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.

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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.

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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.

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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