1 Introduction: Key Concepts

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1. WHY THIS BOOK?

Patients facing illnesses may often use religion as a way to cope with the illness. What is problematic, however, is that sometimes symptoms have religious elements (e.g., delusion with religious content). However, clinicians involved in psychiatric care may have noticed that for patients with mental disorders, religion/spirituality *also* represents an important way of making sense of and coping with the stress that the illness causes. Despite these observations, clinicians often fail to inquire about the religious beliefs, practices, and experiences of patients, sometimes missing an opportunity to help relieve the suffering that psychiatric disorders cause. Some clinicians may have expertise in the religious aspects of psychiatric illness and are knowledgeable enough in this area to integrate it into their clinical practices; others may not know much about religion, may be reluctant to discuss issues related to it, and may completely avoid it in their encounters with patients. Thus, it is necessary to build a bridge between these two groups. This book tries to comprehensively and synthetically address such issues and seeks to give psychiatrists and other clinicians the tools they need to integrate religious and spiritual issues into their daily work with patients. A growing number of texts address religion, psychology, and psychiatry. The present book, however, seeks to give practical knowledge to clinicians who are not familiar with these issues and who may not a priori consider religion/spirituality when they take care of patients. To provide a foundation for the chapters to follow, this chapter briefly discusses definitions of key concepts in this area.

2. DEFINITIONS

There are many definitions for the words *religion* and *spirituality*. The scientific and theological communities are divided on how they define these terms.(1) In this book, the term *religion* is used to indicate specific behavioral, social, doctrinal, and denominational characteristics. In particular, it involves belief in a supernatural power or transcendent being, truth or ultimate reality, and the expression of such a belief in behavior and rituals.

Spirituality is concerned with the ultimate questions about life's meaning as it relates to the transcendent, which may or may not arise from formal religious traditions (but usually does). One may notice that spirituality's definition is more subjective, less measurable. From a clinical perspective, having a term that is broad and diffuse is good because this allows patients to define what it means for them. Using the language of spirituality helps to establish a dialogue with persons who may or may not consider themselves religious. From a research perspective, however, such lack of conceptual clarity is not permitted.

Some authors (2) distinguish *extrinsic* religion, that is, a means to nonsacred goals, such as increasing social contacts or attaining other external benefits, and *intrinsic* religion, that is, religion that is lived, internalized, and motivated for religion's sake, rather than for external benefits.

3. NEW PARADIGM

Religion is unique in the sense that it may involve beliefs that a supernatural being has influence on

how things are. Research on religion and mental health does not address the question of whether God exists. Rather, research on psychological processes involving religion is neutral with respect to the existence or nonexistence of God or any other supernatural being. In the context of care, clinicians should have the same attitude: Facing a patient addressing a religious issue, the question is not to determine whether it is true or false, but rather to consider it in terms of meaning, coping, and its relationship to current therapeutic goal(s). Addressing religion in the care of patients, one should recognize that religion involves multiple dimensions, for example, religious beliefs, religious affiliation, organized religious activity, "private" religiosity, religious commitment, religious experience, and religious coping i.e., religious behaviors or cognitions designed to help people adapt to difficult life situations.(3) A paradigm is needed to serve as a framework for research and patient care activity. Palouzian and Park(4) define a "multilevel interdisciplinary paradigm" as a framework that allows an accurate description of religious phenomena by recognizing "the value of data at multiple levels of analysis while making non-reductive assumptions concerning the values of spiritual and religious phenomena." As an example of the usefulness of this paradigm, Palouzian and Park describe the case of religious conversion, which can be examined both at a neuropsychological level and at a social-psychological level.

The multilevel interdisciplinary paradigm can accommodate subdisciplines of psychology, but also other domains such as evolutionary biology, neurosciences, anthropology, philosophy, other allied areas of science, and pastoral care.

Clinicians need to keep this paradigm in mind, because many disciplines may have something to offer depending on the specific clinical situations.

4. MODEL OF CARE

Psychiatric care often involves a multidisciplinary/multilevel model of care. The overarching paradigm that should be considered in the care of patients with psychiatric conditions is the bio-psycho-social model,(5) which aims at addressing the whole person. This model underscores the need to consider disorders from a holistic perspective, thus avoiding a reductionistic view that considers only biological (e.g., pharmacological treatments) or psychological aspects of the person. Appling this model includes integrating religion/spirituality into the social part of this model or, preferably, including this dimension in all three areas, thus approaching patients from a bio-psycho-social-religious/spiritual model. This is recommended because religion/spirituality affects social, psychological, and even biological aspects of human life, and all domains affect each other, including the spiritual.

5. PLACE OF RELIGION/SPIRITUALITY

Research suggests that religion/spirituality can be helpful for persons with physical disorders. For instance, outcomes of heart disease have been related to religious involvement.(6) This may be due to the relationship between religious beliefs and cardiovascular risk factors such as high blood pressure, cigarette smoking, and diet and to the stress-reducing effects of religious coping. Religion may also influence cancer incidence,(7) notably through dietary and health practices fostered by certain religious groups. The course and outcome of cancer may also be favorably influenced by religious involvement through improved health behaviors, but also by the use of religious coping that may instill hope and reduce anxiety.

In the field of psychiatry, partly for "historical" reasons, the general attitude toward religion has been ambivalent. Religious belief, practice, and experience have often been considered neurotic by mental health professionals, at least in the past. Religion offers a different way of viewing psychiatric illness that may conflict with that of psychiatrists. Evidence also exists showing that religion may offer help to patients with psychiatric conditions, particularly those with substance use disorders. This led to the implementation

of 12-step programs to facilitate the treatment of patients with alcohol or drug problems (see Chapter 9). More recently, religious coping has been shown to influence the outcomes of bereavement and major depressive disorders (see Chapter 8). Concerning patients with psychosis, the diagnosis of "mystical delusion" has hindered clinicians from recognizing the positive influences of religion.(8) However, recent research from Switzerland and other countries has documented the powerful benefits in terms of coping that religion/spirituality can have for psychotic patients.(9, 10)

Thus, although further research on this topic is greatly needed, growing evidence demonstrates that religion/spirituality is important for patients with psychiatric conditions and may be beneficial or detrimental to their illness. We hope that providing updated information to clinicians about the research in this area and describing sensible clinical applications will help to overcome the reluctance among clinicians to address these issues with patients. At a minimum, this book will make mental health professionals more aware of an important area of patients' lives that is rarely addressed in clinical settings.(11)

6. THE ROLE OF CLINICIANS

The role of the clinician is not an easy one. Clinicians involved in psychiatry have many reasons for their reluctance to address spiritual/religious issues with patients.

First, clinicians' own religious involvement (or lack thereof) may influence the value they place on religious/spiritual issues. We are generally less involved in religious activities than our patients are (12) and are thus less likely to be interested in discussing these issues.

Second, there is widespread lack of knowledge about how to address religion or spirituality in clinical practice. Psychiatric training rarely devotes much time to such issues, as described later in this book (see Chapter 22).

Third, as mentioned earlier, there has been historical conflict between psychiatry and religion. Some authors (Freud) have referred to religion as an "illusion," merely a neurotic defense against life's vicissitudes.(13) Antagonism remains today between clergy and psychiatrists, because their domains overlap and they often share the same "customers."

Fourth, some clinicians may fear that addressing issues pertaining to religion may represent walking into unknown territories, thus risking harm to patients. In some areas of the world (e.g., in Europe), clinicians may fear offending patients by bringing up such issues, which patients may not wish to address.

Fifth, psychiatrists may feel uncomfortable being involved in a social/care network in which roles are not well defined between clinicians, chaplains, and clergy. This is likely to be the case in areas where clinicians and clergy have not worked together before.

A common factor at the root of most of these concerns is a lack of knowledge and tools, which this book is intended to help correct.

7. WHO SHOULD READ THIS BOOK?

This book seeks to give knowledge and practical tools to clinicians taking care of patients with psychiatric disorders. The goal is to cover issues pertaining to psychiatry and religion/spirituality in a way likely to engage and maintain the interest of readers who may not be particularly interested in religion. There is a large gap between those who are interested in religion, consider it when treating their patients, and are drawn by books or papers on this topic, and those who have little or no interest in religion, do not broach this topic in clinical settings, and feel reluctant to "waste time" learning about this topic. The present text is designed to fill this gap by providing concise, detailed information that will help clinicians consider integrating spirituality into the care of patients, even if the clinician is not religious.

This book is written by psychiatrists, psychologists, theologians, and pastoral care experts and will be of use to all clinicians treating patients with psychiatric disorders.

8. WHAT THIS BOOK IS NOT

First, this book does not address claims about the supernatural (i.e., whether God exists), whether any particular religion is "true" or "false," or whether one religious tradition is healthier than another. Rather, religion is considered to be an important way of shaping human experience in the context of psychiatric disorders.

Second, this book is not a textbook on the psychology or sociology of religion. We do not emphasize concepts, definitions, or particular models of care. This has been addressed elsewhere.(3, 4) Rather, this book is focused on issues that are directly related to patient care.

9. CONTENT OF THE BOOK

This book presents (1) an overview of theoretical (2) a systematic description of specific psychiatric conditions and their relationship to religion/spirituality, and (3) psychosocial and curricular aspects of religion/spirituality in psychiatry, with an emphasis on clinical applications throughout.

First, we consider historical and theological factors relevant for clinicians, neuropsychiatric aspects of religion/spirituality, and a brief commentary on the Bible from a particular view regarding its "psychological" aspects.

Second, we discuss specific psychiatric disorders to provide a comprehensive update on recent research. This will include "Axis I" disorders, but also conditions such as identity disorders, religious delusions, and personality disorders. These chapters have been written from a multicultural perspective. Spiritual assessment will also be described.

Third, authors will address treatment in the community, which may involve coordination between clinicians, chaplains, and clergy. We include here three examples of treatment approaches involving Christian, Muslim, and Buddhist principles. Including these chapters does not mean that we share or endorse all the views presented here. The goal is to provide the reader with information on various religious ways of approaching the psychological needs of patients. As clinicians, we are confronted with patients who wish to engage in these treatments. Therefore, although many of us may not adopt such approaches, we should at least have knowledge about them so that we can advise patients about their merit. Finally, an overview is presented on what needs to be taught in psychiatric residency programs about religion/spirituality to enhance the competency of future psychiatrists (and other clinicians) in this area.

Thus, we welcome you on an informative and fascinating journey into a critical area of our patients' lives that may represent a powerful resource for healing or be intricately interwoven with psychopathology, requiring both professional psychiatric care and pastoral care to resolve and disentangle.

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2 Spirituality and the Care of Madness: Historical Considerations

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SUMMARY

Spiritual and religious issues are sometimes neglected or misrepresented in histories of psychiatry. This chapter outlines a historical approach to understanding how spiritual and religious ideas are expressed in medical and religious writings dealing with madness. Sacred writings, inscriptions, ancient architecture, commentaries, pastoral letters, medical texts, and religious and spiritual publications all reflect a range of ideas about the role of spirituality and the supernatural in the etiology and treatment of mental disorders. Beginning with ancient pagan and Jewish writings, and continuing with the writings of the early church fathers, medieval physicians and Puritan divines, the chapter describes ways in which spirituality influenced the care of emotionally distressed patients. The chapter discusses the ways in which both naturalistic and supernaturalistic views of madness are reflected in practice in the roots of modern medicine in the eighteenth century and how psychiatrists and others dealt with religious issues during the more secular nineteenth and twentieth centuries. The chapter argues against the position that there has been steady progression from a supernatural to a naturalistic understanding of madness and shows how religious and spiritual ideas continue to affect the psychiatric approach to mental disorders.

INTRODUCTION

The history of psychiatry has often been written as though the emergence of psychiatry involved a transition from superstition to reason, from religion to science, and that only in the modern era have we come to understand that madness is not the result of the influence of spirits, demons, and curses. In fact, the relationship among ideas of madness and religion, medicine and theology, treatment and ritual is complex and varied. Although natural explanations seem to compete with religious explanations, in fact, people actually caring for the mad often (although not always) held these explanations in mind concurrently, and doctors, clergy, and families used this understanding as a basis for managing those for whom they cared.

Different religious traditions, of course, have had different approaches to the mad. This chapter focuses primarily on care given in the Christian tradition in Europe and North America because it is this tradition that has shaped modern psychiatry's way of dealing with religious and spiritual issues. Historical accounts of the Islamic approach to the mad indicate a variety of ways of dealing with madness – from the traditional Islamic methods that involved casting out the devil, to Koran-based methods, to an approach that involves a naturalistic understanding.(1, 2) Hinduism and Buddhism have their own approaches to madness as well.(3–5)

1. THE BIBLE AND MADNESS

For a variety of reasons, including missionary activity, European colonialism, and the adaptable nature of Christian belief, Christians are present in significant numbers in most parts of the modern world.(6) The Bible is, arguably, the most globally influential of ancient religious texts, and

it has influenced the West, both physicians and lay people, since the time of Constantine, so it is important to understand how the Bible presents madness. The Bible has several sections that have shaped views of madness – although in different ways at different times.

The Bible was written and edited over many centuries. The Old Testament (or Hebrew Scriptures), assumed its present form in about 90 AD.(7) The New Testament canon was established at the Council of Nicea in 325 AD. All Christian groups accept the parts of the Old Testament that Jews regard as canonical. Roman Catholic, Eastern Orthodox, and Coptic Christians, variously, include additional edifying Jewish writings that were not accepted as canonical by Jews.

Madness is portrayed in the Old Testament in several ways, sometimes in naturalistic terms, sometimes otherwise. Illustrative of the various ways madness is viewed in the Bible are the accounts of madness in 1 Samuel. In Chapter 21, the young David, not yet king of Israel, finds himself in a dangerous situation in the presence of Achish, a Philistine king, and his comrades. According to the Bible, "he changed his behavior before them, and pretended to be insane in their hands and made marks on the doors of the gate and let his spittle run down his beard" (1 Sam. 21:13, NRSV). Achish was disgusted and declared, "Do I lack madmen, that you have brought this fellow to play the madman in my presence? Shall this fellow come into my house?" (21:15). David was able to escape and carry on unharmed. In this setting, madness is presented as a natural phenomenon that is not unusual.

The same book of the Bible, five chapters earlier, includes an account of Saul that describes a supernatural cause of madness or, in Saul's case, despair. The writer records, "Now the Spirit of the Lord departed from Saul, and an evil spirit from the Lord tormented him" (1 Sam. 16:14). In this story, David was summoned to play his lyre for Saul, because David had musical talent, and David's music greatly consoled Saul. Saul hired David to work for him, and "whenever the evil spirit from God was upon Saul, David took the lyre and played it with his hand. So Saul was refreshed and was well, and the evil spirit departed from him" (16:23).

In the New Testament, madness is sometimes attributed to demons. In the Gospel of John, Jesus's opponents at one point say, "He is demon possessed and raving mad. Why listen to him" (John 10:20). In another incident, Paul tells the recipients of one of his letters, to make a point, that he is speaking as though he is mad, with no implication of a supernatural aspect at all.

These examples illustrate something that is true throughout the Old and New Testaments: when madness is portrayed, it is often seen in naturalistic terms, but the Lord often has something to do with the madness (for example, Deut. 28:28, Jer. 25:16 and 51:7, and Zech. 12:4).

Not only does the Bible contain information on an ancient way of viewing madness in spiritual terms, but it also contains large portions of wisdom literature that is analogous to modern self-help literature, although religious readers would consider it help from God. Wisdom literature exists in many writings from the ancient world, and there are parallels in the Bible to Egyptian wisdom literature. The books of Proverbs, Ecclesiastes, Wisdom, and Sirach all contain advice on how to live life and how to understand life's difficulties.

2. MADNESS AND RELIGION IN THE ANCIENT WORLD

The ancient world presents a wide range of worldviews and a number of philosophies of healing. Religion, psychology, and medicine were intertwined, for example, in the ancient healing cult, the cult of Asclepius. The cult of Asclepius was the most widespread healing cult in the ancient world, originating with the ancient Greeks and lasting until after the time of Christ. Asclepius was a god of healing whose temples were places of healing. One of the principal methods of healing in the temple was making a votive offering of a small replica of the diseased organ and waiting for healing. Healing often came through dreams in which Asclepius would

appear. The Asclepian physicians were practitioners of rational medicine who, when they could not heal through rational medicine, directed the sick to the Asclepian temple (p. xviii).(8) Certain psychological methods were attributed to the god Asclepius. Galen of Pergamum (c. 130–216 AD), the well-known physician of the second century, offered this insight into how Asclepius, the deity, ordered psychological means to cure disordered emotions:

> And not a few men … we have made healthy by correcting the disproportion of their emotions. No slight witness of the statement is also our ancestral god Asclepius who ordered not a few to [write] odes … he ordered hunting and horse riding and exercising in arms.… For he not only desired to awake the passion of those men because it was weak, but also defined the measure by the form of exercises" (pp. 208–209).(8)

More significant for religion in the West were the Hippocratic writings and Plato and Platonism. Hippocratic medicine is highly valued in modern accounts of medical history because it encouraged observation over theory, and because it generally eschewed supernatural explanations of madness.(9)

Early church writers generally respected the work of physicians and had a view of madness that incorporated a spiritual perspective, while acknowledging the physical influences that cause mental distress as well. The writings of John Chrysostom (c. 347–407 AD) reflect this approach. John Chrysostom was bishop of Constantinople, a highly regarded preacher, and a person with considerable skills as a pastor. In a series of letters to Olympias, a deaconess who apparently suffered from bouts of despair, Chrysostom provided a wealth of information about his views on despair and its relationship to physical illness. Melancholia per se is not mentioned. Instead, Chrysostom referred frequently to *athumia* and its relationship to illness. Olympias apparently suffered from a chronic complaint of unclear origin, and this condition was accompanied by a sense of despair and gloom. Chrysostom at times tried to comfort her by assuring her that physical illness often caused despair. "[Job] was not tortured by despondency [until] he was delivered over to sickness and sores, then did he also long for death" (p. 294).(10)

As his correspondence with Olympias progressed, however, Chrysostom began to become somewhat more impatient. In rebuking her for persisting in her state of dejection he told her that he believed that her physical illness was caused by her sense of dejection:

> You lately affirmed that it was nothing but despondency which caused this sickness of yours.… I shall not believe that you have got rid of your despondency unless you have got rid of your bodily infirmity (p. 296).(10)

He then went on to rebuke her for taking pride in her sorrow:

> I …reckon it as the greatest accusation that you should say 'I take a pride in increasing my sorrow by thinking over it': for when you ought to make every possible effort to dispel your affliction you do the devil's will, by increasing your despondency and sorrow. Are you not aware how great an evil despondency is? (p. 301) … Do not then now desire death, nor neglect the means of cure; for indeed this would not be safe (p. 296).(10)

Finally, Chrysostom offered pastoral advice for her dejected state: he suggested that she pray, that she read his earlier letter, and even that she memorize it. He also suggested that she compare the blessings God had given her to her adverse circumstances to help her obtain consolation for her feelings of despair (p. 297).(10)

To the despondent, John Chrysostom recommended the Christian faith as a remedy in his homily on St. Ignatius: "If any is in despondency, if in disease, if under insult, if in any other circumstance of this life, if in the depth of sins,

let him come hither with faith, and he will lay aside all those things, and will return with much joy."(11) Yet his letter to Olympias, directed as it was to a more specific case of despondency, is nuanced and humane.

Not all of the early church writers held a balanced view. Tatian (c. 160) was a disciple of Justin Martyr, a skilled speaker and theologian. In *Oration to the Greeks*, Tatian asserted a view that demons follow sickness.(12) The cure of madness is from God, not from the amulets that madmen were apparently supposed to wear.

> A disease is not killed by antipathy, nor is a madman cured by wearing amulets. These [cures from amulets result from] visitations of demons. … How can it be right to ascribe help given to madmen to matter and not to God? [The] skill [of those who use such means to cure] is to turn men away from God's service, and contrive that they should rely on herbs and roots.(12)

Tatian, however, did not always hold views consistent with orthodoxy, and his view of "herbs and roots" was probably not shared by many early church leaders.

3. RELIGIOUS APPROACH TO MADNESS IN THE MIDDLE AGES IN EUROPE

Of the few extant sources for learning about the spiritual side of the treatment of madness during the Middle Ages, perhaps the Leechbook of Bald is the most interesting. The Leechbook consists of three books owned by Bald, presumably a physician, and compiled in the ninth century in England.(13) The Leechbook contains remedies for all sorts of ailments. Many of the remedies are plant remedies, but the book also contains incantations and rituals to be used in the treatment of disease. Book I of the Leechbook of Bald contains several references to madness and interestingly distinguishes between demon possession and lunacy. Even for demon possession, the physician is to treat the demon-possessed man with an herbal concoction: "For a fiendsick man, or demoniac, when a devil possesses the man or controls him from within with disease; a spew drink, or emetic, lupin, bishopwort, henbane, cropleek; pound these together, add ale for a liquid, let it stand for a night, add fifty libcorns, or cathartic grains, and holy water" (p. 137).(14) This mixture is put into every drink that the possessed man will drink, and he is then directed to sing Psalms 99, 68, and 69, then drink the drink out of a church bell and let a priest say mass over him. For the lunatic the writer prescribes another herbal concoction of costmary, goutweed, lupin, betony, attorlothe, cropleek, field gentian, hove, and fennellet. A mass is to be sung over it, and the lunatic is to drink the mixture for nine mornings, then give alms and earnestly pray to God for mercy (p. 139).(14)

There is an additional instruction for lunatics in Leechbook III, thought to be the most rooted in contemporary Anglo-Saxon medicine.(13) "In case a man be a lunatic; take skin of a mereswine or porpoise, work it into a whip, swinge [beat] the man therewith, soon he will be well. Amen" (p. 335).(15) There was also a formula for dealing with temptation: "Against temptation of the fiend, a wort hight red niolin, red stalk, it waxeth by running water: if thou hast it on thee, and under thy head bolster, and over thy house doors, the devil may not scathe thee, within nor without" (p. 343).(15) Clearly, Anglo-Saxon medicine incorporated a religious worldview, and they used for treatment both material means (the herbal remedies) and religiously symbolic means (drinking a concoction out of a church bell, saying masses as part of the treatment, and singing psalms as a means of receiving healing).

4. EMERGENCE OF A MORE NATURALISTIC CLINICAL APPROACH TO MADNESS AMONG ENGLISH PURITANS

Although in some spheres there was an increased interest in the occult and the supernatural during the Renaissance, those dealing with the mad moved even further away from relying

on supernatural explanations. Reginald Scott's (d. 1599) book, *Discoverie of Witchcraft* (1584) reflects a point of view that grew in the sixteenth century: that people who are sad or distressed suffer from a natural malady and not from supernatural influences. Scott was a surveyor, not a physician, and was active in the county government of Kent, England. *Discoverie of Witchcraft* is primarily an extended and entertaining argument against the notion that witches actually have supernatural powers. In the process, Scott reveals a lot about charlatanism in the sixteenth century, and the book even explains a number of card-and-ball deceptions that in our time are considered to be magic tricks. Scott also touches on the treatment of the insane and, in so doing, reveals how religious reasoning was used by families to help those suffering from religious delusions.

Scott recounts the case of Ade Davie, wife of Simon Davie, a farmer from Scott's home county of Kent, and a person known to Scott. At some time in her early adulthood, Ade, who had no prior history of any sort of melancholy or madness, "grew suddenlie (as her husband informed me…) to be somewhat pensive and more sad than in times past." Simon was worried, but did not tell anyone for fear that he would be thought guilty of "ill husbandrie." But Ade became worse. She could not sleep, she cried, she began sighing and "lamenting," and although her husband pressed her, Ade would not provide any reason for her sadness. Finally, Ade fell to her knees and confessed to Simon that she was depressed because she had sold her soul to the devil. Her husband replied, "Thou has sold that which is none of thine to sell… Christ… paid for it, even with his bloud…, so as the divell hath no interest in it." The husband reasoned with her in this fashion. His wife then told him, "I have yet committed another fault and done you more injurie: for I have bewitched you and your children." But her husband reasoned with her, "Be content… by the grace of God, Jesus Christ shall unwitch us: for none evill can happen to them that feare God." With time, Ade recovered, "and remaineth a right honest woman… shamed of hir imaginations, which she perceiveth to have growne through melancholie" (pp. 31–32).(16)

Scott's account and his general view of melancholy and the supernatural indicate that by the latter part of the sixteenth century, naturalistic explanations for mental disorders were prevalent even among educated laymen. In fact, naturalistic explanations for melancholy were prevalent among physicians throughout the Middle Ages, although spiritual/religious factors were acknowledged as playing a role in mental distress as well.(17)

By the seventeenth century, a rather sophisticated practical way of dealing with psychological distress emerged from the thinking of Puritan writers. These writers, because of their concern with spiritual experience, conversion, and the inner spiritual life, were often very attuned to the existence of states of mental distress and despair. Many offered pastoral advice that reflects a concern for the psychological well-being of the individual and provides a variety of spiritual explanations and remedies.

Among the most influential of the Puritan writers on emotional distress was Richard Baxter (1615–1691), an Anglican priest who, in those tumultuous times, became a "dissenter." Because he could not in good conscience comply with the British Act of Uniformity, he could not preach, and so he had a lot of time to write. Baxter wrote prolifically about many aspects of living a Christian life, and he also wrote about depression. During the 1660s, Baxter wrote *A Christian Directory* (1673), a gigantic compendium of thoughtful and well-organized spiritual counsel on a range of topics, including marriage, business ethics, lawsuits, government, dealing with sickness and dying, church government, recreation, and, most of all, how to lead a spiritual life.(18)

In *A Christian Directory*, Baxter wrote a lengthy set of instructions on identifying and treating melancholy. He thought of melancholy as a "diseased craziness, hurt or error in imagination and consequently of the understanding" (p. 294).(19) It was characterized by preoccupation with having irreparably sinned, perplexing thoughts, and the inability to divert thoughts to