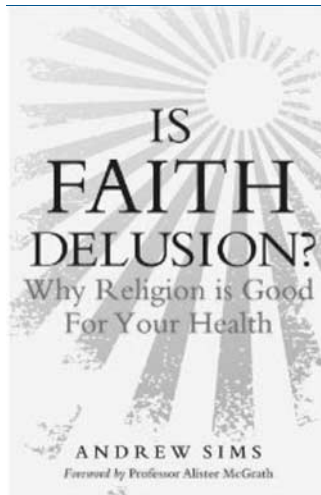


may simply indicate the need for a second text that develops the issues raised and begins to cover the ground that has been missed.

This book is valuable for people who are already interested in spirituality as it relates to psychiatry, but it is also a very useful introduction for those who might be more sceptical but open to the conversation.

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**Is Faith Delusion?
Why Religion is Good
for Your Health**

By Andrew Sims.
Continuum Books. 2009.
£14.99 (pb). 252pp.
ISBN: 9781847063403

This is another riposte to Richard Dawkins's best-seller, *The God Delusion*. Andrew Sims, who is a Christian psychiatrist, confronts the word delusion in Dawkins's attack on the supposed irrationality of religious belief. In this devoutly religious, personal account Sims documents how psychiatrists' and psychologists' hostility to religion has lessened since he started practice. He supports religious psychiatrists who want to include elements of their faith in their work with those patients who share their beliefs. And he wants to show that religion is good for us in terms of improved health and well-being. So does it work? Well, yes and no.

Let me start with the no. Sims has a particular expertise in the descriptive phenomenology of mental illness. He cogently explains the technical meaning of delusion and how it cannot be applied to religious belief. In so doing, however, he risks setting up a straw man. Dawkins is not suggesting believers are mad in diagnostic terms. Rather, he uses the term delusion in an ironic attack on religious belief as illogical, silly and wishful thinking. So I wonder whether a long treatise on the precise diagnostic nature of delusion will do anything to undermine Dawkins' argument. Furthermore, it might just be a matter of pots *v.* kettles. Sadly, the word delusion has a long history in the mouths of Christians as a description for people without faith (see 2 Thessalonians 2:11). I also take issue with the distracting sub-theme 'why religion is good for your health'. It was not too good for the first Christian or for many of those martyred after him. Nor is the claim for the health benefits of religion particularly robust.¹ After adjustment for factors such as social support, such benefits are small. Sims is right to assert that religion is not harmful to your mental and physical health, but to suggest it is good for you is a shakier claim, at least in terms of evidence. Faith does not take you out of the world any more than it makes you comfortable or safe. As Terry Eagleton puts it, to treat God as a 'super-sized version of ourselves that we might then manipulate to our own ends turns faith into idolatry.'² Jesus was so completely good in

terms of love and justice that he threatened the power of organised religion. Religious men could not bear to do other than kill him and he explicitly warned that others who followed his path might meet similar fates. To quote Eagleton again, 'The message of the New Testament is that if you don't live you are dead, and if you do, they will kill you.'² But the hope it gives is that goodness and love have already prevailed and that love and meaning are sometimes to be found in the deepest suffering.

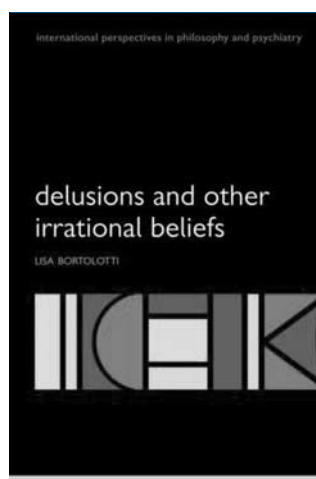
And now for the yes. This is a thoughtful history of the struggle between religion and secular psychiatry. Those of us with rational thoughts and romantic emotions cannot live without faith in God. And as Sims demonstrates, faith and belief can be integral parts of psychiatric practice because, for all our pharmacological, cognitive and analytical tinkering, only faith and hope will change men's hearts. Furthermore, as Sims points out, science does not rule out faith any more than believers can prove the existence of God. They are simply complementary spheres. This personal account is also extremely frank and for that reason highly interesting. It is rare for a psychiatrist to write with so much emotion on his sleeve and for that reason alone it is to be welcomed.

My problem is that I agree with Sims and Dawkins. Paul Tillich, an existential philosopher and theologian who is neglected today, sought to show throughout his writings from the 1940s to the 1960s how 'the Christ' pointed far beyond religion, to something reflected in, but more profound than, the concrete icons of world faiths, including Christianity. Tillich called it our 'ultimate concern', a God that could not be grasped but only hinted at. Therefore perhaps the materialists come closest to what might be 'the truth' as they dismiss religious belief and practice as so much nonsense. Who knows? If you seek certainty, you can go with Sims or Dawkins as both are sure they are right.

- 1 Sloan RP, Bagiella E, Powell T. Religion, spirituality, and medicine. *Lancet* 1999; **353**: 664–7.
- 2 Eagleton T. *Trouble with Strangers: A Study of Ethics*. Blackwell, 2009: 256.

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**Delusions and Other
Irrational Beliefs**

By Lisa Bortolotti.
Oxford University Press. 2009.
£34.95 (pb). 320pp.
ISBN: 9780199206162

This is probably the best treatise in recent times on the subject of delusions. Bortolotti brings her professional expertise to bear on a subject that is central to our understanding of what it means to be severely afflicted with schizophrenia or any psychosis. What is remarkable is that Bortolotti has mastered the literature on delusions as a psychopathological phenomenon. She does not treat delusions merely as an excuse for high-flown philosophical

arguments, but takes the reality of delusions seriously, recognising that the empirical facts about delusions are important and that philosophical enquiry ought to 'make sure that the theory to be developed is *compatible* with the relevant empirical data' (p. 7). This is a refreshing approach from a philosopher.

Bortolotti's thesis is that delusions are beliefs and that they cannot be denied belief status by virtue of being irrational. For most psychiatrists, it is a given that delusions are false beliefs. This distinguishes them from hallucinations, which are defined as false perceptions. In this model the terms 'beliefs' and 'perceptions' are operating as markers of difference that point at the putative domains of cognitive functions where impairments may lie. But in Bortolotti's thesis, for something to count as a belief it must be rational in at least one of three senses: (1) it must be procedurally rational by at least being well-integrated in a system with other beliefs; (2) it must be epistemically rational in that it must be well supported and responsive to available evidence; and (3) the person who is the believer must be agentially rational by being able to offer good reasons in support of the content of their belief and by acting in such a way that is consistent with and explicable by the content of their belief.

Bortolotti goes on to show that delusions do indeed breach these features of what she refers to as the 'rationality constraint of beliefs'. Her aim, though, is to argue that ordinary beliefs also breach these constraints and that there is much continuity between beliefs and delusions. Her analysis is of great importance to psychiatrists, particularly her examination of Berrios¹ contention that delusions are 'empty speech acts' and by implication that they have no intentional content. Bortolotti argues against this position but in the end she misses the point that apparent thought content (i.e. belief), even when that content has symbolic meaning, is not evidence of content-full speech. In other words, it is perfectly possible for a person to utter a speech that has apparent meaning yet for that speech to be empty. An indirect example is an eyewink which is a tic; superficially, it appears to communicate but in reality it is empty of any symbolic communication.

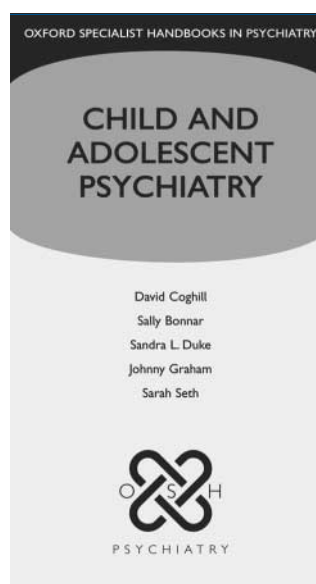
Bortolotti accepts that delusions are not unitary in nature but in her analysis she continues to fall into the trap of treating them as such. There are delusions that occur as sudden irruptions into consciousness; the so-called autochthonous delusions that resemble inspired beliefs; delusions that follow from veridical experiences, usually abnormal perceptions such as hallucinations. There are other delusions that follow from subtle abnormalities of perception that are only apparent under psychometric testing, such as delusional misidentification syndromes that seem at least to require abnormalities of facial or visual perception. And finally, there are other delusions that derive from altered mood, altered atmosphere, or weak reasoning ability. What this means for normal psychology and for philosophy is that the class of cognition termed belief is not unitary or homogeneous, even though, superficially, all beliefs seem to behave similarly.

Bortolotti's book is an important contribution to our understanding of the nature of beliefs and hence of our understanding of delusions. It shows that psychiatry has a lot to learn from philosophy and no doubt philosophy too can only benefit from dialogue with psychiatrists. There are many original insights in this book.

1 Berrios GE. Delusions as 'wrong beliefs': a conceptual history. *Br J Psychiatry* 1991; **159** (suppl 14): 6–13.

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Child and Adolescent Psychiatry (Oxford Specialist Handbooks in Psychiatry series)

By David Coghill, Sally Bonnar, Sandra L. Duke, Johnny Graham & Sarah Seth.
Oxford University Press. 2009.
£39.95 (flexicovers), 520pp.
ISBN: 9780199234998

If a concise introduction to child and adolescent psychiatry is what you are looking for, then here it is. This is a reliable and up-to-date guide, encompassing what one must acknowledge is becoming a dauntingly large amount of new research and clinical evidence. Also, it is refreshing to have a brief history of child and adolescent psychiatry in a practical clinical compendium.

The authors openly acknowledge the isolation that marked the subspecialty during its latter 'child guidance' days, and point to the benefits that have flowed from academic child and adolescent psychiatry, as well as the present inclusion of services for children and adolescents in mainstream psychiatry and medicine.

The book starts with sections on normal development and the role of environmental influences, including family, school, peer relationships and the wider social context. Trainees and clinicians will find the section on general assessment procedures, and specifically 'formulation', particularly helpful for this is often a stumbling block in report writing. Clear plans and algorithms set out management and treatment recommendations. The evidence base for effective treatments points to a persisting lack of systematic research in family therapy and psychodynamic psychotherapy.

Clinical scenarios accompany almost all of the main disorders, but vary in quality. Perhaps this is in itself an indication of the need for further standardisation of our assessments and treatment in everyday clinical practice.

The wider service context is amply covered by describing the interfaces with partner agencies: school and educational psychology services, Social Services and safeguarding structures. The chapter on management will alert the trainee to the realities of service delivery. References to a well-selected list of key reading material are provided, although the list is not as uniformly comprehensive throughout the book.

The five authors, who among them straddle academic and clinical work, initially intended this book as primarily for the use of senior trainees in psychiatry and paediatrics. But it is clear that it will have a much wider appeal to any case-managing clinician and will meet the training and practice needs of a range of professionals. I would recommend this book to anyone starting in the field and, I have no doubt, will benefit from its use myself.

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