Correspondence

Lessons from sacred texts

Professor Cook has written a stimulating article on 'an important opportunity to engage psychiatry in a critical and constructive way with religious texts'.[1] He concentrates on evidence for schizophrenia, but possibly the contribution of sacred texts may be even more helpful in the case of depression. In addition to the unfortunate King Saul,[2] there are probably many accounts of depressed mood, but two examples stand out because the mechanism of the relief of the depression is apparent in the texts.

Job in the Old Testament and Arjuna in the Bhagavad Gita, which is a part of the Mahabharata (the Hindu equivalent of the Bible) both suffered from depression.[3,4] Job was depressed because the Lord had allowed Satan to have his children killed, his livestock driven off and his body to be covered with boils. He felt this was unjustified according to the current philosophy of retributive justice, so he was angry with God. Arjuna was depressed (and had a typical panic attack) because Krishna (the eighth avatar of the god Vishnu) told him to slaughter many of his relatives and mentors, and he was reluctant to take Krishna's order. Both Job and Arjuna have lengthy dialogues with their gods, who express their majesty and omnipotence in marvellous poetry. These displays of dominance have some effect, but final and complete submission is not achieved in either case until the god shows himself in person. Submission is then unqualified in both cases, and both then recover from their depressions and lead successful lives. We concluded from these examples that whereas belief in god may relieve anxiety about the meaning of life and what happens after death, it requires submission to god to relieve depression.[4] Those who believe but do not submit are liable to spiritual struggles, as pointed out by C. S. Lewis in *The of Problem of Pain*.[5]

The Book of Job is of particular interest to psychiatry because the story can be read in two ways. The usual interpretation is that Job suffers from a reactive depression, understandable considering the degree of his misfortune. The other is that he has a psychotic depression and his misfortunes are delusional. Favouring the latter is the fact that his three comforters do not offer condolences on the deaths of his children, and that finally his children are restored to him in the original proportions (seven sons and three daughters), which is more likely to be due to the loss of a delusion than to further childbearing effort on the part of Job and his wife. If the latter is the case, it shows how a delusion may appear real not only to the patient, but to generations of biblical scholars who have read of Job's situation.

The lessons from these extracts from scripture are three-fold. First, that those treating depressed believers should ensure that the patient has made a total submission to the will of God. Second, those studying the relation of mental health to religion should construct a scale which measures the degree of submission *v.* rebellion, or 'my will' *v.* 'Thy will'. Third, those treating depressed agnostics should look for a secular equivalent to joyous total surrender to God.

1 Cook CCH. Psychiatry in scripture: sacred texts and psychopathology. *Psychiatrist* 2012; **36**: 225–9.

2 van Praag HM. The downfall of King Saul: the neurobiological consequences of losing hope. *Judaism* 1986; **35**: 414–28.

3 Kahn J. *Job's Illness: Loss, Grief and Integration. A Psychological Interpretation*. Gaskell, 1986.

4 Price JS, Gardner R Jr. Does submission to a deity relieve depression? Illustrations from the Book of Job and the Bhagavad Gita. *Philos Papers Rev* 2009; **1**: 17–31.

5 Lewis CS. *The Problem of Pain*. Collier Books, 1940.

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Additional influences on provision of mental health services

Commentary on the ageing population is focused on increasing numbers.[1] Less often mentioned, but the critical factor, is the declining number in age groups traditionally providing informal care. In the European Union there are four people of 'working age' for each person over 65 years old and within 50 years there will be two.[2] Add geographical movement of younger age groups away from parents, changing lifestyle and changing roles of women, who provide the majority of informal care, and this challenge is both multiplied and underestimated. If informal care declines (currently providing £8 billion of care per annum for dementia alone in the UK), this will fall to the state. Here, the problem is not the attitude of younger people towards older generations but their availability to provide care.

Age discrimination legislation is a welcome step towards reducing inequalities of access to care, although we have yet to see in which direction this driver takes us. It is naive to trust that legislation will inevitably solve these problems and there is justified concern that hidden indirect discrimination could drive us in the wrong direction.[3] The law of unintended consequences is well known and is the reason why professional position statements and guidance remain important. Access to services is not sufficient to ensure equality.

Finally, there is need to address an increasing mental health workforce gap,[3,4] where the greatest need for specialist expansion is in old age psychiatry,[5] yet it has the highest vacancy rate in specialist training, and to redress previous policy discrimination against older people by positive action.[3]

The Welsh politician Aneurin Bevan described priority as the language of politics and so today's health and social care language is older people. Now is the time for a coordinated policy from government and professional bodies that makes explicit this priority because we cannot complacently wait for natural events to bring solutions. This message needs to be clear. Although hope is invested in ageing bringing more years of life in good health, and that may happen, current data are showing the opposite.[2]

1 Connolly M. Futurology and mental health services: are we ready for the demographic transition? *Psychiatrist* 2012; **36**: 161–4.

2 Fahy N, Mckee M, Busse R, Grundy E. How to meet the challenge of ageing populations. *BMJ* 2011; **342**: d3815.

3 Anderson D. Age discrimination in mental health services needs to be understood. *Psychiatrist* 2011; **35**: 1–4.

4 Draper B, Anderson D. The baby boomers are already here – but do we have sufficient workforce in old age psychiatry? *Int Psychogeriatrics* 2010; **22**: 947–9.

5 Centre for Workforce Intelligence. *Recommendation for Medical Specialty Training 2011*. CFWI, 2010.

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Are the results only limited by ethnicity?

We found the article by Choudhry *et al*[1] a very interesting read. Although retrospective, given a good sample size and appropriate period of follow up, the results are informative and useful. We applaud the effort to identify the subgroup of opiate-free patients who could benefit the most from naltrexone for relapse prevention.

It is striking that the study population had Asian men in such a high proportion, which certainly makes the sample atypical. The authors have mentioned the associated factors predicting a favourable outcome for this group. Could we request the authors to comment on the possible differences in naltrexone metabolism which might influence outcomes? There is now evidence to support the fact that pharmacogenetic characteristics of Asian population are associated with improved biobehavioural and clinical response to naltrexone.[2]

The results might have further been affected by personality characteristics within the study group. This, too, would have been valuable information.

We also wondered why the naltrexone challenge was only done for 80.3% of the study sample. Information about how many failed the challenge would be useful as focusing only on the ones who were successful again selects the highly motivated group, which may not be representative. Finally, we wondered whether the authors might want to comment on the wider context given that the results have shown again that the retention rates in naltrexone treatment are not very high. It is worth noting that even if retained in treatment, efficacy of oral naltrexone in relapse prevention for opioid use is not significant[3] compared with placebo.

1 Chaudhry ZA, Sultan J, Alam F. Predictors for retention in treatment with a UK community-based naltrexone programme for opioid dependence. *Psychiatrist* 2012; **36**: 218–24.

2 Ray LA, Bujarski S, Chin PF, Miotto K. Pharmacogenetics of naltrexone in Asian Americans: a randomized placebo-controlled laboratory study. *Neuropsychopharmacol* 2012; **37**: 445–55.

3 Minozzi S, Amato L, Vecchi S, Davoli M, Kirchmayer U, Verster A. Oral naltrexone maintenance treatment for opioid dependence. *Cochrane Database Syst Rev* 2011; **4**: CD001333.

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