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.

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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

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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**

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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