Correspondence

Saddened and concerned

I was saddened to read the correspondence from Professor Poole and others.¹ Surely members of the College must know that when bodies like the General Medical Council and the National Health Service issue guidelines and regulations, the focus is on acute services. The only exception to this in recent years has been the particular framework for mental health services. We now have the latest initiative for mental health services, New Horizons, which envisages working with housing, education and employment agencies. Are the authors concerned about professional boundaries between these agencies?

The Royal College of Psychiatrists’ Spirituality and Psychiatry Special Interest Group is interested in a patient’s belief system and background, and only marginally in the belief system of the clinician. If a patient is to be treated holistically (and I cannot imagine that any of the signatories would demur from this), then a person’s culture, religious and faith background have to be addressed and, more importantly, be part of the diagnostic process.

There is a distinction to be made between healthy and unhealthy belief systems and this distinction is reached through the diagnostic process. Religion like many other areas of human life and experience lends itself to delusions, which can be part of an unhealthy belief system. Surely Professor Poole and his colleagues would agree and would also accept that healthy spirituality is part of a person’s very being? It is for this reason that I hope he and his colleagues will want to support the Special Interest Group in its work.

² The Venerable Arthur Hawes Archdeacon of Lincoln (retired), Co-Chair of the National Spirituality and Mental Health Forum, Chair of the Church of England Mental Health Advisory Group, Training Consultant with the Lincolnshire NHS Foundation Trust, UK, email: arthur.hawes@yahoo.co.uk doi: 10.1192/pb.34.6.257

Spirituality and boundaries in psychiatry

Poole et al appeared to be re-proving the Spirituality and Psychiatry Special Interest Group for neither endorsing nor refuting their stated opinion that spiritual and religious practices are breaching professional boundaries. They begin by taking issue with the views of Professor Koenig² (a paper to which four members of the Group Executive Committee have also made a considered response²), further citing General Medical Council (GMC) guidance⁶ that, (1) doctors should not discuss their personal beliefs with patients unless these beliefs are directly relevant to patient care, and (2) doctors should not impose their beliefs on patients.

Concerning the GMC guidance, since the Group agrees with both points, it seems there is no argument to be had on this front. As for the Group’s response to Professor Koenig’s paper, we have highlighted why we think the relationship of spirituality (including secular spirituality) to mental health is important for every psychiatrist to be aware of.³ Although we advocate extreme caution in the matter of prayer with patients because of the complex boundary issues raised, we do not see this as something to be ruled by fiat. Enquiring about a patient’s spirituality can be extremely helpful. Psychiatrists routinely ask about other central aspects of patients’ lives such as sexuality which might influence, and be influenced by, psychopathology. There is evidence that religious and spiritual beliefs may similarly affect psychological functioning both positively and negatively and that those beliefs may, in turn, be influenced by mental illness. A tactful enquiry about patients’ belief systems frequently reveals information that may be helpful in understanding coping strategies. Atheism, as a belief system, is no exception.

There is evidence that many patients want to be able to share with mental health professionals their spiritual and religious beliefs and values, to which they frequently turn when under stress.⁵ Indeed, by enabling such issues to come up for discussion, the psychiatrist may well be facilitating the therapeutic relationship.⁶

Mental illness causes fragmentation of the self and finding healing or wholeness (the root of the words is the same) is intrinsic to recovery. This has been endorsed by the World Health Organization: ‘Patients and physicians have begun to realise the value of elements such as faith, hope and compassion in the healing process’.⁷

Given that religious and spiritual beliefs are important for many patients and that for these patients showing interest in, and concern for, their beliefs may have therapeutic value, we feel it is appropriate to routinely enquire about such beliefs. As with all aspects of the clinical consultation, this needs to be done with sensitivity and tact. If a patient does not want to discuss such issues, the subject is gently dropped—there is no question of putting anyone under pressure. The agenda is set by the patient.

We see it as important that enquiry should be carried out in a manner that conveys openness to every kind of belief—humanist, secular, spiritual and religious alike. Patients who have experienced trauma with religious or spiritual organisations (sometimes associated with sexual abuse) may be fearful of speaking out. The psychiatrist who conveys concern, empathy and understanding will give the best chance of finding out which spiritual concerns may need understanding in order to enhance a good therapeutic outcome. The same GMC guidance on personal beliefs and medical practice cited by Poole et al goes on to state:

For some patients, acknowledging their beliefs or religious practices may be an important aspect of a holistic approach to their care. Discussing personal beliefs may, when approached sensitively, help you to work in partnership with patients to address their particular treatment needs. You must respect patients’ right to hold religious or other beliefs and should take those beliefs into account where they may be relevant to treatment options.

Last, we should make clear that the Spirituality and Psychiatry Special Interest Group is precisely that—a Special interest
group. Its function is neither prescriptive nor prohibitive. We would no more advocate proselytising than see spiritual concerns ousted from the clinical consultation.

We wish to make clear that we welcome the debate to which Poole et al are contributing and look forward to further discussion when Professor Poole will be talking at the Group’s programme in October 2010 on ‘Intolerant secularisation’. We do not look for uniformity of opinion, but we do hold that every viewpoint is worthy of consideration and respect.

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**Divine intervention in mental health**

We thank Dein et al for opening up the debate about religion and its impact on mental well-being. This debate does not come a moment too soon.

We feel compelled to refute the suggestions that research unequivocally shows an association between religiosity and well-being. The research findings are wildly contradictory and it would be unreasonable to draw any firm conclusion on the basis of current knowledge. Furthermore, the research in this area is often biased, plagued by poor methodology (definitions of spirituality and religion are controversial, much variation exists between different faith groups, ‘hidden’ supportive measures of any community tend to be responsible for well-being rather than religion per se) and the research is almost invariably carried out by groups of researchers that have a vested interest in showing positive results for religiosity. The last point also applies to Dein and colleagues as they represent the Royal College of Psychiatrists’ Spirituality and Psychiatry Special Interest Group. None of these points of contention is raised in the article.

In our personal experience we can come to think of a handful of patients that indeed seemed to have been consoled by religious beliefs, but hundreds of patients who have been tormented by fear of having transgressed some Bronze Age dogma about sexuality, having sinned in other ways or simply having taken their God’s name in vain. A common sight on psychiatric wards is frightened patients shivering with fear when they hear what they perceive to be God’s, not to mention Satan’s, voice in their hallucinations. Some studies report that patients with schizophrenia and religious beliefs do indeed have worse long-term outcomes than patients with non-religious delusions. The rigid cognitive belief system that underpins religious ideology plays straight into delusional beliefs that cause endless anguish, for example, ‘If I break my pact with God (e.g. divorcing a violent husband, having sex out of wedlock), He will punish me’. Meeting such patients gives the concept of being ‘God fearing’ a whole new dimension. This commonplace suffering seems to have escaped the authors entirely.

Dein et al complain that there is a gap between patients’ and psychiatrists’ level of religiosity, the patients being more religious. Initially, this observation begs the question of whether religion could be part of the complex set of aetiological factors that constitutes the pathogenesis of mental illness in the first place and perhaps maintains it. Unquestioned belief in authorities always spells trouble, which recent events in the Catholic Church so amply exemplify. Some perturbed patients may find the certainties of religion tempting, but at what cost? Nevertheless, a good point is made that we must enquire more about the patient’s religious beliefs as they can have a profound impact on lives from an early age. Yes, just think of the consistent mistreatment of women and children in some religions, beliefs in utterly unverifiable concepts (walking on water, miracles, angels with wings, devils, etc.) and the survival of your own death through an immortal soul, going to Heaven if you have been good but going to Hell if you have not.

No wonder if you have a fragile mind that religious beliefs can push you over the edge.

We remind Dr Dein and his colleagues that instead of promoting private views, however strong and well meant they are, our traditional mandate as doctors is ‘first of all, do no harm’. A more important question than whether the psychiatrist should pray with the patients or not – consider what this would entail if you had a Satanist under your care – is to enquire more about the patient’s religious beliefs as they can have a profound impact on lives from an early age. Yes, just think of the consistent mistreatment of women and children in some religions, beliefs in utterly unverifiable concepts (walking on water, miracles, angels with wings, devils, etc.) and the survival of your own death through an immortal soul, going to Heaven if you have been good but going to Hell if you have not.

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No wonder if you have a fragile mind that religious beliefs can push you over the edge.
they are sources of extreme distress and contribute to ongoing mental health problems.


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**Declarations of interest**

In their article on religion, spirituality and mental health, Dein et al make some important points. I was especially interested in ‘enquiry into meaning’ and some ways of handling prayer. But I wondered why they did not mention attachment theory, which has been used by Kirkpatrick to elaborate or explain many phenomena of religion.

I am left with one big question about declaration of interest. I thought it meant anything about us that might make us less of a ‘disinterested’ observer, researcher, etc. The four authors here declared ‘none’, so I found out more about them: one is a priest in the Church of England, one spent 7 years living in an orthodox Jewish community, one published in a religious journal, and the fourth has been a consultant psychiatrist (retired). This does not mean that potential financial conflicts of interest should not be disclosed, as these arguably come into a different category. However, on matters such as spirituality, everyone has a perspective that is of interest. Being ‘disinterested’, if such a thing is possible, is just as much of a perspective as that of the atheist, humanist or religious person.

A distinction should be made between ‘conflicts’ of interest and ‘perspectives’ of interest. We did not consider that we had any conflicts of interest to declare in regard to our article. We hoped that our perspective of interest was sufficiently identified by the statement which indicated that we were writing on behalf of the Executive Committee of the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists. Does not membership of this group self-evidently imply that we are interested in spirituality?


Christopher C. H. Cook, Simon Dein, Andrew Powell, and Sarah Egger
doi: 10.1192/pb.34.6.259a

**BNF limits v. threshold dosing**

David Taylor is right that there is excessive polypharmacy in routine practice. However, he does not examine or comment upon one of the root causes, **British National Formulary (BNF)** limits. Many clinicians seem to believe they are acting in the patient’s interest by prescribing two compounds at close to the BNF maximum rather than one above this mark. As a clinician it is commonplace to come across patients who respond well to maximum rather than one above this mark. Although this does not mean that potential financial conflicts of interest should not be disclosed, as these arguably come into a different category. However, on matters such as spirituality, everyone has a perspective that is of interest. Being ‘disinterested’, if such a thing is possible, is just as much of a perspective as that of the atheist, humanist or religious person.

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that patients with severe psychosis may be dramatically medication-resistant, unless they have used threshold dosing they do not know that the sensitivity of the patient to antipsychotic medication increases as their mental state improves, allowing a reduction in dose with maintained efficacy. It is worth remembering that BNF limits are usually established in accessible and responsive out-patient populations with moderate symptoms. Practising clinicians treat many patients who do not come from this population and may find themselves with a difficult choice: polypharmacy or prescription outside BNF limits.

The importance of early and accurate diagnosis

The excellent article by Chan & Sireling1 about the recent increase in public awareness of bipolar disorder mirrors our own experience in research and practice, and highlights important issues for health services.

This article is very timely because there is ongoing debate about the extent to which bipolar disorder may be over- or underdiagnosed.2,3 Both over- and underdiagnosis occur and are problematic. Some people may be inappropriately labelled, whereas others who would benefit from the diagnosis are missed. Optimal treatment of depression is different in bipolar and unipolar disorders. This is one of many examples in psychiatry where making an early and correct diagnosis is highly likely to have a very direct and important effect on the quality of care offered to, and quality of life experienced by, a patient.4

Chan & Sireling highlight new cases of bipolar disorder from the primary care setting. Preliminary data from our ongoing studies of primary care patients with depression suggest that bipolar (i.e. manic/hypomanic) features are relatively common in this group (unpublished data; available from the authors on request). In our wider research in individuals with both bipolar and unipolar mood disorders, we have found that those with a diagnosis of recurrent unipolar depression who have a history of mild manic symptoms tend to respond less well to antidepressants.5

Inevitably, increasing awareness of any illness has the potential to lead to overdiagnosis and this could cause problems for the patient as well as for services. Thus, a balance must always be struck between the need to increase awareness appropriately among patients, public and clinicians, while not causing a tsunami of uncritical overdiagnosis and self-labelling. As psychiatrists we must ensure we are pragmatic and put the patient’s well-being at the centre of decision-making. This will require us to have knowledge of the developing evidence base, make a comprehensive diagnosis based on a detailed lifetime history of both depressed and manic mood (including asking an informant), and have an awareness of the boundaries of clinically relevant symptomatology.

3 Smith DJ, Ghaemi N. Is underdiagnosis the main pitfall when diagnosing bipolar disorder? Yes. *BMJ* 2010; 340: c854.

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The suggested obligation to declare mental health issues to employer

I enjoyed Chan & Sireling’s article1 considerably, although I must write in response to the comments about obligatory declarations of mental health to employers.

Although there is little doubt that in most cases employers need to be aware of a bipolar affective condition in employees, this is not always appropriate. Indeed, best practice requires employers to require submission of pre-employment forms not to themselves but to an occupational health professional. Those with a bipolar condition should almost always be invited to a review with an occupational physician.

At that point, and that point only, is it appropriate for there to be discussion as to what is to be shared with the employer. At the very least such a consultation is likely to head in the direction of advice to an employer that the employee has a condition which may require adjustment under the Disability Discrimination Act. What an occupational physician tells an employer is, however, subject to their own professional judgement and indeed ultimately down to what the employee feels is appropriate.

Occupational medicine is a small specialty, although a valuable one, not least for psychiatric patients, for whom we can do a great deal.


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Narrative triad and philosophy

Wallang3 provides a stimulating and insightful consilience of wide-ranging ideas. This is what a journal should be about, not the repetitive reductive statistics cobbled together to further
careers rather than knowledge. The traditional splitting of organic, phenomenological and analytic approaches is rarely appropriately addressed without reference to philosophy and culture; and then usually in an entrenched and divisive manner. Dr Wallang’s very constructive syncretism, described in terms of the narrative triad, is a literate and absorbing one. Can we not give more prominence to such informed articles which enrich debate rather than burying it in computation?


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Anyone for critical psychiatry?

An admissions tutor in my medical school interview poured a helping of caution on my wary expression of interest in psychiatry. ‘That often changes after your rotation in it,’ he quipped, as if this was an old medical education in-joke.

Now sampling some ‘real medicine’ as the hackneyed jibe goes, I am still digesting my psychiatry rotation. I am starting to see how psychiatry’s relationship with medicine is fraught with unrequited love. The tender issues of identity related to this are all too plain for undergraduate students to see. In his masterful anthropological survey of a London medical school in the nineties, Sinclair remarks that the stigma attached to psychiatry and the profession’s dubious ranking on the hierarchy of specialty ‘sex appeal’ are part of the informal curriculum. That this subtext is so deeply entrenched to show itself to one potential psychiatrist before even starting medical school is a sign of how great a challenge the Royal College of Psychiatrists faces in boosting recruitment.

One approach would be to incorporate an element of critical psychiatry into the undergraduate curriculum. For those at the helm of the profession’s recruitment efforts giving space for dissent might seem counter-intuitive. However, such a strategy might resonate strongly with those students whose response to their first experience of psychiatry was largely negative. Encouraging discussion conducive to critical thought might protect against marginalising their experience as non-conformist and so inconsistent with pursuing a career in the specialty. It would allow them to see that their instinctive doubts as to the efficacy of the profession’s pharmacopoeia and its biological reductionism are shared and hotly debated by many at the top of the profession. In addition, it might serve as an early lesson in the value of tolerating ambiguity and uncertainty, transforming the clichéd critique of ‘wooliness’ levelled at psychiatry into something richer in possibility.

An awareness of the critical psychiatry movement and the culture war within the profession would give students a more favourable portrait of the specialty’s willingness to engage with and accommodate dissenting voices. Undergraduates deserve being granted a broader perspective with which to make sense of their responses to psychiatry and more effectively challenge its epistemological frailties. With a more sophisticated understanding of the forces and philosophical concerns underpinning the profession, those deciding to join its ranks might be in a stronger position to more meaningfully participate in its evolution.


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Hospital transfers need proper assessment

Wilson et al highlight the delays in transferring prisoners to hospital, including a suggestion that a ‘postcode lottery’ operates. Although we agree with much of the article, we would contest the statement that ‘Given the extensive development of mental health in-reach services, and the fact that referrals are made by senior psychiatrists, it seems surprising that it has become routine for receiving units to undertake their own assessment, apparently duplicating work.’ Clearly, it is important that the transfer of mentally ill prisoners needing hospital treatment is expedited and this is no doubt a view shared by both prison psychiatrists and those in the receiving units. However, although this is the main concern of prison psychiatrists, receiving units also have to consider the appropriateness of the placement and issues of risk.

Furthermore, it is not always the case that referrals are made ‘by senior psychiatrists’. And regardless of the author of the referral, assessment by a receiving unit provides an opportunity for additional and often significant information to be collected. This enables the unit to carefully consider risk issues and prepare for a safe admission to an appropriately secure unit, an issue highlighted by the core Never Events relating to escape from medium or high secure units. Sometimes this more properly informed assessment clarifies that a prisoner does not need transfer for treatment. This was highlighted in the sensible guidance from the Department of Health, which distinguished between routine and urgent referrals, allowing assessments to be appropriately prioritised.

Given that beds are usually at a premium in secure services, simply accepting every prison referral would lead to even further unacceptable pressure on beds and perversely exacerbate the very problem Wilson et al seek to address.

Declaration of interest

O.C. and G.D. work equal time between a London remand prison and on secure admission wards.


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