they are sources of extreme distress and contribute to ongoing mental health problems.

1 Dein S, Cook CCH, Powell A, Eagger S. Religion, spirituality and mental health. *Psychiatrist* 2010; **34**: 63–4.

2 Blazer DG. Religion, spirituality and mental health: what we know and why this is a tough subject to research. *Can J Psychiatry* 2009; **54**: 281–2.

3 Doering S, Müller E, Köpcke W, Pietzcher A, Gaebel W, Linden M, et al. Predictors of relapse and rehospitalization in schizophrenia and schizoaffective disorder. *Schizophr Bull* 1998; **24**: 87–98.

Lars K. Hansen Consultant Psychiatrist, Hampshire Partnership Trust, email: lh4@soton.ac.uk, **Nick Maguire** Lecturer in Clinical Psychology, Southampton University.

doi: 10.1192/pb.34.6.258

Declarations of interest

In their article on religion, spirituality and mental health, Dein *et al*[1] 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[2] 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 support of spirit release therapy.

I have no objection to how the authors spend their time outside their psychiatric jobs, but am I misunderstanding declaration of interest? I think that in the spirit of openness with us, and of 'disinterestedness' in relation to the subject of their article, those are important matters. That they were not disclosed leaves me ethically puzzled.

1 Dein S, Cook CCH, Powell A, Eagger S. Religion, spirituality and mental health. *Psychiatrist* 2010; **34**: 63–4.

2 Kirkpatrick LA. *Attachment, Evolution, and the Psychology of Religion*. Guilford Press, 2004.

Peter Bruggen is Consultant Psychiatrist (retired), atheist, member of the British Humanist Association, London, UK, email: pbruggen@blueyonder.co.uk

doi: 10.1192/pb.34.6.259

Authors' reply Peter Bruggen suggests that a declaration of interest is concerned with 'anything about us that might make us less of a 'disinterested' observer, researcher, etc.' However, instructions to authors on *The Psychiatrist* website indicate that: 'A Declaration of Interest must be given and should list fees and grants from, employment by, consultancy for, shared ownership in, or any close relationship with, an organisation or individual whose interests, financial or otherwise, may be affected by the publication of your paper.'

The clear emphasis here is on possible financial interests, although other 'close relationships' and interests are also mentioned. The problem is that if we take inclusiveness of the latter to an extreme, then all possible matters of deep concern, including our professional and academic interests and beliefs, as well as environmental, political, ethical and other concerns, as well as spiritual and religious beliefs, are potentially conflicts of interest. A cognitive–behavioural therapist involved in a trial of cognitive–behavioural therapy *v.* antidepressant treatment would have to declare a conflict of interests. A researcher studying any particular condition or disorder would have to declare an interest if they or their family had suffered from this condition, or if they treated any patients suffering from it in the course of their clinical work. In fact, arguably, anyone who publishes a paper on anything is far from 'disinterested' or else they would not be bothering to publish their paper.

But do we want thoroughly 'disinterested' people doing research, publishing papers or editing journals? Leaving aside for a moment the likelihood that none of us can claim to be completely objective about anything, is it not better that letters and papers are published by people who are deeply concerned to explore, research and express views which they hold dear? 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.[1] 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?

1 Cook CCH. Letter to the Editor. *Addiction* 2010; **105**: 760–1.

Christopher C. H. Cook, **Simon Dein**, **Andrew Powell**, and **Sarah Eagger**

doi: 10.1192/pb.34.6.259a

BNF limits *v.* threshold dosing

David Taylor is right that there is excessive polypharmacy in routine practice.[1] 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 sub-*BNF* doses as well as those who are untouched by a drug at the *BNF* maximum dose. In the case of antipsychotic drugs, Agid *et al*[2] have once again demonstrated that response to these drugs is related to the measured blockade of striatal receptors. As I suggested in my paper 12 years ago,[3] this allows the clinician to quickly and accurately judge the sensitivity of an individual patient to antipsychotic treatment by increasing the dose rapidly to the point at which extra-pyramidal side-effects are just discernible – and then waiting for a response. Following this threshold dosage scheme has led me to occasionally use a much wider range of doses than the *BNF* limits allow. For example, I have prescribed risperidone in schizophrenia with good effect at as little as 0.5 mg per day and as much as 32 mg per day, a 64-fold dose range. Although those who practise acute adult psychiatry often observe

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.

1 Taylor D. Antipsychotic polypharmacy – confusion reigns. *Psychiatrist* 2010; **34**: 41–3.

2 Agid O, Mamo D, Ginovart N, Vitcu I, Wilson AA, Zipursky RB, et al. Striatal vs extrastriatal dopamine D2 receptors in antipsychotic response – a double-blind PET study in schizophrenia. *Neuropsychopharmacology* 2006; **32**: 1209–15.

3 Searle GF. Optimising neuroleptic treatment for psychotic illness. *Psychiatr Bull* 1998; **22**: 548–51.

Geoffrey F. Searle is Consultant Psychiatrist, Dorset Healthcare NHS Foundation Trust, UK, email: geoff.searle@dhft.nhs.uk

doi: 10.1192/pb.34.6.259b

The importance of early and accurate diagnosis

The excellent article by Chan & Sireling[1] 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.

1 Chan C, Sireling L. 'I want to be bipolar' . . . a new phenomenon. *Psychiatrist* 2010; **34**: 103–5.

2 Zimmerman M. Is underdiagnosis the main pitfall in diagnosing bipolar disorder? No. *BMJ* 2010; **340**: c855.

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

4 Craddock N, Antebi D, Attenburrow MJ, Bailey A, Carson A, Cowen P, et al. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.

5 Smith DJ, Forty L, Russell E, Caesar S, Walters J, Cooper C, et al. Sub-threshold manic symptoms in recurrent major depressive disorder are a marker for poor outcome. *Acta Psychiatr Scand* 2009; **119**: 325–9.

Nick Craddock is Professor of Psychiatry, **Ian Jones** is Senior Lecturer in Perinatal Psychiatry and **Daniel J. Smith** is Senior Lecturer in Psychiatry, Department of Psychological Medicine and Neurology, School of Medicine, Cardiff University, UK, email: craddockn@cardiff.ac.uk

doi: 10.1192/pb.34.6.260

The suggested obligation to declare mental health issues to employer

I enjoyed Chan & Sireling's article[1] 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.

1 Chan C, Sireling L. 'I want to be bipolar' . . . a new phenomenon. *Psychiatrist* 2010; **34**: 103–5.

Clive H. Morgan is Occupational Physician, Cardiff, UK, email: chmorgan@doctors.org.uk

doi: 10.1192/pb.34.6.260a

Narrative triad and philosophy

Wallang[1] 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