faith and join me as a fellow God-less person, where will the guidance come from?

It appears that the inequality of power in the doctor–patient relationship has been forgotten in the heat of this debate. God help me and my fellow confused brethren. It looks like we have been hit for six at this boundary.

Declaration of interest

S.P.S is a member of the Royal College of Psychiatrists' Special Committee for Professional Practice and Ethics and a past member of the College's Ethics Committee.

1 Poole R/Cook CCH. Praying with a patient constitutes a breach of professional boundaries in psychiatric practice (debate). *Br J Psychiatry* 2011; **199**: 94–8.

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The debate between Professors Poole and Cook[1] appears to ignore the fact that spirituality, transcendency and individual religious beliefs expressed in prayer are historically and culturally bound to the social institution of organised religion: the first estate. Neither author acknowledges how the sociology of religion and its place in our society affects whether prayer should be shared between doctor and patient. The Christian religion has been firmly bound to the functioning of organised Western society for well over a thousand years. Consideration of the spiritual needs of patients has been part of holistic care models for decades and is present in the delivery of individualised care plans in most mental health services. However, prayer in day-to-day life does not have an individual identity that is divorced from structured religion. There is a potent social boundary here and it should not be crossed, for sociocultural reasons as well as individual professional ethics.

Poole focuses on the individual boundaries that are appropriate in the doctor–patient relationship, but we have social boundaries based on our religious history that have resulted in our modern social institutions having a broad secular base. When in the UK in 2011, religious assassination of police officers occurs within 'the single-faith Christian tradition', when football managers receive bullets in the post because of their particular Christian tradition, when the UK still has regions where religion is more about the fire in the belly and less about the angst between the ears, less 'happy clappy' and more 'happy slappy', it seems a little naive of Cook to view prayer as a therapeutic tool that can exclude the history of Christianity in this country and the challenges this may pose.

Cook's arguments emphasise the individual's connection to the Divine through prayer and the potential benefits this may bring. Historically, this is the argument of the 'dissenter', the evangelical Protestant tradition which is a rich faith that can deliver spiritual fulfilment, as can all the branches of the Christian church that exist in the UK today. But again historically, prayer is not just about an individual's spiritual needs and fulfilment. For St Augustine and St Patrick and onwards, it is also a tool of the missionary for conversion. The form of words used, the rituals and the rites of prayer have an uncomfortable history of conflict and even the unstructured prayer within a nonconformist 'free church' comes with a history of struggle.

Within my own psychiatric service, I am happy to say that we can allow everyone the freedom to pray and express their religion as they wish, a right that has emerged from the religious history of the British Isles. I am fortunate in having a specialised team of professionals with decades of training and expertise in meeting and fulfilling the spirituality of our service users. I turn to their wisdom and guidance often when prayer and religious needs present with mental health problems. We call them the hospital chaplains. I don't pray with the patients. They don't give depot injections. It works.

1 Poole R/Cook CCH. Praying with a patient constitutes a breach of professional boundaries in psychiatric practice (debate). *Br J Psychiatry* 2011; **199**: 94–8.

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Author's reply: I am grateful to Dr Davies for highlighting the importance of faith and belief in psychiatry. Atheism, materialism and biological determinism are as much belief systems as are religions. Because of a mismatch between systems of belief, it will often be inappropriate for clinicians to pray with patients. But what about prayer in contexts where faith and belief are shared? In faith-based organisations, in faith communities and in other contexts where doctor and patient are brought together knowing that they share the same belief system, 'praying with a patient' takes on a different connotation. The psychiatrist who prays with a patient in such contexts should still be able to justify their reasons for thinking that this would be helpful, and their reasons for expecting that it would do no harm, but I do not see why it should automatically be excluded.

Pace Dr Haley, I do not view prayer as a therapeutic tool that 'can exclude the history of Christianity in this country and the challenges this may pose'. In some parts of the UK, sectarianism is such that differences between some 'Christian' groups are greater than those between people from completely different faith traditions. Naive attempts to pray across these divides, in the clinical context, are ill advised. Haley describes my view of prayer as a means of 'the individual's connection to the Divine'. I limited prayer to being defined as 'conversation with God' only because this appeared to be the understanding of prayer that was causing concern. This approach to prayer is not associated preferentially with the Protestant or dissenting tradition, and is encountered in the writings of Catholic saints such as Ignatius Loyola and Teresa of Avila. The writings of Ignatius and Teresa, among others, now unite many Christians from different spiritual traditions (e.g. Catholic and Protestant).

The idea that spiritual and pharmacological treatments are analogous, and that they should be dealt with in completely separate departments, may have some attraction to Dr Haley. However, I am frequently approached by service users who find this kind of fragmentation of their care to be unhelpful and unacceptable. We do not accept separation of the psychological from other aspects of well-being. Similarly, I do not see why prayer should be excluded.

A position statement on spirituality and religion in psychiatry has recently been published by the College.[1] Although this statement does not explicitly address Dr Sarkar's concerns about praying with patients, it provides guidance that should be very helpful in avoiding breaches of professional boundaries in clinical practice. I think that the situations in which praying with a patient represents as serious a breach of professional boundaries as preaching to a patient will usually be because they are just that – preaching (albeit under the pretext of prayer). I find this just

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as unacceptable as those situations encountered by service users who feel that they have been 'preached at' by their atheist psychiatrist.

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C.C.H.C. is in receipt of a grant from the Guild of Health and is an Anglican priest. He is currently Chair of the Spirituality and Psychiatry Special Interest Group (SPSIG) at the Royal College of Psychiatrists. The views expressed in this article are his own.

1 Cook CCH. *Recommendations for Psychiatrists on Spirituality and Religion* (Position Statement PS03/2011). Royal College of Psychiatrists, 2011.

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Author's reply: Drs Haley, Davies and Sarkar raise issues concerning religion, spirituality and clinical practice beyond the narrow question of prayer.

I am grateful to Dr Haley for setting a broader sociopolitical context. I concur with the points he makes, which underline the fact that this debate is concerned with tangible realities, not abstract differences of belief.

Dr Davies uses three rhetorical devices that have been recurrently utilised by 'the other side' in the broad debate. First, he argues on the basis of the fundamental philosophical fallacy of a category error. Religious faith, ethical codes, cognitive therapy and, for that matter, science may all in some way involve belief, but they are not comparable, competing belief systems. They are fundamentally dissimilar. Religious faith is concerned with transcendent, immutable truths that are outside of the realm of reason or evidence. This does not invalidate faith, but it is dissimilar to other types of belief.

Second, Davies assumes that my position is primarily determined by my atheism. However, many professionals with a strong religious faith agree with me,[1] because the debate is concerned with professional boundaries, not personal convictions. In the debate with Professor Cook, I mention my participation in a meeting on 'intolerant secularism' at the Royal College of Psychiatrists in October 2010.[2] Professor Andrew Sims, Lord Carey and Andrea Minichiello Williams had hoped to persuade the College's Spirituality and Psychiatry Special Interest Group (SPSIG) to campaign for the right of professionals to express disapproval of homosexual lifestyles in their work, and for a distinctively Christian orientation to public and professional life in general. The SPSIG showed no inclination to support this, which does not suggest that it is only atheists who are troubled by the implications of some of the realities of integrating religion into clinical practice.

Finally, Davies leaps to the suggestion that my stance is associated with an attachment to biological determinism and overattachment to a particular theoretical stance within psychiatry. There is no logical link. Personally, I reject biological determinism and theoretical fanaticism because, in my opinion, they are based on bad science. I cannot see how religious belief (or non-belief) is relevant.

Dr Sarkar has published extensively on boundary violations, and I am pleased that he agrees with me that the issues concerning prayer and religious practice are not intrinsically different from other boundary issues.

In calling for the College to commission a working group, he echoes a similar suggestion published in *The Psychiatrist* in October 2010.[3] This was addressed to the immediate past-President of the College, who did not respond. Instead, a position paper, written by Professor Cook on behalf of the SPSIG, has quietly passed through the College committee machinery, and is now Royal College of Psychiatrists policy.[4]

On the one hand, the College's position paper[4] emphasises that proselytisation is unacceptable, which is welcome. On the other hand, none of the key boundary issues is addressed, a scientifically controversial position has been adopted with regard to evidence, and the official position of British organised psychiatry is that 'an understanding of religion and spirituality and their relationship to the diagnosis, aetiology and treatment of psychiatric disorders should be considered as essential components of both psychiatric training and continuing professional development' (p. 8). This is already having an impact on services. For example, Mersey Care NHS Trust is holding a conference to promote integration of spirituality into psychiatric care[5] on the basis that this is a College recommendation.

This debate has teeth, and we are already set on a course that I find extremely worrying. Those who agree with me on the importance of boundaries should make their voices heard now, as we may soon find ourselves in a very difficult place.

Declaration of interest

R.P. is an atheist.

1 Poole R. Higgo R, Strong G, Kennedy G, Ruben S, Barnes R, et al. Religion, psychiatry and professional boundaries. *Psychiatr Bull* 2008; **32**: 356–7.

2 Poole R. Secularism as a professional boundary in psychiatry. Spirituality and Psychiatry Special Interest Group Newsletter, no. 30, December 2010. (http://www.rcpsych.ac.uk/members/specialinterestgroups/spirituality/publicationsarchive/newsletter30.aspx).

3 Poole R, Higgo R. Psychiatry, religion and spirituality: a way forward. *Psychiatrist* 2010; **34**: 452–3.

4 Cook CCH. *Recommendations for Psychiatrists on Spirituality and Religion* (Position Statement PS03/2011). Royal College of Psychiatrists, 2011.

5 Mersey Care NHS Trust. Living in Hope: Spirituality and Practice in Mental Health Care. Mersey Care NHS Trust, 2011 (http://www.merseycare.nhs.uk/Library/Living_in_Hope/Living%20in%20Hope%20Flyer.pdf).

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Clozapine and bladder control

Harrison-Woolrych *et al*[1] present an interesting exploration of the association between nocturnal enuresis and clozapine (and other atypical antipsychotic) use. They report a significantly higher rate of nocturnal enuresis with clozapine use than with the other antipsychotics assessed in the study. This suggests a possible mechanism specific to clozapine in causation of this event.

Clozapine has been shown to adversely influence bladder control.[2–4] Various putative mechanisms to explain this observation include retention overflow consequent to inhibition of detrusor contraction due to anticholinergic action, reduced sphincter tone due to anti-adrenergic activity,[5] sedation and lowering of the seizure threshold,[6] drug-induced diabetes mellitus resulting in polyuria[6] and drug-induced diabetes insipidus.[7] Preclinical studies have demonstrated clozapine's effects on urodynamics, with a centrally regulated reduction in activity of the external urethral sphincter.[8]

Bladder deregulation among patients with schizophrenia was described by Kraepelin, who postulated it to be an accompaniment of the ongoing 'dementia' process, as evident by the

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