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

Declaration of interest

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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