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Bedeviled Minds: Reflections on the History of "Satanic Thoughts"

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In his classic account of Christian awakening, *Grace Abounding to the Chief of Sinners* (1666), John Bunyan described how the Devil planted evil thoughts in his mind. The spiritual enemy assailed him with "whole floods of blasphemies, both against God, Christ and the scriptures". These shocking ideas came with unbidden and terrible force; suddenly his mind would be "strangely snatched away" by thoughts that he could not control, which assailed him like "a mighty whirlwind".[1]

Bunyan's experience was by no means uncommon. Indeed, it belonged to a long tradition of ascribing extremely wicked and unnatural cognitions to the immediate influence of Satan. This tradition was strong in Tudor and Stuart England, where the Protestant Reformation did much to promote the Devil's role as an invisible tormenter of the godly.[2] While most bad thoughts arose from the sinful nature of those that experienced them, a special category of evil ideas were viewed as demonic "injections". These were transmitted directly into the minds of individuals by unclean spirits. As late as 1698, the English minister William Chilcot noted that it was a "matter not questioned" that "Satan can throw wicked thoughts into our minds".[3] Most physicians agreed. While they focused their attention on the natural causes of mental distress, medical experts acknowledged that evil spirits could act alongside physical maladies to produce shocking and unwanted thoughts. As the physician David Irish observed in 1700, the Devil "hath spiritual access into our spirits to trouble them", and could thereby create "molestations" of the mind.[4]

The existence of "satanic thoughts" led to some obvious questions. How could they be distinguished from the ordinary, sinful ideas to which fallen men and women were prone? The conventional answer was twofold. First, satanic cognitions were exceptionally shocking and extreme; and second, they blasted the mind with a sudden, irresistible force. As a consequence, the Devil's injections were a cause of acute distress to their unwilling recipients.

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INSIDE

Welcome to the fall/winter 2017 edition of *Synergy*.

Our first essay explores the history of "satanic thoughts" in Early Modern England. Do our current ways of understanding and diagnosing psychiatric symptoms sully our appreciation of the past? Or might the past inform and clarify our present understanding of the human mind? Professor Darren Oldridge brings some differences in the "interior world of the mind" over four centuries into focus. "The shock of this discontinuity," he writes, "is bracing, but also stimulating."

Dr. Dusan Kolar then reflects on what may be an insidious but monumental shift in how we are thinking about treatment in psychiatry. He examines two current drugs that do not fit with our traditional understandings of how to treat and care for our patients.

Finally, Dr. Anees Bahji writes about the emotion of sadness, and whether it has a role, not just in dysfunction and pathology, but in function. Should we attend to sadness, not just to define and eradicate it, but to give it its due?

We hope you enjoy the prose and, as always, welcome your comments.

SYNERGY SUBMISSION GUIDELINES

Synergy invites submissions from members of the mental health community in Southeastern Ontario and beyond. We encourage articles on current topics in psychiatry. Our essays are scholarly in outlook but not number of footnotes. We strive to publish good prose and ideas presented with vigour. Articles range from 500 – 1000 words. Longer articles may be accepted.

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Another question concerned responsibility. Were the victims of satanic cognitions accountable for the horrible ideas in their own minds? Here the conventional answer was no. Wicked thoughts implanted by demons belonged to their spiritual authors: they were "set on Satan's score".[5] There was an important caveat, however. The recipient of an invading thought became culpable if he or she chose to entertain or act upon it. At this point the person became an accomplice of the spiritual enemy that sought to lead them astray.

The dreadful ideas injected by demons were of three broad kinds. Many were blasphemies. This was the case with a London stationer who felt impelled to curse God on his sickbed in 1647.[6] Others involved extreme and unorthodox religious speculations, often tending towards unbelief. John Bunyan was vexed with diabolical "suggestions" of this kind; and in 1683 the minister Samuel Annesley described others who were assailed with unholy "injections at which they tremble, and yet cannot keep them out of their mind, either to doubt of the scripture or Christianity, or the life to come".[7] The third kind of satanic idea was the suggestion of homicide. Sometimes this involved conjectures about murder – like the one described by a godly woman in London in 1652.[8] More often, the Devil invited his victims to contemplate suicide in moments of religious despair.

What should twenty-first-century people make of these experiences? Perhaps the first response is to assume that men and women in the past were simply mistaken to ascribe such powers to evil spirits. As an atheist I take this view myself: whatever else may have vexed the mind of John Bunyan during his conversion experience, I cannot accept that the Devil launched "blasphemous thoughts" into his head. Many Christians will share these reservations. While some Catholics and evangelical Protestants today accept that demons can intervene directly in human affairs, this view is considerably less prevalent among believers than it once was.[9] At the same time, psychological and physiological explanations for aberrant mental experiences are now widely embraced in western culture.

It is at this point that the historical evidence of "demons in the mind" raises some fascinating and tricky problems. Should the experiences of men such as Bunyan be recognized, retrospectively, as symptoms of mental illness as it is understood today? In some ways, the satanic incursions that troubled the minds of pre-modern Christians resemble the recurrent and unwanted thoughts associated with obsessive compulsive disorders. The way that sufferers understood these experiences, however, echoes a symptom of schizophrenia: the belief that alien thoughts have been placed inside the subject's mind. As a sign of psychosis, this belief is described as "thought insertion".

According to *Sims' Symptoms in the Mind* (5th ed. 2015), "thought insertion" involves a state of cognitive passivity in which the subject perceives "his thoughts as foreign or alien, not emanating from himself and not within his control". When no organic cause can be identified for this phenomenon, and it occurs recurrently, it can be used by psychiatrists to confirm a diagnosis of schizophrenia.[10]

Does this mean that Bunyan, and fellow victims of satanic "injections", should be diagnosed in this way? This view is hard to sustain. It involves the importation of modern-day assumptions into a very different cultural context. Significantly, the men and women who endured the Devil's mental assaults did not normally

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think of themselves as mentally ill; nor did the wider community in which they lived. Moreover, the identification of "satanic thoughts" was made not only by those that experienced them, but also by the churchmen and doctors from whom they sought advice. As the English pastor Robert Bolton observed in the 1620s, some Christians only realized that the evil thoughts that tormented them came from the Devil when this was explained by sympathetic ministers.[11]

In other words, the belief that is now viewed as a signifier of mental illness was shared, and endorsed, by experts in the community at large. The idea of "satanic injections" belonged to a wider understanding of the activity of the Devil, rather than the aberrant perception of distressed individuals. We may never know what caused particular men and women to experience apparently demonic thoughts, but we can be confident that the meaning of the experience was determined by the culture in which it occurred.

Experts in mental health will not be surprised by this conclusion. Modern psychopathology is sensitive to the cultural circumstances in which unusual states of mind occur. To take a contemporary example, the experience of spiritual rapture that takes place in some evangelical congregations is not normally defined as pathological. This is because it is consistent with "recognizable religious traditions". Similarly, a study of trance and possession experiences in the context of Latin American spirituality in 2011 found that these conditions were not psychotic: they emerged naturally from local religious culture, and their recipients showed no concomitant signs of mental illness.[12] A similar case could be made for the victims of "demonic thoughts" in the pre-modern world.

Such a sympathetic approach can help us to understand the inner lives of pre-modern men and women. The alternative approach—to pathologize their perception of their own experience—makes such understanding more difficult. In most cases the victims of satanic "injections" were not mad: rather, they belonged to a religious culture profoundly different to our own, in which these experiences, while sometimes traumatic, made sense.

By taking seriously the belief in powerful invisible spirits—whether or not we feel able to accept this belief ourselves—we can also appreciate the complexity of the world view to which they belonged. It is sometimes asserted that people in the past lacked explanations for things; but in fact the opposite was often true. In the case of early psychology, the acceptance of evil spirits meant that thoughtful investigators had, if anything, too many explanations for the phenomena that they observed. The pioneers of Tudor and Stuart psychology, Thomas Bright and Robert Burton, sought to explain the "inward and natural causes" of mental distress. But they also accepted that demons could meddle in human minds. Burton noted in 1621 that the Devil tortured his victims with strange thoughts: "things opposite to nature, opposite to God and His word, impious, absurd, such as a man would never of himself, or could not conceive".[13] These incursions were sometimes combined with the natural causes of mental unrest, which made their unlucky targets particularly vulnerable to Satan's assaults.

Above all, the bedeviled minds of the pre-modern world point to an important transition in western self-consciousness in the last four hundred years. The philosopher Charles Taylor has argued that in the sixteenth and seventeenth centuries people believed themselves to be open to supernatural influences of various kinds: divine interventions, good and bad spirits, and objects imbued with magical or religious power. Their sense of self was porous, or "unbuffered". For Taylor, the emergence of an insulated sense of self, immune to these external forces, was part of the process of secularization. Viewed from this perspective, the demonic interventions described in this essay provide a striking illustration of the unbuffered sense of identity that once characterized western Christians.[14]

The shock of this discontinuity is bracing, but also stimulating. It invites us to reflect on the role of historical context in shaping the facts of lived experience, including the interior world of the mind. It may also encourage us to engage imaginatively, and sympathetically, with the rich and complicated—and sometimes frightening—way of thinking that underpinned the lives of many pre-modern people.

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[3] William Chilcot, *A Practical Treatise Concerning Evil Thoughts* (1698), 118.

[4] David Irish, *Levamen Infirmi: Or Cordial Counsel to the Sick and Diseased* (1700), 48-50.

[5] This phrase was used often in English texts on the phenomenon. See, for example, Robert Bolton, *Instructions for a Right Comforting Afflicted Consciences* (1631), 339.

[6] For this case, see Darren Oldridge, *The Supernatural in Tudor and Stuart England* (Routledge: 2016), 71-2.

[7] Samuel Annesley, *A Continuation of Morning-Exercise Questions and Cases of Conscience* (1683), 271.

[8] See Oldridge, *The Devil*, 127-8.

[9] On this point there is a marked divergence between Europe and North America. While only around 20% of Europeans believe in the Devil, a US poll in 2005 found that as many as 60% accepted his existence.

[10] I am grateful to Profs Eleanor Bradley and Lisa Jones for their guidance on the clinical manifestations of this experience. Femi Oyebode, *Sims' Symptoms in the Mind: Textbook of Descriptive Psychopathology* (Saunders Elsevier, Philadelphia: 5th edition 2015), 152-3.

[11] Robert Bolton, *A Three-fold Treatise* (1634), 206-7.

[12] Oyebode, *Sims' Symptoms in the Mind*, 199, 264.

[13] Robert Burton, *The Anatomy of Melancholy* (1621), part 3, section 4, member 2, subsection 6.

[14] Charles Taylor, *A Secular Age* (Harvard University Press, Cambridge, Massachusetts: 2007), 27-41.

Darren Oldridge is Professor of Early Modern History at the University of Worcester, UK. He has published widely on religion in the sixteenth and seventeenth centuries. His most recent work includes *The Supernatural in Tudor and Stuart England* (Routledge: 2016) and *Strange Histories* (Routledge: 2nd ed. 2017).

Controversies in Psychiatry

DUSAN KOLAR

Change in the field of medicine is common. Some recent changes in treatment approaches in psychiatry, however, may present a silent paradigm shift. We were teaching psychiatry trainees until recently how cannabis abuse could be detrimental for patients with bipolar disorder or how using cannabis could trigger panic attacks and overall cause an increase in baseline anxiety in spite of the patients' subjective feeling that anxiety may temporarily improve with marijuana. We also taught generations of students and psychiatry residents that a common comorbidity in patients with PTSD is a substance use disorder, but currently there are reports of marijuana being used successfully in treating PTSD symptoms.[1]

More recent trends in treating patients with mood and anxiety disorders promote medical cannabis and synthetic cannabinoids in the treatment of these conditions, although still as off-label treatments. Is this a silent change in psychiatry paradigms or a change in our understanding of the etiology of mental illness, or is it the result of a crisis in developing novel treatments for refractory psychiatry conditions? Is the recently increased scientific interest in cannabinoids and cannabinoid receptors motivated from our belief that these substances are the future of psychiatric treatments, or are economic and political factors in the process of legalizing marijuana driving it? Is medical cannabis a "medication" that can treat a wide range of medical conditions such as various pain syndromes, MS, Parkinson's disease, migraines, seizures, glaucoma, cancer, schizophrenia, PTSD, depression, and anxiety? The issue of cannabis addiction has become almost irrelevant now as medical cannabis is presented as a valuable treatment option, and even if high-THC medical marijuana prescribed to patients for medical conditions is very potent and potentially more addictive than recreational marijuana,[2] many professionals are still not concerned about addiction or simply ignore this issue. I recommend reading a good review paper on cannabis withdrawal published in 2014 in the *Israeli Journal of Psychiatry and Related Sciences*.[3]

Nabilone is another popular off-label medication in psychiatry. Use of this synthetic cannabinoid medication in psychiatry started after the first Canadian military psychiatry study on the effects of nabilone in reducing the frequency of nightmares in patients with severe PTSD was published,[4] and then followed by the replicated study from the same group of authors published in 2015.[5] These studies conceptualized using nabilone temporarily as a part of a multimodal treatment program for PTSD, and they proposed that nabilone was to be discontinued over time with progress in cognitive-behavioral therapy. Currently, nabilone is a commonly and uncritically prescribed medication for various sleep disturbances, anxiety, and depression, and some patients may be taking nabilone for years or longer. It is common to hear that there is no dependence to nabilone. Reports of nabilone abuse are rare[6] and there are no research studies in psychiatry on any long-term use of nabilone and the risk for

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developing addiction. However, if there is no research on nabilone's addictive potential, it is not evidence that the risk does not exist. In clinical practice there is enough evidence that discontinuing nabilone after long-term use of this medication may result in severe anxiety, relapsing nightmares, lack of energy, lack of motivation, depressed mood, and even suicidality.

The efficacy of ketamine infusion in patients with major depressive disorder (MDD) is well established, and patients may have fast and significant improvements in depressive symptoms. However, early research studies on ketamine in MDD demonstrated that effects of ketamine infusions are short-lived. The lack of sustained benefits of ketamine motivated clinicians and pharmaceutical companies to explore possibilities of using oral and intranasal ketamine formulations. As benefits are short-lasting, it is postulated that ongoing treatment with ketamine could help in the same continuous way SSRIs, SNRIs, and other antidepressants are used. This regular treatment with ketamine would be the first time in the history of medicine that an anesthesia medication for short-term usage is then supposed to be used for the long-term treatment of a chronic condition without enough knowledge about possible consequences and risks of prolonged therapy.[7]

Many clinicians and patients are very enthusiastic about these trials as a way of getting sustained antidepressant effects but, on the other hand, there are concerns about interstitial cystitis, memory impairments, reports of neurotoxicity in animals, the well-known addictive potential of ketamine, and the risk of addiction with long-term use—and any other unknown detrimental effects, as there are no clinical trials to prove the long-term safety of this medication. Although antidepressant effects of ketamine are partially mediated by NMDA receptors, ketamine also has both opiate and stimulant effects and a significant potential for abuse. Allan Schatzberg, one of the most influential ketamine researchers in the US, said that "this unbridled enthusiasm needs to be tempered by a more rational and guarded perspective."[8] Finally, it seems that the conclusion of the group of authors from Australia, the UK, Canada, and the US in the *British Journal of Psychiatry*'s editorial published in 2016 is probably the best recommendation on using ketamine in clinical practice: "Much more needs to be learnt about the maintenance of response and long-term outcome before using ketamine more widely in clinical practice."[9]

As clinicians and teachers, we should always follow a gold standard in clinical practice known as "first do no harm," adhere to principles of medical ethics, and teach these aspects of medical practice to our students. The principle of beneficence is fulfilled if our prescribed treatment is helping with the patient's symptoms and reducing the patient's suffering. However, if long-term detrimental effects are possible or unknown as a result of insufficient clinical trials, or if developing addiction is a predicted consequence with long-term treatment, then the ethical principles and standards of good clinical practice are not fulfilled.

I think that we should learn lessons from the benzodiazepine era when we created millions of people addicted to benzodiazepines around the world—or the lessons from overprescribing opioid analgesics nowadays and the ensuing enormous public health problem.

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Summertime Sadness: A Brief Foray into the Functional Role of Depression

ANEES BAHJI

As the summer fades and the days become shorter, the air has somehow become heavier. Perhaps it's sadness, perhaps it's something more. Patients often struggle immensely with this time of year, particularly those who have had a history of depression, so their psychiatrists often intervene in an attempt to help. However, the mandate of physicians to relieve human suffering may face a formidable opponent in the form of sadness, which is perhaps the most intrinsic part of the human experience, as a life without sadness is not a life at all but, rather, an illusion.

For centuries there have been myriad disagreements on what sadness precisely is, and what—if anything—to do about it. This is a particularly important point of contention in the field of psychiatry. The way that we define mental illness is often up for debate, for the act of distinguishing "normal" from "abnormal" often infringes on the defining moments of the human experience.

I've often thought of sadness as the natural or expected reaction to a difficult situation. Many of us have felt sad when a dear friend has moved away, when a loved one has passed on, or when a relationship—particularly one we were deluded into thinking would last forever—is no more. So strongly do we hold this association—this belief that sadness is the effect that follows cause—that the prototypical response to someone that expresses sadness is a question: *What happened?*

Perhaps the assumption that sadness comes from the outside deserves a second thought. Interestingly, this assumption that sadness is always external is a relatively new idea. The Ancient Greeks often disagreed with this notion, and physicians of the day believed that dark fluids—humors—controlled the body, mind, and soul. In fact, they described four such fluids, whose balance directly influenced our health, our wellbeing, and even our temperament.[1] In fact, the word "melancholia," which comes from the Greek *melaina kole*, the word for black bile, was the very humor believed to cause sadness.[2] It seems likely that the Greeks believed sadness was not always external, but could also be internal, intrinsic, or from within. Interventions such as diet or certain medical practices could lead to a balancing of the humors (or *eucrasia*), and this they believed would lead to a correction of sadness.[3]

Although our understanding of the systems that govern the human body are far more advanced, these ancient ideas still resonate with our current views of clinical depression. These days, more psychiatrists have adopted a medical model of depression, and there is evidence that certain kinds of long-term emotional states such as Major Depressive Disorder and even Bipolar Affective Disorder are at least partially related to our brains' neurochemistry. As with the humoral system, the balance of various neurotransmitters—serotonin, norepinephrine, and dopamine—appear to be somewhat responsible for serious sadness. And current medical interventions like Electroconvulsive Therapy or antidepressant medications often change the balance of these neurochemicals and, in turn, can deeply alter how we feel and how we respond to the most difficult of circumstances.

As doctors who have sworn the Hippocratic Oath, we may have pledged to first do no harm. But perhaps viewing all levels of sadness as suffering is doing more harm than good. Many have attempted to determine what value sadness adds to society. Many thinkers and philosophers have argued that sadness partly defines the human condition: that sadness is not only an inevitable part of life, but an essential one. When asked if he was happy, Enoch Powell, one of the most brilliant and controversial figures of British political life in the 20th century, replied:

"Unhappiness, like grey hairs, is part of life. I am as happy as the human condition allows".[4]

Those who have failed to experience deep sadness or melancholia have missed out on the human ordeal, and may also have failed to acquire wisdom, which may require sadness as a prerequisite. For example, the English scholar, Robert Burton, spent his life exploring these ideas and, echoing Ecclesiastes 1:18, wrote:

"He that increaseth wisdom…increaseth sorrow".[5]

Likewise, romantic poets of the early 19th century believed melancholy allowed us to more deeply understand other profound human emotions: joy, beauty, love, and even anger and wrath. For example, to understand the sadness of the death of a loved one is to more fully understand the totality of the cycle of life that breathes life into a newborn. Thus, sadness may serve a role in accruing wisdom and acquiring emotional intelligence.

These functions seem fairly high on the hierarchy of human needs. But sadness appears to serve a more basic and tangible role that may in fact be evolutionarily informed. Many anthropologists believe that expressions of sadness such as crying and social isolation may have initially aided our ancestors in developing social bonds and forming social networks in order to acquire the support they needed to survive.[6] Unlike expressions of anger or violence, expressions of sadness denoted suffering, which immediately attracted others to the individual who was suffering and this, in turn, aided not only the victim but helped the larger community unite and flourish. Sadness, in turn, might actually support not only the needs of the one but also the needs of the many. But this then raises the issue of discerning whether the experience of sadness is wholly individual, or if it is a universal phenomenon. Emily Dickinson (1830-1886) wrote:

"I measure every grief I meet with narrow, probing eyes….I wonder if it weighs like mine or has an easier size…"[7]

The medical anthropologist Arthur Kleinman gathered evidence from the way people talk about pain to realize that emotions aren't universal at all but, rather, culturally-specific.[8] In fact, language itself shapes how we feel: when we speak of a death, the feeling of there being a void becomes a part of our experience; however, in a culture that talks about a death not as a void but as a feeling of paralysis, there actually appears to be a different subjective experience.

Others still have concerned themselves, not with describing suffering, but

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rather with the use of technology to destroy suffering in all its forms. For example, David Pierce's "paradise engineering" theory purports that contemporary processes like genetic engineering cannot only alter human experiences, but also the experiences of animals in the ecosystem.[9] Ironically, a world without sadness may be sad, and many who support the role of sadness may not wish to partake in such a paradise.

For the time being, the role and value of sadness is still up for debate, but we appear to universally agree upon one thing: that sadness has been felt by most people throughout time. Despite an era dominated by an ever-increasing desire to describe and diagnose all that is, the humanity we all share is more important than the mental illness we may not. To this day, one of the best ways to deal with this difficult emotion is to articulate it. In fact, this is what we often attempt in psychiatry, and most often what our patients have the most difficulty doing – to try to express what feels inexpressible. As Emily Dickinson put it:

"'Hope' is the thing with feathers that perches in the soul…and sings the tune without the words, and never stops at all".[10]

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