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’. 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, 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. 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 and their depressions and lead successful lives. We concluded from these examples that whereas belief in god may relieve anxiety and

Additional influences on provision of mental health services

Commentary on the ageing population is focused on increasing numbers. 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. 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 naïve 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. 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, where the greatest need for specialist expansion is in old age psychiatry, yet it has the highest vacancy rate in specialist training, and to redress previous policy discrimination against older people by positive action.

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.