BJPsych | The British Journal of Psychiatry (2014) 205, 248–249

Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

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The clinical implications of church attendance and suicide

Kleiman and Lui[1] have conducted a respectable study that suggests that people in the USA who attend church frequently are less likely to die by suicide than other people. Although the finding is interesting, it is not surprising. It is congruent with Durkheim's 19th-century theory about the role of anomie.

Chris Cook,[2] in a moderately worded editorial, suggests that this finding has implications for British clinical practice. In my opinion, this is profoundly misguided.

First, the finding is specific to the USA, a country with exceptionally high rates of religious involvement, where church attendance and social respectability are intimately linked. The social meaning of church attendance is completely different in the UK. Although I guess that a UK study would be likely to yield similar findings, scientific rigour demands that this cannot be assumed.

Second, Cook says that the finding merits discussion with patients at risk of suicide. It is far from clear what he means by this. I doubt if he means to imply that psychiatrists should explain to patients abstracted epidemiological factors that might affect their actuarial risk of suicide.

It is always important to understand the social and emotional supports that tend to protect patients from taking their own lives. This is a matter of proper assessment. However, there are no grounds for psychiatrists to advocate church attendance to individuals who consult them. Kleiman and Lui have identified a demographic factor that appears to be protective. They have not evaluated an intervention. Even if they had, in the UK setting proselytising of religion by medical practitioners is a serious breach of professional boundaries.

It is difficult to identify the line between evangelisation and ostensibly more benign types of religious intervention (for example, suggesting that churchgoers might attend more frequently), which illustrates why boundaries need to be clear rather than blurred. It is hard to understand how a discussion of churchgoing as part of a psychiatric intervention could avoid promotion of a particular religious viewpoint. With regard to protection of patients, Cook cites the College Position Statement[3] that he wrote: 'much is properly left to the judgement of the psychiatrist'. Everything we have learnt about boundary violations over the past 20 years tells us that this is an unreliable way of protecting patients, which is why some of us strongly disagree with the College Position Statement.

Fortunately, Chris Cook and I are not simply trapped in a cycle of disagreement.[4] With colleagues from Bangor and Durham, we have been developing research to explore the boundary issues over religion and spirituality. Until that work is completed, and possibly thereafter, it is important to be clear that there is a serious difference of opinion over bringing religion into the clinical setting. This is determined by factors other than religious faith, or the lack of it.

1 Kleiman EM, Liu RT. Prospective prediction of suicide in a nationally representative sample: religious service attendance as a protective factor. *Br J Psychiatry* 2014; **204**: 262–6.

2 Cook CCH. Suicide and religion. *Br J Psychiatry* 2014; **204**: 254–5.

3 Cook CCH. *Recommendations for Psychiatrists on Spirituality and Religion* (Position Statement PS03/2013). Royal College of Psychiatrists, 2013.

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

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doi: 10.1192/bjp.205.3.248

Author's reply: I am interested, although not surprised, to hear that Professor Poole thinks that my suggestion that a significant prospective study of religion and completed suicide[1] might have implications for British clinical practice is 'profoundly misguided'. It is true that the study in question emanates from the USA, not the UK, but Poole concedes that a study undertaken here 'would be likely to yield similar findings'. Nor did I have space to expand in any detail upon exactly how the matters in question might be discussed with patients, but I did cite Koenig *et al*[2] as urging caution with regard to any religious/spiritual interventions that might be contemplated. I am therefore surprised that Poole found necessary to emphasise the dangers of proselytism, as though I might have been opening the door to this, especially given that he notes that I wrote the College Position Statement that clearly states 'Psychiatrists should not use their professional position for proselytising or undermining faith'.[3]

Poole, in turn, does not expand upon his side of the 'serious difference of opinion' between us over 'bringing religion into the clinical setting'. Presumably, he does not mean that religion may never under any circumstances be discussed with patients. But if we have reason to believe that religion might be one factor which influences the likelihood of completed suicide, is it not, as I suggested, 'wise to take religion into account when assessing suicidal risk'? Some patients will raise the subject themselves and this study suggests that we should at least not discourage them from doing so. In other cases, should we not enquire about spiritual/religious beliefs that might contribute to a fuller understanding of a patient's self-understanding?

My chaplaincy colleagues working in NHS mental health services tell me that 'Will I go to hell if I kill myself?' is one of the questions most frequently asked. Might referral to a suitably qualified mental health chaplain sometimes be a helpful intervention for some religious patients who have not previously felt able to discuss the matter with anyone else? And why do we not have more research on how patients deal with this question, and how we might help them to deal with it in a constructive way?

I certainly do think that the study by Kleiman and Lui has implications for British clinical practice. I think that we should be debating – in this journal and elsewhere – exactly what these implications are, and conducting research in order to provide an evidence base that will better define them. Happily, as Poole has indicated, he and I do at least find common ground for research which might clarify some of the boundary issues. But boundaries must not be created that will prevent us from sensitively and respectfully discussing spirituality and religion with our patients when it is clinically relevant to do so.

https://doi.org/10.1192/bjp.205.3.248a Published online by Cambridge University Press

1 Kleiman EM, Liu RT. Prospective prediction of suicide in a nationally representative sample: religious service attendance as a protective factor. *Br J Psychiatry* 2014; **204**: 262–6.

2 Koenig HG, King DE, Carson VB. *Handbook of Religion and Health* (2nd edn). Oxford University Press, 2012.

3 Cook CCH. *Recommendations for Psychiatrists on Spirituality and Religion* (Position Statement PS03/2013). Royal College of Psychiatrists, 2013.

Christopher C. H. Cook, Professor, Durham University, UK.

doi: 10.1192/bjp.205.3.248a

Retraction

Epigenetic traces of childhood maltreatment in peripheral blood: a new strategy to explore gene–environment interactions. *BJP*, **204**, 3–5. We wish to retract this editorial as it was partly based on an article that has been retracted (Childhood maltreatment and methylation of the glucocorticoid receptor gene *NR3C1*in bipolar disorder. *BJP*, **204**, 30–35).

R. Uher, I. Weaver

doi: 10.1192/bjp.205.3.249

https://doi.org/10.1192/bjp.205.3.248a Published online by Cambridge University Press