

Anxiety, Anxiety Disorders, Religion and Spirituality

Gerrit Glas, MD, PhD, and Zwolse Poort

From the dawn of history, anxiety has been associated with religious, spiritual and existential issues. In animistic cultures people suffered from anxiety when rules and rituals that were meant to calm deities and ancestral spirits were disobeyed. Fear of being accused of being the source of some misfortune paralyzed members of tribal communities believing in the power of the “evil eye.” Many religious traditions attributed illness and disease to the work of demons and other spiritual entities. Mystics of all times reported inner turmoil and fearful darkness on their route to inner peace and lucidity. Orthodox Christians endured fear of a threatening God, who will punish by eternal damnation. Existentialist philosophers, psychotherapists and novelists introduced the idea of anxiety as loss of inner freedom—a freedom which was considered to be the core of human existence. And finally, since the end of the 19th century, philosophers, social scientists and psychopathologists have associated anxiety with the cultural and spiritual transitions that took place when stable feudal societal arrangements transformed into modern society with its individualism and its more subtle and pervasive insecurities.

Contemporary social studies and psychopathological investigations seem to have lost contact with these spiritual, existential and cultural dimensions of anxiety. They describe and analyze anxiety from the perspective of the individual as a self-realizing agent in an increasingly complex environment. Self-preservation is the ultimate goal of this agent. “Stress” is the umbrella term for conditions that result when pressures and demands exceed the organism’s capacities. Psychopathology is concerned with specifying the type of dysfunction, the cause of the breakdown of normal functioning.

It is in the nature of scientific thinking to specify, to localize and to abstract from the full picture. However, by doing so, we run the risk of losing the comprehensive view that is needed to keep in touch with the anxieties underneath our daily worries and sorrows. In other words, instead of zooming in we have to zoom out and try to engage with the



existential and spiritual concerns that are implicit in the attitudes and doings of ourselves and of our patients. Once we have a clearer picture of these meanings and how they are interwoven with other psychological, social and behavioral manifestation of anxiety, we can, once again, “zoom in” and try to unravel the dependencies between different aspects of fear and anxiety, their elicitors and the way we cope with them.

The first aim of this article is to give a very brief overview of the literature on religion and anxiety. Then, in a discussion of two case vignettes, I will give an impression of religious and spiritual aspects of anxiety in the clinical (psychiatric) situation. In the final part I will indicate how these religious and spiritual issues may be addressed.

Religion and Spirituality in Anxiety and Anxiety Disorder

Given the ubiquity of anxiety and religion it is surprising how little research has been done with respect to the relationship between the two. There are indeed some studies on religion and anxiety in somatic disease and on religion and pathologic forms of anxiety like obsessive-compulsive disorder and posttraumatic stress disorder. There are also a remarkable number of studies on death anxiety and anxiety at the end of life. However, generally speaking, the investigation of religious and spiritual issues in anxiety lags behind compared with the research on mental abnormalities like de-

From Leiden University Medical Centre, Leiden, The Netherlands.
Reprint requests to Professor Gerrit Glas, MD, PhD, Leiden University Medical Centre, Leiden, Zwolse Poort, PO Box 110, 8000 AC Zwolle, The Netherlands. Email: glasg@xs4all.nl

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pression and psychosis. In this brief review I will restrict myself to some of the larger studies and overviews.

Having some type of religious affiliation appears to be related to lower anxiety levels in the general population. Intrinsic religiosity is associated with less worry and anxiety, whereas contemplative prayer is correlated with increased security and less distress.¹ Intrinsic religiosity refers to a lifestyle in which religion is personally appropriated and “lived” from within. Extrinsic religiosity, in contrast, refers to a lifestyle in which religion is related to social convention.^{2,3} There are, however, studies that find a relationship between religion and increased anxiety. Some of these seem to focus on extrinsic forms of religion.

In a comprehensive review of the relation between religion and medicine Koenig summarizes findings in seven clinical trials and sixty-nine observational studies examining the religion—anxiety relationship.⁴ Almost half of these studies show lower levels of anxiety among more religious people; seventeen studies report no association; seven report mixed or complex results whereas ten studies suggest greater anxiety among the more religious.

Another (epidemiologic) study in the general population finds that religion and anxiety are only related in young people.⁵ Church attendees, mainline Protestants, and those considering themselves “born again” show less evidence of anxiety disorders, whereas young fundamentalist Pentecostals, persons with no religious affiliation, and frequent religious television viewers have more anxiety disorders.

Kendler and coworkers⁶ report their findings in 2,616 twins who were investigated on the possible differential relationship between aspects of religion and internalizing and externalizing disorders. Since anxiety can be seen as the expression of an internalizing tendency, this study is relevant for this review. One out of seven religiosity factors could be associated with internalizing disorder: unvengefulness, “an attitude toward the world emphasizing personal retaliation rather than forgiveness.” Two factors (social religiosity and thankfulness) were related to both internalizing and externalizing disorder.

Research on the relationship between obsessive-compulsive disorder (OCD) and religion is contradictory. There is partial support for a relation between high religiosity and perfectionism, lack of tolerance of uncertainty and other OCD related cognitions, like responsibility for and need to control one’s thoughts.^{7,8} Studies assessing the impact of religion and spirituality on posttraumatic stress disorder (PTSD) have mixed findings.⁹ Religion may positively affect one’s ability to cope with trauma and may deepen one’s religious experience.¹⁰ Connor and coworkers,¹¹ however, find that religion has little or negative impact on post trauma symptoms. The direction of causality is uncertain in these studies. Religion may, for instance, not function as protector against developing PTSD, but as a way of coping in those with high levels of distress and/or poor health.

There has been a lot of research on spirituality and psychological wellbeing in medically ill patients. The relationship between religiosity/spirituality and anxiety in these patients has been studied much less, however. In a review on depression and anxiety in heart failure, Konstam and coworkers¹² report that people with higher levels of religiosity/spirituality respond to illness with better coping or improved adjustment and health-related quality of life, compared with individuals who report lower levels of religiosity/spirituality. McCoubrie & Davies¹³ find a negative correlation between spirituality, in particular its existential aspect, and anxiety (and depression) in patients with advanced cancer. Remarkably enough, religious wellbeing and strength of belief has no impact on psychological wellbeing in their study. Thus it seems that making sense of one’s circumstances and finding meaning and purpose when faced with life-threatening illness “has far more impact on psychological wellbeing than does religious faith.” For similar studies in cancer patients see Kaczorowski¹⁴ and Bosacaglia.¹⁵

Studies on death anxiety also suggest a more complex relationship between religiosity and fear of death and dying. Death anxiety seems to be related to both high and low religiosity and to “ambivalence,” that is, lack of congruence between belief in afterlife and certain religious practices.¹⁶ Findings among hospice patients suggest that a sense of purpose in life rather than religiosity has a direct positive effect on subjective wellbeing and a direct negative effect on fear of dying.¹⁷ Intrinsic religiosity has an indirect positive effect on subjective wellbeing when mediated by shared spiritual activities. Frequency of prayer does not appear to add much to subjective wellbeing. The results indicate, according to Ardelt & Koenig, that “private prayer might be less effective in eliciting a sense of purpose in life than spiritual activities that are shared with others.” McClain-Jacobson and coworkers¹⁸ also conclude that instead of beliefs held about afterlife it is rather spirituality that has a powerful effect on psychological functioning. In their study among terminally ill cancer patients belief in afterlife was associated with lower levels of end-of-life-despair such as desire for death, hopelessness and suicidal ideation. These beliefs show no relation to levels of depression or anxiety. Spirituality is defined in these studies as “having meaning and purpose in life,” which is more earthly and “social” than the activities that are assumed to belong to the concept of religion.

Overall these results suggest that there are associations between religiosity/spirituality, anxiety and general psychological wellbeing in various situations, but that the direction of causality and the factors mediating between the three are still unclear. Some findings suggest that shared practices and having meaning and purpose in life are stronger predictors for psychological wellbeing than the content and strength of one’s beliefs.

Case Vignettes

Religious Experiences in a Period of Stress

Ms. A, office manager in a factory, is 29 and suffers from panic attacks, generalized anxiety disorder and an atypical somatoform disorder. Several months before coming to treatment she had met a man with whom she had started a relationship. One month before, she had tried to improve her ambivalent relationship with her mother, whom she describes as self-absorbed and unsupportive.

She complains about headaches, strange sensations behind the eyes, paraesthesias of the arms and legs and stiff muscles. She gives explanations with a psychotic flavor of these complaints: she has the feeling that the sensations behind her eyes are due to gas bubbles rising up in her brain but never reaching the surface due to some blockade. She sometimes associates this bubbling with the activity of the Holy Spirit, who in some way is involved in taking away the blockade.

She describes herself as a sensitive and slightly childish woman, who already when she was fifteen suffered from the experience of living in two parallel streams, ie, a normal world and a world in which she observed herself as if she were looking through a camera. This depersonalization impedes her in her daily activities. Her sense of self is discontinuous; she sometimes has the feeling as if she were another person. There are, however, neither amnesic periods, nor other signs of a dissociative disorder. She has mood swings and panic attacks. During bouts of depression and anxiety her mental state may dramatically change: moments of religious elation are followed by episodes in which she is convinced that the world is at the point of being destroyed. She recalls periods of complete transparency at which words from the Bible are “completely true for her.” While praying in church she has sometimes a lively imagination of an open connection to heaven, almost a vision. It is at these moments that she feels that the “bubbles: in her brain are moving more freely and dissolve in the open air/heaven. She sometimes thinks she might become a prophet.

Some of the patient’s experiences have a clearly erotic background and are related to emerging feelings toward her new friend. Another biographical element of some importance is the recent reconciliation with her parents. The relationship with her mother has always been difficult and ambivalent in the sense that her mother kept treating her as if she were a child even when she grew up into adulthood. On the other hand, her mother was appealing and dependent as long as Ms. A remembers. Her father had always been dominant and degrading. With the support of her friend Ms. A could now discuss these old issues.

The working hypothesis in this case was that the openness and symmetry in the relation with her friend reawakened old feelings of vulnerability. The patient began to live between hope and fear—hope that she would finally be able to

give up old relational patterns of submission and denial of own wishes and feelings, and fear that in the end she would not be able to really change her life. These feelings were framed in a religious way and were accompanied by corresponding “visions” and bodily experiences. Fear of abandonment and punishment complicated this picture. The course of this case was favorable: reassurance, psycho-education and a short treatment with Selective serotonin reuptake inhibitors (SSRIs) were sufficient to restore the inner balance.

Anxiety, Obsessions and Fear of Being Possessed by Demons

Ms. B is a 19 year-old-woman with a history of two year, residential psychiatric treatment because of self-mutilation, suicide attempts, trichotillomania, outbursts of anger and impulsive eating and purging.

As long as she can remember, her inner life has been dominated by anxiety: she feels extremely vulnerable, insecure, powerless and prone to failure. This incapacitating feeling disturbed her schoolwork and impeded contacts with siblings and peers. Life does not offer any challenge, excitement or surprise for her, not because of depression (though she has met criteria for depressive disorder in the past), but because she does not dare to let anything become challenging, exciting or surprising enough to urge her to meaningful activity. She suffers from a core sense of powerlessness and behaves accordingly: she is unable to give shape to her existence. This powerlessness leads to self-reproach and feelings of insufficiency and guilt, which she enacts in her relationship with her parents and teachers. She typically shows a completely “blank” face when she fails on a certain task and this blankness sometimes drives her father and her teachers to fury.

At night she feels paralyzed, unable to resist her anxiety. It is as if something takes over, as if she is possessed by an external power. In periods of such almost psychotic anxiety she has obsessive thoughts inciting her to self-mutilation and suicide attempts. She often thinks this power has something to do with the devil or evil spirits. In calmer periods she thinks that the frightening experiences and thoughts are products of her own mind.

She has been brought up in a Protestant family. Her mother also feels insecure and suffered from periods of depression. She has an older sister and a younger brother. Belief in spirits and demons does not play an important role in the teachings of her church, nor in the life of her family and her few friends.

She meets criteria for panic disorder without agoraphobia, social phobia, depressive disorder (recurrent, in remission), atypical eating disorder, and borderline personality disorder. From a psychodynamic point of view she functions at a low-level borderline personality organization, which means that stressors that interfere with her central feeling of vulner-

ability and powerlessness easily lead to psychotic decompensation. These psychotic episodes typically last for only a few minutes or hours.

The patient is not convinced of the existence of spiritual entities interfering with her mental condition. Such entities are also uncommon in the belief system of her congregation. It is, therefore, explained to her that her anxiety and feelings of insufficiency, powerlessness and guilt—and the underlying feeling of hatred and rage—are so unbearable that they are warded off by a process of externalization (projection) and reification. Her guilt and anger become concretistic entities (ie, demons; evil powers) that threaten her. This concretization and reification protects her against psychotic breakdown. The enemy gets a name. On the other hand, this concretization also further confirms and deepens the ambivalence of her inner world, ie, the irresolvable split between her self-condemnation and her hidden longing for independence and individuation. The course of this case was complicated but in the end favorable. The patient was psychotherapeutically and pharmacologically treated in a day clinic. She met a friend with whom she developed a relatively stable relationship. She worked as volunteer in a book shop and made plans to finish her high school education.

The Existential Dimension

Anxiety may be difficult to recognize. In some cases it is only the psychomotor expression which gives a clue that the patient is anxious. In other cases the anxiety is primarily expressed in the form of avoidance behavior. In still other cases bodily complaints are predominant in the patient's story.

The worries of our patients are often common and understandable. Doctors will discuss them, try to reassure the patient, and give a realistic perspective, never without hope. However, these worries are usually not the primary target of medical intervention. One level deeper we will find the pathologic anxieties like those that are enumerated in psychiatric classification systems such as DSM-IV and ICD. Some of these anxieties may be difficult to detect, most notably social anxiety disorder, obsessive-compulsive disorder, posttraumatic stress disorder, and simple phobia. Patients tend to hide their symptoms because they feel ashamed and fear that their fragile balance will be disturbed.

However, interwoven with both these common worries and psychiatric anxieties there is a third, more global and encompassing level of analyzing anxiety: the level of the existential (or basic, fundamental) anxieties. Ms. A, for instance, had common worries (for instance, that her parents would not accept her friend), she had psychiatric anxieties (panic disorder, generalized anxiety disorder), but her anxiety had also an existential meaning: could she, perhaps for the first time in her life, be herself in front of her parents? Could she endure the alarming feeling of vulnerability when she would give up her attitude of submission and over-adapta-

tion? Ms. B had also anxieties at these three levels: daily worries concerning her friend and the apartment where she had to live, psychiatric anxieties in the form of panic disorder and social phobia; and the existential anxiety that is expressed by her attitude of powerlessness, inertia, and inability to give shape to her life (an inability which often was misunderstood as unwillingness).

Elsewhere I have discussed seven types of such fundamental (basic, existential) anxiety: anxiety related to loss of structure (of the I-self relationship; the anxieties at night of Ms. B for example); anxiety related to the fact of one's existence ("inability to live"); anxiety expressing lack of safety and physical protection; anxiety as an expression of unconnectedness and isolation; anxiety related to doubt and inability to make choices; anxiety as expression of sense of meaninglessness; and death anxiety.¹⁹ The latter four of these anxieties (isolation, loss of freedom, meaninglessness, death) are extensively discussed in the work of humanistic psychotherapists²⁰ and have a background in the phenomenological tradition.^{21,22} Descriptions of the first three can be found in the Continental psychopathological literature.²³⁻²⁵

Discussion

Patients may greatly benefit from doctors who are sensitive for the existential dimension in their stories. Such sensitivity does not mean that the physician has to give up his professional attitude. One important characteristic for professionalism is that the physician is able to grasp the full picture which implies, among others things, that the physician is able to attend to and to understand the more subtle language of existential worries and concerns. These worries and concerns are "global", ie, they affect one's basic attitude, one's stance toward life. They do not have a concrete focus; the object (or focus) of the fundamental anxieties becomes apparent in the way these anxieties are expressed and "lived". They have, so to say, their object not before them but behind them. Or, more accurately, the object is "embodied" in the anxiety itself.

One way to look at religion and spirituality is to consider them as offering a way to deal with the existential concerns that are inherent in life. Religions and different forms of spirituality offer a framework—cognitively, affectively, and socially—which provides meaning with respect to the "big" questions. Addressing religious and spiritual issues in the consulting room is one way to get in touch with how the patient deals with these questions.

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