

**Anxiety disorders: Psychopathology, psychotherapy, and the Church**

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### **Abstract**

Discussed herein is a general overview of anxiety disorders including separation anxiety disorder, selective mutism, specific phobia, social anxiety disorder, panic disorder, agoraphobia, generalized anxiety disorder, substance / medication-induced anxiety disorder, anxiety disorder due to another medical condition, and other specified / unspecified anxiety disorder. Diagnostic criteria and characteristics of each anxiety disorder are briefly reviewed. Etiology, developmental, and prognosis factors of anxiety disorders are discussed. Specific neurobiological structures and psychological components that may contribute to the development of anxiety disorders are briefly examined. Assessment procedures and psychometric inventories for assessing a client that may have an anxiety disorder are mentioned. Several treatment options are examined including, but not limited to, cognitive behavior therapy (CBT), mindfulness, religiously adapted cognitive behavior therapy, and *in virtuo* cognitive behavior therapy (CBT-VR). A Christian perspective of anxiety disorders is provided, as well as a discussion of how it may be time for the Church to reconsider their position on psychology / psychotherapy. Future research considerations and prevention strategies are also addressed.

*Keywords:* Anxiety Disorders, Psychotherapy, Psychopathology, Psychological Disorders, Christianity, Mental Health

### **Anxiety disorders: Psychopathology, psychotherapy, and the Church**

With the rise of a worldwide, cataclysmic event comes the rise of those experiencing anxiety (Twenge & Joiner, 2020). Research reveals that, compared to measures of anxiety symptoms in the first two quarters of 2019, anxiety symptoms have increased in 2020 (Twenge & Joiner, 2020). Given the increased number of those experiencing anxiety symptoms, perhaps mental health professionals can find an ally in the Church.

Research has indicated positive correlations between mental health outcomes, spiritual practices (Brewer-Smyth, & Koenig, 2014; Chapman & Steger, 2010), and incorporating religious content in psychotherapeutic treatments (Lim et al., 2014). Literature has called for psychotherapists to consider the spiritual dimension of the individual (Hodge, 2005; Saad et al., 2017), perhaps it is also time for religious leaders to reconsider their emphasis on the psychological dimension of the individual.

Despite the mention of anxiety and fear all throughout the Word of God (Amplified Bible, 1954/1987, John 14:1; Proverbs 12:5; Ecclesiastes 2: 22; Isaiah 41:10; 2 Timothy 1:7; John 14:27; Philippians 4:6-7), the Church seems fixed in their position of keeping psychology and psychotherapy out of consideration; it seems to be treated as a dimension of the individual that can be easily dismissed (Entwistle, 2015). Perhaps it is time for the Church to reconsider its long-held animosity towards psychology and psychotherapy (Entwistle, 2015) and give psychological disorders a new look from a different perspective.

### **Overview**

#### **Separation Anxiety Disorder**

Separation anxiety disorder (SAD) is characterized as an excessive anxiety or fear of becoming separated from an entity to which the individual is attached which interrupts normal

functioning or is considered an antecedent to complaints concerning physiological symptoms (American Psychiatric Association (APA), 2013; Mohammadi et al., 2020). A diagnosis of SAD includes the presence of at least three anxiety or fear related psychophysiological symptoms. (APA, 2013). Those symptoms include, but are not limited to, recurrent nightmares that involve a separation theme, exorbitant, consistent worry about severing connection with a major attachment figure or potential injury to that figure, and persistent reporting of somatic symptoms in anticipation of being separated from a major attachment figure (APA, 2013). In addition, adolescents and children must experience symptoms for at least 4 weeks and adults for 6 months (APA, 2013). SAD has a 12-month prevalence of approximately 0.9% - 1.9% (APA, 2013). SAD is most prevalent in children (4%) ages 12 years and younger (APA, 2013). Differential diagnoses include generalized anxiety disorder (GAD), agoraphobia, depressive and bipolar disorders, psychotic disorders, and personality disorders (APA, 2013).

### **Selective Mutism**

Specific situations that inhibit the ability to speak which interferes with occupational pursuit, educational achievement, or social interaction is known as selective mutism (APA, 2013; Oerbeck, et al., 2018). In this case, lack of knowledge is not a contributing factor to the failure to speak. The issue must be disturbing the individual in at least one domain, educational, or social, or occupational and the individual must experience a continuous failure to speak in certain social situations where speech would otherwise be expected (APA, 2013). Duration of symptoms must last for at least 1 month (APA, 2013). A 12-month prevalence of selective mutism is low, ranging between 0.03% and 1% (APA, 2013). Differential diagnoses include but is not limited to, social anxiety disorder, schizophrenia, and communication disorder (APA, 2013).

### **Specific Phobia**

Irrational and disproportionate fear of a situation or object that creates a dysfunction in daily activities is classified as specific phobia (APA, 2013; Ruiz-García & Valero-Aguayo, 2020). Diagnostic criteria include a persistent anxiety, fear, or avoidance lasting 6 months or longer and the anxiety, fear, or avoidance must cause functional impairment across several domains (social, education, and occupational). The specific situation or object must elicit instantaneous anxiety or fear most of the time and cannot be better explained by another psychological or medical disorder (APA, 2013). Prevalence rates for specific phobia differ around the world. The United States and European countries report an approximate 6% - 9% 12-month prevalence estimate, while Asia, Africa, and Latin American countries report lower rates at approximately 2% - 4% (APA, 2013). Differential diagnoses include agoraphobia, social anxiety disorder, eating disorders, and panic disorder (APA, 2013).

### **Social Anxiety Disorder**

As social anxiety disorder is one of the most common psychological disorders with an average prevalence of 4%, it is surprising that significant gaps in understanding the etiology and long-term medical socioeconomic effects still exist (Vilaplana-Pérez et al., 2020).

Psychotherapists evaluating for social anxiety disorder should look for the following: anxiety or fear causing clinically significant impairment across several domains (occupational, situational, and/or educational), anxiety or fear concerning social situations where the individual may be scrutinized by peers, social situations nearly always eliciting anxiety or fear, and the avoidance, fear or anxiety must not be better explained by another psychological or medical disorder (APA, 2013). A 12-month prevalence rate in the United States is the highest worldwide at approximately 7%, while other countries report approximate prevalence rates as low as 0.5% (APA, 2013). Differential diagnoses include panic disorder, agoraphobia, personality disorders,

delusional disorder, and major depressive disorder (APA, 2013).

### **Panic Disorder**

Those who are suffering from panic disorder may experience sudden panic attacks that can last minutes at a time (APA, 2013; Kavita et al., 2020). When evaluating for panic disorder, psychotherapists should look for four or more of the following: sweating, feelings of choking, feeling dizzy, fear of dying, and nausea or abdominal distress (APA, 2013). Panic symptoms must not be better explained by another psychological disorder or medical disorder and must have lasted for at least 1 month (APA, 2013). In European countries and in the United States, 12-month prevalence rates are approximately 2% - 3%, while lower 12-month prevalence of approximately 0.1 % - 0.8% are reported by other countries in Asia, Africa, and Latin America (APA, 2013). Differential diagnoses include anxiety disorder due to another medical condition, and substance/medication-induced anxiety disorder (APA, 2013).

### **Agoraphobia**

Due to the changing diagnostic status of agoraphobia, investigating this psychological disorder has been convoluted (Breuninger et al., 2019). The current diagnostic criteria psychotherapists should consider when making a diagnosis of agoraphobia includes an anxiety or fear of two or more of the following situations: utilizing public transportation, being alone outside of one's home, being confined in an enclosed location, being in a crowd or standing in line, or being in exposed spaces (APA, 2013). The individual purposefully avoids or fears social and public situations due to the probability that if they start to develop panic-like symptoms it would be difficult to escape or find help (APA, 2013). Other diagnostic criteria include, but are not limited to, the anxiety or fear lasting at least 6 months, the given situations nearly always prompting anxiety or fear, and the anxiety, fear or avoidance must not be better explained by

another psychological or medical disorder. Agoraphobia typically peaks in adulthood and has a 1.7% prevalence rate in adults and adolescents (APA, 2013). Differential diagnoses include major depressive disorder, specific phobia, panic disorder, and acute stress disorder (APA, 2013).

### **Generalized Anxiety Disorder**

fMRI studies on those who have been diagnosed with generalized anxiety disorder (GAD) have revealed consistent abnormalities in the prefrontal cortex (PFC) region of the brain (Li et al., 2020). Psychotherapists should take this into consideration when assessing for GAD. Additionally, when considering a diagnosis of GAD, psychotherapists should look for the following: disproportionate worry and anxiety occurring more often than not for at least 6 months, difficulty controlling the anxiety or worry, and the anxiety or worry is causing significant dysfunction in several domains (educational, occupational, and/or social) (APA, 2013). The United States reports the 12-month prevalence rates at 2.9% for adults and 0.9% among adolescents while other countries range from 0.4% to 3.6% (APA, 2013). Differential diagnoses include social anxiety disorder, depressive, bipolar, and psychotic disorders, and adjustment disorders (APA, 2013).

### **Substance / Medication-Induced Anxiety Disorder**

Several substances can induce physiological responses when introduced into the body or when the body is withdrawing from them (APA, 2013). Those who experience symptoms of panic and anxiety soon after using a substance are typically diagnosed with substance / medication-induced anxiety disorder (APA, 2013). An essential feature of substance / medication-induced anxiety disorder is prominent symptoms of panic or anxiety that are observed to be due to substance use (APA, 2013). A 12-month prevalence rate for this disorder is

approximately 0.002%, however, it is important to note that the data provided for the prevalence rate is not clear (APA, 2013). Differential diagnoses include delirium, anxiety disorder due to another medical condition, and substance intoxication and substance withdrawal (APA, 2013).

### **Anxiety Disorder Due to Another Medical Condition**

Other medical conditions can manifest anxiety and panic attacks. Diagnostic criteria for anxiety disorder due to another medical condition includes, but is not limited to, the disturbance being a direct consequence of another medical or pathophysiological condition, the disturbance causes clinically significant distress across several domains, and the distress does not transpire during a course of delirium (APA, 2013). The prevalence rate of anxiety disorder due to another medical condition is unclear (APA, 2013). Differential diagnoses include delirium, illness anxiety disorder, adjustment disorder, and substance/medication-induced anxiety disorder (APA, 2013).

### **Development and Prognosis Factors**

Prognostic and developmental factors that may contribute to an anxiety disorder span several human domains such as behavioral, cognitive, genetic, and neurobiological (Kring & Johnson, 2018). The behavioral theory of developing an anxiety disorder originates from Mowrer's two-factor model which includes classical conditioning and operant conditioning (Kring & Johnson, 2018). Although Mowrer's original two-factor model is not fully supported by the literature in regard to developing an anxiety disorder, it has provided a foundation to further investigate behavioral factors that impact the prognosis and development of anxiety disorders (Kring & Johnson, 2018). One identified behavioral factor is that those with anxiety disorders are much more responsive to actual and perceived threats (Kring & Johnson, 2018).

To account for this behavioral factor, researchers have investigated neurobiological



components and found several neurobiological structures that, when dysfunctional, may contribute to anxiety disorders (Kring & Johnson, 2018). These structures include the amygdala, the medial prefrontal cortex, the stria terminalis, the anterior cingulate cortex, the insula, and the hippocampus (Kring & Johnson, 2018). Although it is difficult to determine the causality of dysfunctional neurobiological structures, literature shows that it may be a combination of one's genetics and environment (Kring & Johnson, 2018; Brewer-Smyth & Koenig, 2014; Mahajan, 2018; Forkey, 2019).

Aside from neurobiological and behavioral factors, researchers have identified several cognitive factors as key components to anxiety disorders as well (Kring & Johnson, 2018). Some examples of these cognitive factors are intolerance of uncertainty, continuous negative beliefs concerning the future, perceived absence of control, and overactive consideration to indicators of threat (Kring & Johnson, 2018). While an anxiety disorder may seem inevitable given the associated risk factors mentioned above, these factors are only antecedents to the possibility of developing an anxiety disorder (Kring & Johnson, 2018).

### **Assessment**

Given that other psychological disorders can appear as an anxiety disorder (APA, 2013; Kring & Johnson, 2018), it is important to properly differentiate between psychological disorders. Understanding key differences in disorders helps drive treatment planning (Falk et al., 2020). Understanding the diagnostic criteria for anxiety disorders is the most important factor as it allows the psychotherapist to identify key characteristics that will help with diagnostic precision (Falk et al., 2020). Because anxiety disorders can resemble other psychological disorders (Mohammadi et al., 2020; Kring & Johnson, 2018), the psychotherapist should carefully consult the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; APA, 2013)

when assessing for anxiety disorders.

In addition to consulting the DSM, the psychotherapist should formulate a complete clinical picture of the client. Formulating a comprehensive clinical picture involves three general processes: tests, observations, and interviews (Sheperis et al., 2020). Though a streamlined psychological assessment process would be optimal, the reality is that no two clients are the same and predicting which psychological assessment method will provide the necessary clinical data for developing a reasonable hypothesis of a client's presenting psychopathology is challenging (Sheperis et al., 2020).

The initial interview is considered the foundation of assessments (Sheperis et al., 2020). During the clinical interview, a psychotherapist may rely on observation and active listening to formulate a general hypothesis of the presenting psychopathology (Sheperis et al., 2020). Depending on the information disclosed within the initial interview, the psychotherapist may utilize a series of psychometric instruments to formulate a more precise clinical picture. In the case of evaluating a client for an anxiety disorder, a psychotherapist could utilize the following process: perform an initial interview and then perform a battery of psychometric instruments assessing for anxiety characteristics. It is important to note that it is the responsibility of the psychotherapist to determine which psychometric instrument to use (Sheperis et al., 2020).

The psychotherapist should select psychometric instruments that will yield the clinical data needed and that align with the initial diagnostic impression (Sheperis et al., 2020). There are many anxiety-related psychometric instruments available for use including, but not limited to, Social Phobia and Anxiety Inventory (SPAI; Panayiotou et al., 2017), Penn State Worry Questionnaire-Abbreviated (PSWQ-A), Generalized Anxiety Disorder-7 (GAD-7), Geriatric Anxiety Inventory-short form (GAI-SF; Shrestha et al., 2020), and the Beck Anxiety Inventory

(BAI; Ayala et al., 2005). Given that no two clients are the same, the process outlined above may differ depending on the client. Generally following the above process, however, should provide the necessary clinical data to properly assess a client with an anxiety disorder.

### **Treatment**

Although cognitive behavioral therapy (CBT) is an effective, evidence-based psychotherapeutic orientation for treating anxiety disorders (Alavi & Hirji, 2020; Nordh et al., 2017; Alavi & Hirji, 2020; Bogels, et al., 2014), it can only be as effective as it is available. Barriers to treatment for those diagnosed with anxiety disorders include lack of trained psychotherapists, clients being unable to take time off of work for treatment, and long-distance traveling (Nordh et al., 2017), to name a few. To overcome these barriers, the literature supports receiving evidenced-based CBT via the internet (Nordh et al., 2017; Alavi & Hirji, 2020). Researchers conducting a study with internet-delivered CBT (ICBT) showed a significant decline in participants' anxiety severity scores post-treatment ( $t(26.05)=5.62, p<0.001; 95\% \text{ CI } 0.61 \text{ to } 1.72$ ; Nordh, et al., 2017). These results are consistent with a similar study in which researchers explored the effectiveness of delivering CBT via email and PowerPoint (eCBT) to a sample of Iranian participants diagnosed with an anxiety disorder (Alavi & Hirji, 2020). Compared to the control group, researchers found a significant difference in those who received eCBT ( $F_{3,57} = 101.5, P<0.001$ ; Alavi & Hirji, 2020). These studies indicate that where in-person CBT is not available, there are effective treatment alternatives for treating anxiety disorders.

As exposure is a focus for effective treatment of anxiety disorders, CBT is commonly utilized provided that the CBT involves the exposure of an anxiety-provoking situation or object (Robillard et al., 2010; Kring & Johnson, 2018). Although the ideal exposure is *in vivo*, at times

it is difficult for the psychotherapist to properly provide a controlled *in vivo* experience (Robillard et al., 2010). To overcome this, researchers have started to explore the effectiveness of utilizing technologically based *in virtuo* (VR) exposure as an alternative to *in vivo* exposure (Robillard et al., 2010; Kring & Johnson, 2018). During an empirical study, results indicated that both CBT with *in vivo* exposure and CBT with *in virtuo* exposure (CBT-VR) were significantly more effective when compared to a wait list control (Robillard et al., 2010).

Although CBT has been shown to be effective in treating anxiety disorders, other psychological treatment modalities are available such as CBT with religious content (Lim et al., 2014), psychodynamic psychotherapy (Bögels et al., 2014), applied gaming (Schoneveld et al., 2020), acceptance and commitment therapy (ACT; Fathi et al., 2017), mindfulness, and psychopharmacological therapies (Kring & Johnson, 2018). While several treatments for anxiety disorders are available, it is important for the psychotherapist to consider culturally based factors when evaluating treatment options (Hays & Erford, 2018).

### **Christian Worldview**

Though not specifically considered a psychopathology within the Word of God, anxiety and fear are mentioned frequently. All throughout the Word of God, anxiety and fear are discussed as negative elements that should not be overlooked and should be taken control of (Amplified Bible, 1954/1987, John 14:1; Proverbs 12:5; Ecclesiastes 2: 22; Isaiah 41:10; 2 Timothy 1:7; John 14:27; Philippians 4:6-7). It is difficult for one to haphazardly put aside the importance of identifying anxiety- and fear-provoking situations in light of these scriptures. The Word of God teaches that, though troubles are inevitable, believers should rejoice and purposefully keep good attitudes (Amplified Bible, 1954/1987, John 16:33).

The bible teaches an effective method to overcome anxiety, fear, and the pressures of

inevitable troubles, calling it *renewing of the mind* (Amplified Bible, 1954/1987, Romans 12:2). It is, in essence, a form of CBT. The idea of focusing on thought processes (meta-cognitions) is found in Romans 12:2 (Amplified Bible, 1954/1987) and all throughout the Word of God (Amplified Bible, 1954/1987, Colossians 3:2; Romans 8:5; Philippians 3:19; Psalm 1:2; Psalm 63:6; Psalm 119:15; Proverbs 4:4; Proverbs 3:1).

Though it may be foreign to some, the literature does show support for the integration of religious content and CBT in treating psychological disorders (Lim et al., 2014). Although researchers failed to find evidence to support religiously modified CBT as a suitable psychological intervention for treating psychological disorders, findings did show that incorporating religious content with CBT was an adequate treatment modality for religious individuals (Lim et al., 2014). Further research by Chapman and Steger (2010) showed a negative correlation between positive religious coping strategies and measures of anxiety ( $r = -.43, p < .001$ ). These studies and the above referenced scripture suggest that religious-themed psychological interventions for treating anxiety disorders may be effective for religious individuals.

### **Future Research Considerations**

Though the literature supports the idea of updating the biopsychosocial model to include the spiritual dimension of the individual (Saad et al., 2017), it would appear that the Church is still holding a strong separation between psychology / psychotherapy and Christianity (Entwistle, 2015). The discussion of updating a mental health professional's paradigm to include spiritual development seems one-sided. While the literature discusses the need for mental health professionals to include the spiritual dimension of the individual (Saad et al., 2017) and suggests the incorporation of spiritual assessments within the psychological assessment process (Hodge,

2005), little is mentioned about updating the Church's theological paradigms to put a greater emphasis on the psychological dimension of the individual. Due to the limited research on the relationship between Christianity and mental health (Santos & Kalibatseva, 2019) and the hostility regarding the place of psychology and psychotherapy within the Church (Entwistle, 2015), future studies could investigate factors that inhibit church leaders from considering psychological disorders in the same perspective as biological ailments (heart disease, cancer, etc.).

### **Conclusion**

Human development is multidimensional and complex (Wong et al., 2015) which can make it difficult to properly diagnose an individual experiencing a psychological disorder. The ability to differentiate between psychological disorders is important (Falk et al., 2020) and failing to do so may result in a misdiagnosis. Given that anxiety disorders have similar characteristics to other psychological disorders (Kring & Johnson, 2018; Falk et al., 2020), a thorough psychological assessment is necessary (Sheperis et al., 2020).

A generalized assessment strategy for anxiety disorders includes the initial interview and the psychotherapist's discretion in the utilization of psychometric instruments (Sheperis et al., 2020). The goal for a psychological assessment is eliciting enough clinical data to formulate a comprehensive clinical picture of the client's symptomology (Sheperis et al., 2020). Equipped with a comprehensive clinical picture, the psychotherapist may decide upon the psychotherapeutic techniques that best fit the client (Sheperis et al., 2020).

Though anxiety disorders are prevalent (Chapman & Steger, 2010), several evidence-based treatment options are available including, but not limited to, CBT (Kring & Johnson, 2018), CBT-VR (Robillard et al., 2010), internet-based CBT (Alavi & Hirji, 2020; Nordh, et al.,

2017), and psychodynamic psychotherapy (Bögels et al., 2014). Though there is reluctance to incorporate psychology and psychotherapy into the Church (Entwistle, 2015), research has indicated positive mental health outcomes in those who practice positive spiritual coping strategies (Chapman & Steger, 2010). Given the prevalence of anxiety disorders (Chapman & Steger, 2010) and the frequent mention of anxiety and fear throughout the Word of God (Amplified Bible, 1954/1987, John 14:1; Proverbs 12:5; Ecclesiastes 2:22; Isaiah 41:10; 2 Timothy 1:7; John 14:27; Philippians 4:6-7), the effective discussion and treatment of anxiety-related disorders in the Church should no longer be ignored.

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