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Praying with patients: belief, faith and boundary conditions

The debate between Professors Poole and Cook[1] focuses on what might be termed an epiphenomenon of faith. Poole in particular avoids any interpretation of the values he espouses for psychiatry as a belief system. In my view, this is fundamentally erroneous. The set of principles avowed by Poole find their origin in both Greek philosophy and in the Judaeo-Christian system of ethics. These are essentially systems of beliefs and in that sense, particularly for the secularist, are no different from a religious doctrine. In considering this issue it is impossible to start from a position that does not invoke shared belief, and that personal position of belief that is termed faith. I would assume that Poole would take the position that psychiatrists should practise using 'evidence-based' techniques and therapies. If one is to take cognitive therapies as an example of this, problems of belief immediately arise, as a primary aim is to change patients' erroneous and maladaptive belief systems. I would ask to what belief system should one change them? Should it reflect the psychiatrist's beliefs, the patient's community and cultural beliefs or something else?

A common example of the integral involvement of belief with therapy is the Alcoholics Anonymous programme. Would Poole refer a patient to this as part of his treatment or would he regard it as the unethical imposition of a belief in a 'higher power'? More broadly, in psychotherapy there exist a number of theoretical belief systems which have some level of evidence in their favour, particularly in the belief of their proponents. Having observed successful psychotherapists with a variety of backgrounds, I am tempted to say that their theories support their therapies by providing a belief structure that supports their faith that treatment can be of benefit when progress is slow, and that this faith in the future is a key element in their success. If the argument that faith is a fundamental part of the treatment process is accepted, and I would argue that, while this is particularly so for psychiatry it also applies in other areas of medicine, then the major question is the degree to which it is synonymous with belief. If faith provides strength and purpose to both psychiatrist and patient and can be asserted a positive asset without much criticism, belief can be considered as being more problematic and potentially dangerous. In a broad sense, depressive disorders may be considered to reflect a deficit of faith, whereas mania and psychoses reflect an excess of belief. This may apply to therapists as much as patients. Doctors with a high level of belief in particular therapeutic modalities have a history of causing harm as well as good. An uncritical belief in materialism and biological determinism can cause as many, if not more, problems than a Cartesian view.

It seems that the divergence of opinion between Professors Poole and Cook arises not from the potential for good but the potential for harm. Both are men of belief and even if their beliefs are considered existentially 'good', assertion that an atheistic belief system is the only basis for treatment is potentially treacherous if imposed on a patient. Even our present evidence-based structure is predicated on a belief about an organised and regular universe. Speaking as a slightly irreverent theist, I would argue that the question posed in their debate does not have a single correct answer. In judging the most appropriate manner of dealing with a particular situation, the important thing is to consider the principles to be applied. There are some behaviours that would be generally agreed to be inappropriate and damaging without recourse to argument, but others may be appropriate only in certain situations. My recommendation would be that there should not be an overall statement or conclusion that the use of prayer in therapy is either right or wrong. It would have to be considered as an uncommon and unusual part of a therapeutic programme which can only be justified in very particular circumstances. It should be accepted that there are occasions when its use is appropriate and therapeutic. Nonetheless, because of its controversial nature, and the possibility of abuse by both therapist and patient, prayer should be considered an unusual therapeutic modality. The therapist should therefore be prepared to justify its use on a case-by-case basis and be able to demonstrate that no harm was likely to arise.

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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I read with interest the debate between Professors Poole and Cook in this month's journal.[1] I have been following the exchanges on these two highly polarised positions in the College for quite a while. Not wishing to take a position on the acceptability of praying with patients, I find myself astounded by the inability in some quarters to accept or even recognise the fact that praying with a patient may be as serious as preaching to a patient. Boundaries are set in professional practice to protect both the patient and the doctor. Would a physician feel easy taking stock market tips from their Wall Street banker patient? Or accepting racing tips from their very informed bookmaker patient? How about setting up a business venture with a venture capitalist patient with significant 'daddy issues'?

Would it be appropriate for a doctor to tell his patient that his Church offers the best chance of redemption, or that she should divorce her cheating husband because this is what is perpetuating her depression? These are all hypothetical examples of boundary violations and are rightly proscribed in all codes of ethics worldwide. In deciding harm in a doctor–patient interaction, surely it is for the doctor to decide where the boundary lies and then to maintain it. The sexual boundary is not the only boundary we should be taught not to cross, although arguably it ought to be the first.

The fact the College has given so many column inches to the issue means that, even if there are no cogent arguments, this matter is something that has immense political clout. Matters are not being helped by letting this issue simmer. We need decisive action. Why can't the College commission a working group representing all sides of this debate and issue a consensus statement to help believers and non-believers equally to navigate what appears not so much a moral conundrum as political posturing? When I am hauled before the GMC by a patient for inviting him (and encouraging with his 'consent') to give up his

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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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