

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.

1 Poole R, Higgs R, Strong G, Kennedy G, Ruben S, Barnes R, et al. Concerns over professional boundaries remain unresolved. *Psychiatrist* 2010; eLetter (<http://pb.rcpsych.org/cgi/eletters/34/2/639866>).

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Spirituality and boundaries in psychiatry

Poole *et al*¹ appear to be reproving 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 response³), further citing General Medical Council (GMC) guidance⁴ 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