of basic psychological distress was possible using widely available phrase books and whether vocabulary requesting access to psychiatric services was covered. Seven publishers of phrase books were identified: Teach Yourself, Dorling Kindersley Eyewitness, Lonely Planet, Berlitz, Rough Guide, Collins and BBC Active. For each publisher we aimed to assess phrase books in Spanish, Portuguese, Mandarin Chinese and Polish. All seven publishers produced phrase books for Spanish and Portuguese, two did not publish a Mandarin Chinese phrase book and one did not publish a Polish one. We assessed whether a particular phrase book contained a section on health and vocabulary regarding symptoms of depression, anxiety, psychosis, suicidal ideation, asking to see a psychiatrist, requiring psychotropic medication, specifically explaining that one is taking psychotropic medication, explaining that one is taking lithium. We obtained a total of 25 phrase books from the seven identified publishers.

All the books had sections on health: 12% (n=3) had vocabulary for depression and 40% (n=10) had vocabulary for anxiety disorders. Two of the publishers had produced phrase books which contained a word for 'anxious' in the general dictionary, without any cultural context, 16% (n=4) had a (context-free) expression for 'I feel strange,' but none had a word for 'psychosis' or stated how to say 'I have a diagnosis of schizophrenia.' None had any of the other vocabulary elements surveyed.

Publishers of phrase books were contacted for their comments and advice before the survey. The one representative of a publishing house who responded informed the authors that phrase books follow a set template closely (personal communication with Anna Stevenson, Harrap Publishing Manager, Chambers Harrap Publishers, 26 October 2007). It would be irresponsible to suggest that anything more than very basic expression of psychological distress and relevant needs would be possible using a phrase book. Cultural sensitivity would be required to help facilitate effective communication of the most immediate needs. However, as phrase books are prepared according to a template, it would seem a straightforward matter for psychiatrists to approach the publishers of phrase books with a few suggested phrases. Perhaps this is an opportunity to the specialty to work with the publishers to help, in a small way, make the lives of our patients easier.

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***Seamus Mac Suibhne** Special Lecturer and Senior Registrar in Psychiatry, Department of Psychiatry and Mental Health Research, St Vincent's University Hospital/University College Dublin, Elm Park, Dublin 4, Ireland, email: seamus.macsuibhne@ucd.ie, **Aoife Ni Chorcora** Senior Registrar in Psychiatry, Connolly Hospital, Dublin

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Attitude to workplace-based assessment

We conducted an email survey to evaluate attitudes to workplace-based assessment. The questionnaire was sent to consultants, career specialists and trainees working in the East London Trust (n=245). We received 59 responses (response rate 24%). Among the responders there were 25 consultants, 12 specialist registrars/specialty trainees year 4, 19 specialty trainees years 1–3, 2 associate specialists and 1 staff grade. Almost two-thirds of the responders (n=39, 66%) were uncertain whether the system of competency assessment was better than older systems; 21 (35%) were unsure whether it would improve patient care in the long run and 18 (30%) believed it would not improve patient care. Thirty-six responders (61%) believed that it would increase their paper work and distract from their clinical work. The majority (42% *v.* 21%) of the workplace-based assessment trained group also believed that new tools would fail to provide more non-judgemental and informative feedback compared with established assessment procedures. The survey shows uncertainty among trainees and trainers about the effectiveness of the new workplace-based assessment tools. However, attitude changes with familiarity. In case of the Calman reforms trainees were more satisfied after 18 months of initial application of the system (Paice *et al*, 2000). This survey indicates the need for further robust investigation to examine the questions of confidence in the workplace-based assessment, the content of the workplace-based assessment tool training sessions and the development of workplace-based assessment methods requiring less time to reach valid and reliable conclusions about the competency of the trainees.

PAICE, E., AITKEN, M., COWAN, G., *et al* (2000) Trainee satisfaction before and after the Calman reforms of specialist training: questionnaire survey. *BMJ*, **320**, 832–883.

***Tayeem Pathan** Specialty Trainee Year 4, North Hackney Community Mental Healht Team, Anita House, Wilmer Place, Stoke Newington N16 0LN, email: tayeem@gmail.com, **Mark Salter** Consultant Psychiatrist, North Hackney Community Mental Health Team

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Religion, psychiatry and professional boundaries

Rob Poole, Robert Higgo, Gill Strong, Gordon Kennedy, Sue Ruben, Richard Barnes, Peter Lepping and Paul Mitchell

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