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Multiple choice questions

1 Religious delusions may occur in:
a schizophrenia
b depression
c anxiety states
d anorexia nervosa
e organic states.

2 In terms of religious beliefs and practices:
a psychiatrists are generally more religious than their patients
b religious teaching plays little part in psychiatric training
c there is some evidence that religious patients prefer religious therapists
d a significantly greater number of mental health professionals undergo religious conversion compared with the general population
e hospital chaplains in the UK have no training in mental health problems.

3 Mystical states:
a are usually pathological
b can lead to changes of personality
c may occur in epilepsy
d require medication
e are more common in men than women.

4 In terms of psychotherapy:
a Freud held a negative view of religion
b Jung held a positive view of religion
c perceptions of God derive from early childhood relationships
d perceptions of God never change during psychotherapy
e the addition of religious components to cognitive therapy may enhance efficacy for religious patients.

5 Religious patients' reluctance to engage in psychiatric treatment may be overcome by:
a using a culture broker
b using religious symbols
c neuroleptic administration
d brief cognitive therapy
e using the Mental Health Act.

MCQ answers

1	2	3	4	5
a T	a F	a F	a T	a T
b T	b T	b T	b T	b T
c F	c T	c T	c T	c F
d F	d F	d F	d F	d F
e T	e T	e F	e T	e F

Epidemiological medicine's best-kept secret?

Invited commentary on... Working with patients with religious beliefs

Andrew Sims

Even to have a paper on working with patients with religious beliefs in a psychiatric journal is a liberating experience, and Dr Dein (2004, this issue) has dealt with his subject with thoroughness and fair-mindedness. We have come a long way since the standard British textbook of psychiatry in the 1960s (Mayer-Gross *et al*, 1960) could state that religion is for 'the hesitant, the guilt-ridden, the excessively timid, those lacking clear convictions with which to face life'. At that time religious belief

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in patients was equated with neurosis, and in trainees in psychiatry it was regarded as being seriously unscientific and was strongly discouraged.

Although this topic comes over to us in Western Europe as refreshing and novel, in many countries this would be the everyday experience of clinical psychiatrists, who would be likely to respond 'Of course we work with patients with religious beliefs; all patients have religious beliefs'. In fact, most of our patients too have religious and/or spiritual beliefs, but they are not in the habit of talking about them, especially to psychiatrists, who they suspect might attempt to discredit them.

One of the best-kept secrets of modern epidemiological medicine is the effect that religious belief and practice have upon outcome from both physical and mental disorders. Twelve hundred outcome studies and 400 critical reviews have formed the subject matter of the *Handbook of Religion and Health* by Koenig *et al* (2001). On all of the 13 factors for improved mental health, religious belief proved beneficial in more than 80% of studies, despite very few of these studies having been initially designed to examine the effect of religious involvement on health. If the overall effects of our patients' religious beliefs are so beneficial, then we, as psychiatrists, have no business to undermine or ignore them.

It is important to make a distinction psychiatrically between those who hold, with absolute conviction, extreme beliefs, as have been described by Galanter (1989), and the vast majority of patients who hold, with varying degrees of doubt and questioning, more conventional and culturally accepted beliefs. This does make a difference for the attitudes and practice of the psychiatrist. It is therefore important that psychiatrists respect and differentiate unusual but integrating experiences from those that are distressing or disorganising.

In this connection Dein's idea of a 'culture broker' is attractive. In fact, it is relevant to more than just religious discrepancies between psychiatrist and patient. The culture broker accepts and respects the knowledge and skills of the professional and realises that they can be helpful for the patient. The broker should be a person of good standing in their community, who can advocate this treatment, and this treater, to the patient, while helping the professional to present psychiatric knowledge in a culturally acceptable manner.

Treating psychiatrically disordered people with religious beliefs is a true test of the psychiatrist's capacity for empathy. As well as having a good knowledge of psychiatry, the psychiatrist needs to know about the nature of the religious beliefs and their relevance for the patient's individual condition – to understand so exactly the interplay between belief and subjective experience by inquiry of the patient that, when the psychiatrist gives an account back to the patient describing the patient's own experience and conflict, the patient recognises this with ownership.

Since 2000 the Royal College of Psychiatrists has had a Spirituality and Psychiatry Special Interest Group (http://www.rcpsych.ac.uk/spirit). This was established following greater recognition by psychiatrists of the spiritual and religious needs of their patients, and also because psychiatrists wanted to explore the relationship between their own beliefs and practice and their professional work. With regard to the treatment of patients, the Special Interest Group presents us with a further opportunity to develop Dr Dein's excellent lead. However, it must be remembered that there is for psychiatry the same danger that the highly successful hospice movement met for terminal care just because of its success. Sometimes, it was found that general hospitals did not improve the quality of their terminal care but just referred all patients on to a hospice. Psychiatrists who are not members of the Special Interest Group should not consider that referral of a 'spiritual' issue to the Group absolves them, personally, of all further concern or involvement and that religious patients have to be referred to a 'specialist' who is a member of the Group.

Dr Dein has made an excellent start. As he writes, there is a need for more work in this area. I hope that *APT* will follow his lead and regularly carry articles on working with patients with religious beliefs in different contexts and specialties within psychiatry.

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