

“The Effects of Religion on Anxiety Disorders, Schizophrenia & Other Psychoses

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Today and Upcoming Thursday Class Schedule

- **March 17: Effect of Religion on Anxiety Disorders, Schizophrenia, and other Psychoses (ch. 9 - 10, HRH)**
- **March 24: Effect of Religion on Alcohol and Drug Use, Delinquency (chapter 11 - 12, HRH)**
- **March 31: Effect of Religion on Heart Disease & Hypertension (chapters 16-17, HRH)**
- **April 7: Effect of Religion on Immune System Dysfunction and Cancer (chapter 19-20, HRH)**
- **April 14: Effect of Religion on Longevity and Disability (Chap. 21-22, HRH)**

Outline for today – Anxiety, Schizophrenia & Psychosis

I. Introduction

II. Anxiety Disorders

Panic Disorder

Obsessive-Compulsive Disorder

Post-Traumatic Stress Disorder

Causes of Anxiety Disorder

Anxiety and Religiousness

Death Anxiety and Religiousness

III. Schizophrenia and other Psychoses

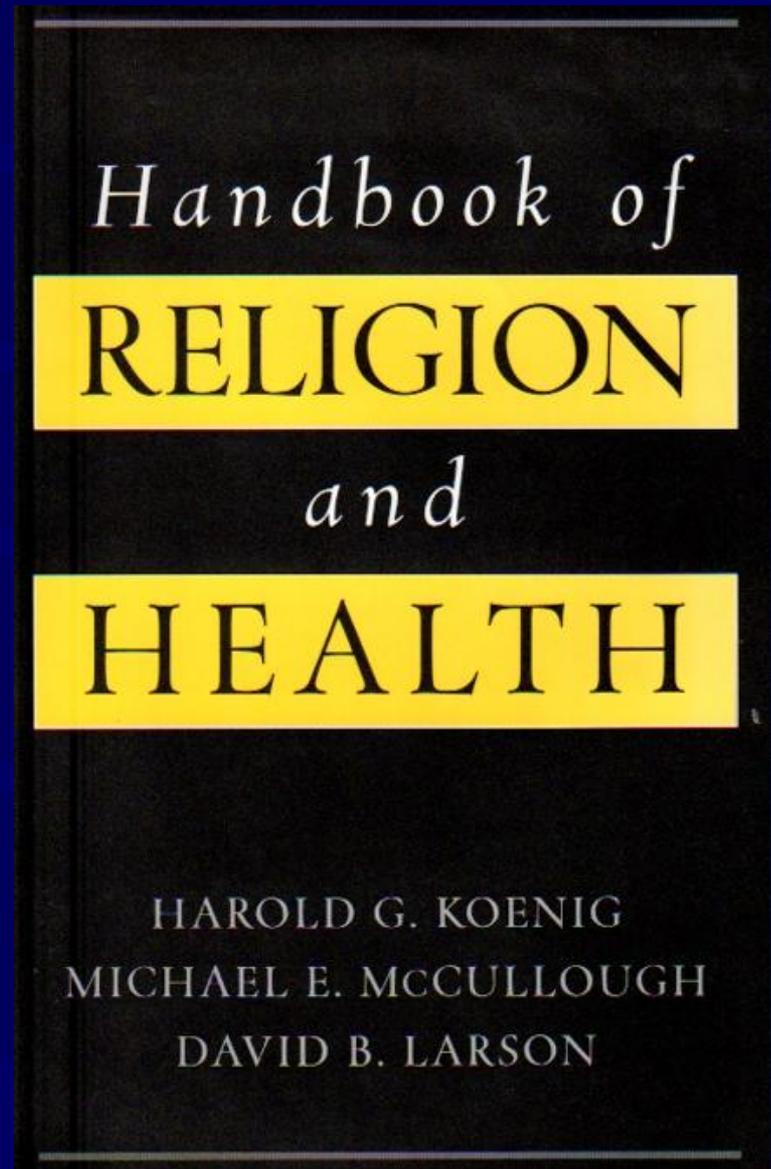
Psychotic & Delusional Disorder

Religious Affiliation and Psychosis

Religiousness -- a cause of Schizophrenia & psychosis?

I. Introduction:

- Today we are looking at Chapters 9 & 10 of Dr. Harold Koenig, Michael McCullough and David Larson's book,
- ***Handbook of Religion and Health (2001)***
- published by Oxford University Press, New York.



Last Week -- Religion & Mental Health

In the majority of studies, religious involvement is correlated with:

- Well-being, happiness, and life satisfaction
- Hope and optimism
- Purpose and meaning in life
- Higher self-esteem
- Adaptation to bereavement
- Greater social support and less isolation, loneliness
- Lower rates of depression and faster recovery
- Lower rates of suicide and less positive attitude towards suicide
- Less anxiety, psychosis and fewer psychotic tendencies
- Lower rates of alcohol and drug abuse
- Less delinquency and criminal activity
- Greater marital stability and satisfaction

Mental Health, as a continuum



Today we are looking at the two extremes of the continuum – Anxiety Disorders to the left and Psychotic Disorders to the right

II. Anxiety Disorders

- Definition: Anxiety is a normal emotion associated with the anticipate of what is perceived to be a potentially threatening event.
- Normal, everyday anxiety serves a useful purpose by preparing our bodies and minds for perceived stresses that we may confront.
- However, for many people, anxiety is a continuous part of their lives as it becomes prolonged and excessive beyond that needed for optimal functioning.
- When exaggerated, worry and tension persist even when there is no immediate physical or emotional threat, and in these cases can evolve into a full-blown psychiatric disorder.

II,a: Generalized Anxiety Disorder (GAD)

- GAD refers to anxiety that is much more intense and generalized than the normal anxiety people have.
- Someone with GAD anticipates disaster and worries excessively even though they usually realize their anxiety is more intense than the situation warrants.
- GAD sufferers cannot relax, have trouble sleeping and may experience trembling, twitching, headaches, irritability, and sweating.
- GADs may feel light-headed, out of breath, or nauseated. They may have difficulty concentrating, chronic fatigue, and depression. They are more easily startled than normal people.

II, b: Panic Disorder

- Over 6 million Americans, more often women than men, have overwhelming feelings of terror that strike suddenly and repeatedly without warning, lasting but a few minutes.
- Because they can't predict when it will happen, many develop intense anxiety between episodes – when will it happen next? Often accompanied by agoraphobia (fear of leaving the house)
- The attack usually begins with a sudden onset of heart palpitations, breathlessness, sweating, and feelings of weakness, faintness or dizziness.
- Others experience chest pain or smothering sensations, a sense of unreality, fear of impending doom, or fear of loss of control. Many think they are having a heart attack or that they are losing their mind, or are about to die.

II, c: Phobias

- A phobia is fear of a particular object or situation. Many people experience intense, irrational fears centered on a particular place, activity or thing.
- I.e., fear of heights, tunnels, highway driving, water, flying...
Fear of public speaking is very common.
- Specific phobias strike 1 in 10 Americans. We do not know their origin, but frequently run in families and are a little more often found in women than men.
- Usually appear first in adolescence or young adulthood. When children experience fears (i.e., of animals), these phobias usually disappear with time but may persist.

II, d. Obsessive-compulsive Disorder (OCD)

- Characterized by anxious or disturbing thoughts or rituals that appear out of the individual's control (1:50 in the USA)
- The disturbing thoughts or impulses are called obsessions.
- The rituals that are performed to try to prevent the obsessions are called compulsions.
- People with OCD usually have no pleasure in carrying out the rituals they are forced to perform. The relief the rituals give is short-lived from the discomfort of the disturbing thoughts and impulses.
- Many are plagued with thoughts of violence and have fear they may harm someone. Thoughts of sexual acts bring shame.

II, e. Post-Traumatic Stress Disorder (PTSD)

- This debilitating condition can occur soon or years after the patient witnesses a terrify or traumatic event.
- People with PTSD have persistent frightening thoughts and members of their ordeal. Sometimes referred to as “shell shock” or “battle fatigue” during wartime.
- However, PTSD can result from any adverse psychology or physical event and is often associated with co-morbidity: panic disorder, substance abuse, depression and suicide attempt is high as 20%.
- The co-morbidity of PTSD leads to high cost for society totally 46.6 billion dollars a year – 1/3rd of all mental health costs.
- 75 per cent of that cost is due to loss of productivity.

II, f: Consequences of Anxiety Disorder

- Anxiety disorders are exceedingly common in society, with as many as 27 million Americans developing it in their lifetime.
- Anxiety disorders are associated with many adverse psychological and physical consequences:
 - Major depression often
 - Substance abuse is high
 - Impaired quality of life relationships
 - Suicide
- Surprisingly, suicide attempts are very high (20%); higher than that of major depression (15%).
- Many who have anxiety disorder turn to alcohol to alleviate their symptoms -- worsening life style, relationships, and work

II, g: Anxiety and Religiousness

- Freud argued that religion's focus on punishing wrong or sinful thoughts or deeds can lead to excessive guilt. He felt this guilt lead to an increase in anxiety and neuroses.
- Conversely, others have argued that religion often buffers against and relieves anxiety (Bergin, 1983)
- Spellman and colleagues (1971) found that individuals who had recently undergone a sudden religious conversion experienced significantly higher anxiety than those who became religious gradually over time.
- In Israel, Zeidner and Hammer (1992) found a positive relationship between increased religiosity and anxiety in Israeli's who experience missile attacks during the gulf war.

II, g: Anxiety and Religiousness, continued...

- Zeidner and Hammer concluded that the spiritually-minded likely perceived war as a threat not only to themselves but to their religious culture and nation (an attack on God's people).
- Dhawan and Sripat (1986) studied 40 undergraduate students in India, examining the moderating influence of religiosity on experimentally induced death anxiety.
- Fear of death was experimentally induced by exposing subjects with high and low religiosity to death threat cards. After the threat, they measured the need to seek affiliation as a measure of anxiety.
- They found that religiosity did not reduce the induced fear of death.

II, g: Anxiety and Religiousness, continued...

- However, research has found that whether one's religious orientation is intrinsic or extrinsic may be a key factor in determining whether or not religiousness has a positive or negative effect on anxiety.
- Baker and Gorsuch (1982) administered an intrinsic-extrinsic measure on religious orientation and anxiety to 52 participants.
- They found that anxiety was *negatively* correlated with intrinsic religiosity, and positively correlated with extrinsic.
- This correlation (extrinsic vs. intrinsic) has been confirmed in other studies, as well (Sturgeon & Hamley, 1979; Bergin et al, 1987; Tapnanya et al, 1997).

II, g: Anxiety and Religiousness, continued...

- Tapananya & colleagues (1997) compared the effects of intrinsic/extrinsic on anxiety among elderly Buddhists and Christians in Canada.
- Buddhists who were more extrinsic in their religious orientation showed more profound worry/anxiety than extrinsic Christians. The authors felt the difference may be the result of differences in belief systems.
- Christianity allows for redemption from a forgiving God; whereas, Buddhism offers the promise of enlightenment.
- But, the majority of Buddhists know they will not achieve enlightenment before death and will not be liberated from samsara, the cycle of death and reincarnation.
- The researchers felt this may explain their higher level of anxiety in elderly when compared to the Christian group.

II, g: Anxiety and Religious attendance

- Measures of Intrinsic and Extrinsic religiosity help explain the findings regarding the religion-anxiety relationship. Another measure is the significance of attendance at religious services.
- Hertsgaard and Light (1984) surveyed a random sample of 760 women on farms in North Dakota and found women who attended church more than once a month scored significantly lower on anxiety and depressive symptoms as measured by the Multiple Affect Adjective Check List (MAACL).
- In the same study, Catholic and Lutheran women scored significantly higher on anxiety and depressive scales than did Protestant women.

II, g: Anxiety and Religious Involvement

- Koenig, et al (1993) measured the relationship between religious involvement and anxiety disorders among 2,969 young, middle aged, and elderly adults in North Carolina.
- Among young adults (18-39) rates of anxiety were lower among frequent church attenders, mainline Protestants, and those who considered themselves born-again Christians.
- In contrast, anxiety was higher in young adults who were affiliated with fundamentalist Pentecostal religious groups, those with no religious affiliation, and those who frequently watched/listened to religious programs on TV or the radio

II, g: Anxiety and Religious Involvement

- For middle-aged (40-59), social phobia was less common among frequent church attenders and among those who considered themselves born-again.
- However, this relationship could be explained by the greater social support of those who attend church regularly.
- Koenig concluded that “a pattern of both positive and negative relationships exist between religion and anxiety disorder that is most evident among young adults (18-39) and weakens with age as dynamic factors increase the complexity of the relationship.” (HRH, p149)

II, g: Anxiety and Religious & Complexity

- The complexity of measuring the effect of religion on anxiety may be illustrated this way: A positive correlation may mean that religious activities lead to increased anxiety or guilt.
- On the other hand, it may also mean that anxiety acts as a stimulus for prayer and other religious activities, which over time may help to relieve the anxiety and guilt.
- Williams et al (1991) followed 720 adults for two years to judge the effect of religious attendance on “psychological distress” and found the frequency of attendance at religious services was inversely related to psychological distress, and also, religiosity buffered the stresses the religious experienced, as well.

II, h: DEATH Anxiety and Religiosity

- Anxiety and fear of death are closely related. “Fear” is usually associated with a specific threat, while anxiety is non-specific. The predominant distress associated with death is the fear of the unknown.
- So, “fear” of death is not so much a fear as it is an anxiety state about the existential fact of life – we all will die.
- Research has provided mixed results. Gartner et al (1991) reviewed the literature and found:
 - six studies which showed less fear of death among subjects who were more religious.
 - Three studies showed more fear with religious folk
 - five studies showed no relationship between religious commitment and death anxiety.

II, h: Death Wish and Religiosity, cont

- A more comprehensive study (Templer, 1972) revealed that religiously involved individuals had lower anxiety about death, and, of those who were affiliated with a religion, the most religious had the least death anxiety.
- Likewise, Florian and Kravety (1983) found that Jews who were more religiously involved had less fear of personal death than Jews who were only moderately religious or non-religious.
- Minear and Brush (1980) found a significant inverse relationship between death and anxiety and belief in an afterlife.
- Kacqorowski (1989) found that cancer patients with high levels of spiritual well-being, had lower levels of death anxiety.

II, h: Death Wish and Intrinsic Religiosity

- Again, it is significant if religion is intrinsic or extrinsic.
- Thorson and Power (1990, 91) found that those who were older and scored higher on intrinsic religiousness had significantly less anxiety about death.
- Alvarado et al (1995) explored the relationship of eight separate religious variables on death anxiety and depression. They found that those with less death anxiety also had a greater religious conviction.
- Interestingly, these same people were less likely to say the most important aspect of religion is that it offers the possibility of life after death. But, those who scored high on death anxiety believed eternal life was an important part of religion

The authors, Alvarado and colleagues concluded:

“Perhaps, faith, belief and commitment must come first before one experiences a lowering of death discomfort.” (HRH, p 151)

In other words, having an “intrinsic” religiosity is the important thing.

III. Religion and Schizophrenia & Other Psychoses

- Psychotic disorders are a group of mental illnesses characterized by an imbalance of brain neurotransmitters (dopamine, in particular).
- This causes symptoms such as:
 - paranodia (fear that someone intends you harm)
 - delusions (fixed, false beliefs from which the person cannot be dissuaded)
 - hallucinations (sounds, sights or sensations that are perceived, yet are not real)
 - abnormal thought processes (looseness of associations, tangential thinking, circumstantiality, or flight of ideas)

III. Religion and Schizophrenia & Other Psychoses

Psychotic disorders may also be associated with disorders of:

- Affect (difficulty expressing emotion), i.e.,
 - May be unable to express emotion
 - May express too much emotion
 - May express emotion inappropriately to the circumstances
- The psychotic person is often described as having lost contact with “reality” and live in their own private world of delusion.
- Lay terms used are often “insane” and “crazy”

III: Types of Psychotic Disorder

- A. Schizophrenia – a chronic, often lifelong psychotic disorder that typically begins in your adulthood (between 16 and 30) and affects about 1 % of population worldwide.
- Is characterized by “positive” and “negative” symptoms
 - Positive symptoms -- include hallucinations, delusions, and disorganization of thought and/or behavior
 - Negative symptoms -- include a flattened affect (face appears immobile or unresponsive), alogia (poverty of speech – brief, empty replies), and avolition (inability to initiate or persist in activities).
 - Social withdrawal is perhaps the earliest symptom to be recognized
 - Problems with interpersonal relationships – at work, school, self-care
 - To justify the diagnosis, symptoms must persist for 6 months.

III: Types of Psychotic Disorder

- B. Delusional Disorder – the presence of one or more non-bizarre delusions (fixed, false beliefs) that last one month or more.
- Other mental disorders have delusions – schizophrenia, substance intoxication, mania, psychotic depression, dementia and delirium – so these must be ruled out
 - The non-bizarre nature of these delusions help separate them from schizophrenia. Presence in population is about 0.3%.
 - Erotomaniac (belief that a particular person is in love with the patient)
 - Grandiose (belief that the person has a great but unrecognized talent, insight, or a special relationship with a person like Jesus or Moses.
 - Religious (believe that the devil or other spirits are watching, tormenting)
 - Jealous (belief person's spouse is unfaithful; Othello syndrome)
 - Persecutory (belief someone has conspired against them)
 - Somatic (belief that they are infested with insects, malfunctioning organ)

III: Consequences of Psychotic Disorder

When chronic, psychotic disorders disrupt people's lives:

- Impairs the ability to work.
- Social relationships are difficult / impossible to maintain
- Fear, anxiety, and confusion can be overwhelming emotions
- Suicide rate among schizophrenics is high
 - (50% attempt suicide and 10% succeed within 20 years)
- Most schizophrenics cannot work (up to 50% are homeless)
- With proper treatment, many are able to live in community
- Schizophrenics occupy nearly 50 % of mental hospital beds.
- The cost is high – \$ 22.7 billion annually in US alone

III: Religious Affiliation and Psychosis

Is there a relationship between religious affiliation and psychotic disorder?

- Bohrnstedt (1968) surveyed 3,700 freshmen college students at the U of Wisconsin. The study showed that students who had no religious affiliation had higher incidence of:
 - Hypochondriasis
 - Depression
 - Hysteria
 - Psychopathic deviation
 - Lack of interest
 - Paranoia
 - Schizophrenia
 - Hypomania
 - Social introversion

III: Religious Affiliation and Psychosis

Spencer (1975) studied 50 Jehovah's Witness patients with Schizophrenia who were admitted to psychiatric hospital:

There were three times more schizophrenics and nearly four times more paranoid schizophrenics in the Jehovah's Witnesses than among other persons living in the country.

- Spencer concluded that either Jehovah's witnesses tend to be pre-psychotic individuals who then break down when pressures are placed on them by aggressive proselytizing or being a Jehovah's Witness itself induces stress that precipitates psychoses.
- Ullman (1988) found similar results with Bahai' and Hari Krishna converts suggesting non-traditional groups may be a higher risk for psychosis (or draws in pre-psychotic individuals)

III: Religious Affiliation and Psychosis

Wilson and Colleagues (1983) surveyed 73 schizophrenics and learned the fathers of the subjects were less likely to be involved in their children's religious instruction than fathers of controls (19% vs. 35%).

- Parents of schizophrenics were also less likely to:
 - practice family devotions regularly (8% to 32%),
 - more likely to teach that God is punitive and harsh (73% to 30%)
 - more likely to teach religion in an authoritarian manner (40% to 14%)
- Schizophrenics themselves were less likely:
 - to read the bible (26% to 49%)
 - to say grace at meals (51% to 80%)
 - to have a religious conversion experience before 21 (63% to 78%)

Authors felt this suggests they received less religious nurturance as children and why they are less regular in religious devotions as adults

III: Is Religiosity Connected to Psychosis?

Some Mental Health specialists maintain that religiousness can facilitate the development of schizophrenia.

- Prometheusian & Psychiatrist, Wendall Watters, (1992) argues that devout religious beliefs contribute to the development of schizophrenia in persons born with a limited capacity to adapt.
- He claims that religious teachings interfere with the process of “related individuation” because the schizophrenogenicity of western Judeo-Christian culture acts through the family to make it difficult for parents to be effective catalysts for their children’s growth. (think Watters is biased?)
- William James (1902) noted that the “sick soul” is a more likely candidate for sudden conversion than the “healthy-minded.”

III: Is Religiosity Connected to Psychosis?

There is no doubt, that delusions and hallucinations seen in acute schizophrenia and schizotypal personality disorder frequently have religious content (as high as 55%).

- However, findings do not support the hypothesis that religious content in psychotic delusions results from the patient being more fundamentalist or religiously active.
- Strongly held religious beliefs are often present among persons with pre-morbid schizophrenia. These observations, however, are based on single case reports of acutely psychotic patients and not on systematic research in population-based studies.

III: Is Religiosity Connected to Psychosis?

Feldman and Rust (1989) conducted two studies to determine the association between religiousness and schizotypal thinking

- In their first study, the “religious” were significantly less likely than the “less religious” to demonstrate schizotypal thinking
- In their second study, overall religiosity level was not significantly different for chronic schizophrenics and normal controls.
- Neeleman and Lewis (1994) found that Psychotic schizophrenics and depressed patients were more likely to hold religious beliefs and to seek relief through religion. Again, this does not indicate religion is a cause of their psychoses.

III: Schizophrenia and demon possession

Some Christian fundamentalists have maintained that the bizarre behaviors of schizophrenics and psychotic patients is due to demonic possession.

- Possession was a concern in the 15th and 16th centuries when persons with chronic mental illness were burnt at the stake because they were thought to be witches, sorcerers.
- If demonic possession plays a role in etiology, then these patients would benefit with exorcism of the demon(s). That has not been the case over the centuries, however.
- A psychiatrist at Duke U, William P Wilson, has described the differences between demon possession and schizophrenia of biologic origin.

III: Difference between Schizophrenia and demon possession (William Wilson, 1998):

- The possessed person does not have:
 - the affective changes (blunting of affect)
 - the disturbances of thought (looseness of association)
 - the ambivalence usually seen in schizophrenia
- The presence of evil does not characterize the schizophrenic state (Peck, 1983).
- Koenig says: “The primary influence in Judeo-Christian beliefs and practices on schizophrenia and other psychotic disorders is in providing comfort, hope, and a supportive community to individuals who must cope with their emotionally devastating, largely biological illness.”

III: Religion as a Source of Comfort and Hope:

- Carson and Huss (1979) conducted an intervention study with 20 Christian schizophrenic patients in a state mental hospital.
- The intervention was weekly prayer and Scripture reading conducted one-on-one by a student nurse for 10 weeks.
- The focus of prayer and scripture readings was God's love and concern for each individual and the worth of each individual to God. Result?
 - Patients became more verbal about what bothered them
 - Acted out their anger and frustration in healthier ways
 - Were more willing to express their inner feelings
 - Were more likely to express a desire for change in their lives
 - Were more likely to desire a normal life (compliant with medications)
 - Were more articulate, showed more appropriate affect, fewer somatic Sx

III: Religious Communities as a Source of Care:

- If a mission of Churches & Synagogues is to minister to less fortunate members of society, might religious communities play a role in meeting the needs of persons with schizophrenia or other chronic mental disorders?
- Katkin et al (1975) recruited volunteers from the community to work with mental health patients in Cincinnati. Volunteers spent 2 hours per week: to ensure that the schizophrenic patient took medications, to evaluate for de-compensation, to help patients find jobs and housing, and to give supportive counseling.
- After 2 years, the recidivism rate for the patients was: 33% for those treated by volunteers and 56% for a control group. The implication is religious volunteers might have an impact on the quality of life for those with Chronic mental illness.

IV: Summary and conclusions

- Schizophrenia and psychotic disorders are common, disabling, isolating, frightening, and costly illnesses that have an enormous impact on the quality of life of patients and family.
- It is unlikely that religious factors contribute much to the cause of the disease or negatively impact its course. A number of studies show an inverse relationship between religiousness and psychotic tendencies.
- What can be shown is that religion provides a powerful source of comfort and hope for many who are mentally ill.
- Religious communities can play an important role in helping to meet the emotional and practical needs of those with schizophrenia and chronic mental illness.

Next Thursday's Class

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