benefit is beyond objective scientific measurement. Despite this the World Health Organization clearly stresses the value of concepts such as faith, hope and compassion in the healing process from any illness (World Health Organization, 1998). Religions based on strong faith and beliefs have evolved and persisted over centuries, and people do turn to religion when coping with life stressors (Pargament, 1997). If this spiritual craving is to be utilised for promoting better mental health and holistic care, stronger collaboration between psychiatrists and religious professionals is important (Rattray, 2002; Dein, 2004).

It is encouraging to note, despite the constant suspicion between psychiatry and religion (Bhugra, 1997), the incorporation of religious principles based on faith into treatment strategies especially in psychotherapy, and this should be welcomed. Christian principles have been effective in cognitive therapy and help to improve spiritual well-being (Lipsker & Oordt, 1990; Hawkins *et al*, 1999). The third-wave cognitive–behavioural therapies such as dialectical behavioural therapy, acceptance and commitment therapy, and mindfulness-based cognitive therapy are closer to religious belief systems and practices (Andersson & Asmundson, 2006). Zen Buddhist ideas have been woven into the fabric of dialectical behavioural therapy (Robins, 2002). Acceptance and commitment therapy connects with the Buddhist philosophy and practices in accepting the four noble truths and the eight-fold noble path (Hayes, 2002). The mindfulness-based therapies have stronger associations with Buddhism, its empirical database and its application for stress reduction, health promotion and improved personal functioning (Robins, 2002). This gives an early hope that mainstream psychiatry and religions with strong faith and belief systems can work together to ameliorate psychopathology and improve the well-being of patients.

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Authors' reply: Dr Dein argues that our editorial (Leavey & King, 2007) on collaboration between psychiatry and religion is biased because we failed to discuss what religion has to offer psychiatry. We feel that many faith-based organisations and their clergy contribute much towards human welfare and healing and we would have been happy to discuss this in more detail. However, the focus of the paper was to highlight the potential barriers and dangers arising from partnerships between religion and psychiatry. Our own research with clergy has helped clarify some of these issues (Leavey, 2007; Leavey *et al*, 2007). Thus, clergy of all sorts find themselves perplexed by people with mental health problems and appear to be generally untrained and unsupported by both their own organisations and by mental health services. Although some clergy are able to distinguish religious from psychiatric phenomena, others are not. Dr Dein's reference to his study of lay members of a White Pentecostal congregation does not relate to this issue. Moreover, we did not suggest that biomedical and spiritual models of illness necessarily conflict but in some instances, and among some religious groups, they do. To treat faith communities and their clergy as homogeneous entities is somewhat simplistic. Dr Dein advocates a more holistic approach in medical care, but does he intend this to extend to exorcism and deliverance rituals? This question touches on the central concern of our editorial. We like to talk about inclusivity in psychiatry but it becomes more problematic when clinicians find themselves encouraged to engage with some of the less mainstream aspects of spirituality and religion.

Although we agree with Dr Masil that religion and spirituality, or in his own terms 'faith', should be of greater interest to psychiatric practice and research, we cannot agree that 'its benefit is beyond objective scientific measurement'. Although problems of definition and measurement exist, many health studies of this kind have been undertaken, particularly in the USA where there is less hostility to research on spirituality and health than in the UK.

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