Religiosity and Anxiety Disorder in Peshawar

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The present research examined the relationship between degree of religiosity and level of anxiety in males and females suffering from anxiety disorder and those who were not suffering from any psychological disorder. A sample of 80 adults was taken from the hospitals and other areas of Peshawar city. It was hypothesized that the subjects suffering from generalized anxiety disorder would be having a lower degree of religiosity as compared to those who were not suffering from any psychological disorder; and females would have a higher level of anxiety and higher degree of religiosity as compared to males. IPAT Anxiety Scale and Index of Religiosity were administered on the subjects. The results supported the main hypotheses and it was found that both males and females suffering from generalized anxiety disorder had a lower degree of religiosity as compared to those males and females who were not suffering from any psychological disorder. The results demonstrated that anxious females had a higher level of anxiety, as compared to anxious males. The degree of religiosity was found to be higher in males than in females in both anxious and nonanxious groups.

Key words: Religiosity, Anxiety, Generalized Anxiety Disorder

Religion has always played a very important role in human life. Religion is analysed by psychologists as a prominent and leading force that drive people's behavior in a certain direction. Religion is typically associated with commitment to a supernatural power that is expressed through ritual and celebration both individually and within the context of a faith community. According to Yinger (1970) religion is a structure of practices and beliefs, which people use to solve problems in their lives. The term "religion" connotes a common belief system, a set of principles and practices, a code of conduct, and doctrine or dogma. (Hill et al. 2000; Knox et al. 1998; Love 2001, Love, 2002)

The term religiosity, from Islamic point of view, is related to religious faith, practice, knowledge and general code of conduct. The fundamental principles of Islamic doctrine include belief in (a) oneness of God (b) Prophethood of Muhammad (Peace Be Upon Him) and in his leadership and direction, (c) the life after death and in man's accountability before God on the Day of Judgment. Prayer (Salat), fasting (sawm), charity (zakat) and pilgrimage (Hajj) are some of the mandatory rituals. The knowledge about the teachings of Islam comes from the Holy Quran and the life and teachings of the Holy Prophet (PBUH). Islam provides a code of life. Its principles are so inclusive as to include the whole of the human survival. Faith in religion plays a very important role in reforming human life, and motivates people for the pervasiveness of good (Ahmed, 1993).

Some theorists propose that religiosity is unidimensional (e.g., Allen and Spilka, 1967), while others deem it to be multidimensional (Broen, 1957; Cline and Richards, 1965). Glock and Stark (1965) proclaimed that belief, practice, experience, knowledge and the effects of religion on one's life are the different dimensions through which we can define religion. Kendler et al. (2003) explained seven dimensions of religiosity, i.e., "general religiosity, social religiosity, involved God, forgiveness, God as judge, unvengefulness and thankfulness."

There are many different religious doctrines in the world. Despite the tremendous religious diversity that exists all over the world, there is one thing that all groups have in common. They all believe they're right. It is this faith of being on the right path which makes people turn towards religion in the times of problems and worries. They try to find solutions to their problems through prayers, chanting and other types of rituals. In other words, they seek refuge in religion in the time of worry and anxiety. Sometimes the individual fails to defeat his or her anxiety, and the problem may get severe. If the anxiety persists for a longer period of time, and severe enough to interfere with normal functions of the individual, this situation may signal towards developing anxiety disorder.

Anxiety and fear are basic human emotions that have been crucial for survival both as an individual and as a species. Anxiety can be seen as a normal reaction to a stressor, which may be external - or internal (Boon 2003).

Barlow believed that each individual has a defensive motivational system. In this system, people have an articulate cognitive-affective construct that he called anxiety. This anxiety can be explained as a feeling of lack of control that is primarily

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related to future, i.e., regarding some danger, threat or some challenge that may have negative result (Barlow, 2002). When this sense gets severe, it may lead to anxiety disorders.

According to Boon (2003) "Anxiety disorders is a term used to describe imbalance in an individual's feelings or 'states' of anxiety, that is, the levels of tension, nervousness, distress, or uncomfortable arousal, which they perceive." Feldman (1990) defines anxiety disorder as "the occurrence of anxiety without obvious external cause, intruding on daily functioning."

As described in the *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition, (DSM IV), anxiety disorders include generalized anxiety disorder (GAD), phobias, panic disorder, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), anxiety secondary to medical condition, acute stress disorder (ASD), and substance-induced anxiety disorder.

People with Generalized Anxiety Disorder (GAD) feel anxious most of the time. Their worries are exceptionally high about usual events or conditions in their lives. Their worries are often related to money, relations, health, and interaction with others. They are aware that their anxiety is illogical but they find themselves unable to control their worries (DSM IV, 1994). For example, they may worry extremely about their financial position in spite of the fact that there is no problem with the situation.

Most anxiety disorders, as well as depressive disorders, are at least twice as common in women (Dickstein, 2000). Women are more prone to anxiety and depression due to a variety of biological, psychological and cultural factors (Smick, 2001).

A commonly advanced explanation for gender differences in these disorders is that women are relatively powerless when compared with men, and are more likely than men to suffer from the kind of social deprivation and stress which may lead to depression or anxiety (Loewenthal, 2007). Biologically, this has to do simply with women's different reproductive role. Socially, it is not at all surprising that in a male-dominated society like ours, women face a lot of pressures in their lives, whether they are students, on job or stay and work at home. So the woman is simply more vulnerable than the man and perhaps even more in need of the social and psychic comfort of religion. Scholars have noted that women are religious at rates significantly higher than men.

Religious differences between women and men have been documented across the life span. Among adolescents and college students, girls and women are significantly more likely than boys and men to be religious in variety of aspects like attending religious services, feel assured that God is present and active in their lives, and derive comfort and security from faith (Smith et al. 2002; Smith & Denton 2005; Buchko 2004).

Religious gender differences in adulthood are also implied in much of the literature. Bergan and McConatha (2001) found that measures of religiosity increased with age, and also found a higher level of religiosity in women as compared to men.

Gendered patterns in religiousness have also been studied in later adulthood. For example, Neill and Kahn (1999) reported that among older widowed women, religious involvement is associated with peace, pleasure, and satisfaction in life. They articulate that through faith in God and prayer, women are able to cope with stress and find meaning and purpose to life and death. In addition, feminist therapists have drawn on spirituality as an avenue for women to find solace, healing, and direction (Hunt 1995; Kaschak 2001) in the period of chaos which make them prone towards anxiety and depression.

It is quite understandable that when we feel most vulnerable, we are the most religious. We seek help of divine powers through different means depending on one's religious teachings. In our society, it is our common observation that in troublesome situations, people increase the frequency of prayers (nawafil), utter different holy recitations (vird or wazaif), or visit religious or spiritual teachers.

Religion profoundly influences our social environment. It guides us towards our goals and social interactions. Belief in religion is a feature of our propensity to struggle for excellence, precision and pre-eminence. It is also seen as a way of coping with stress. So religion seems quite relevant to our understanding of human behavior and treatment of psychological disorders because of its immense applicability to mental health concerns. Many studies have focused on the relationship between religion and psychological disorders which is evident by the following researches.

Gartner, Larson and Allen (1991) analyzed empirical data and found some relation of religion with psychopathology, but they found strong association between religiousness and mental health.

It has also been found that religious commitment is linked to greater life satisfaction and improved psychological health (Kaldestad E.1996; Coke M.1992). Kendler (1997) found association of religious devotion with lower incidence of depression, while Koenig, George and Meador linked religiosity to lower incidence of psychiatric disorders in general (Koenig, George, Meador, et al. 1994).

Davis, Kerr, and Kurpius (2003) studied intrinsic religious orientation, religious, spiritual and existential well being, and anxiety. They concluded from their study that the higher a man feels or rates him on these dimensions, the lower is the level of anxiety that he experiences.

A study, "Religion and Immune Function" by Koenig et al. (1997) found that people who attend church more often have better working immune systems as compared to those who attend church less often. This gives us a clue to explain the reason behind better health outcomes of those who frequently attend church.

Larson, D. B. (2003) conducted longitudinal studies and found that being religious, especially active involvement in religious rituals and activities are related to longer life span. This signifies religion to be a possible cause of health. For many people, who are either mentally or medically not well, religiosity can provide resilience, defend against depression and decrease possibility of suicide and substance abuse.

Harris, Schoneman, and Carrera (2002) investigated trait anxiety in college students. They found from their study that the characteristics of an individual's prayers, religious loyalty and connections with other religious fellows are negatively related to trait anxiety.

According to Pargament (2002), being religious especially helps in the times of stress. He adds that the usefulness of religiosity highly depends on how well the religion is incorporated in a person's life.

Several studies have shown that those who are religiously active have lower mortality rates and lower levels of anxiety and depression (Maltby 1998; Hummer, Rogers and Nam 1999). In Iran, Vasegh and Mohammadi (2007) found evidence for a protective role of religion against anxiety and depression. Similarly, Alsanie (2002) conducted a study in Saudi Arabia and found a significant negative relationship between religiosity and anxiety.

In accordance with these findings, this study attempts to find if people suffering from generalized anxiety disorder have a lower degree of religiosity as compared to those people who are not suffering from any psychological disorders.

Hypotheses

The subjects suffering from generalized anxiety disorder will have a lower degree of religiosity as compared to those who are not suffering from any psychological disorder.

Males suffering from generalized anxiety disorder will have a lower degree of religiosity as compared to those males who are not suffering from any psychological disorder

Females suffering from generalized anxiety disorder will have a lower degree of religiosity as compared to those females who are not suffering from any psychological disorder

Females suffering from generalized anxiety disorder will show a higher level of anxiety as compared to the males suffering from generalized anxiety disorder

The females suffering from generalized anxiety disorder will have a higher degree of religiosity as compared to the males suffering from generalized anxiety disorder.

Method

Sample

The sample consisted of 80 subjects (N=80), which included those who were suffering from generalized anxiety disorder (n=40) and those who were not suffering from any psychological disorder (n=40), including equal number of males and females. The sample ranged in age from 18 to 45 years, with mean age of 31.5 years. All of them were matched on educational and socioeconomic level. The subjects suffering from generalized anxiety disorder were taken from Khyber Teaching Hospital and Lady Reading Hospital, Peshawar. The subjects who were not suffering from any psychological disorder were selected from inside Peshawar. Convenient sampling technique was used for this purpose.

Instruments

1. Index of Religiosity (IR) was administered to measure the degree of religiosity of the subjects. It was developed by Shagufta Aziz and Ghazala Rehman at the National Institute of Psychology, Quaid-i-Azam University, Islamabad, Pakistan. The Urdu version of IR consists of 27 questions. It provides a valid measure of religiosity of the Muslim subjects on three dimensions, i.e., religious faith, religious doctrine and religious effect. The reported split half reliability of the test is 0.80 and KR-20 is 0.83 (Aziz, S. & and Rehman, G. 1996).

2. IPAT Anxiety scale was used to measure the level of anxiety of the subjects. It was developed by R.B.Cattell and I.H. Scheier in 1963. This scale consists of 40 questions and gives an accurate appraisal of free anxiety level, supplementing clinical diagnosis and facilitating all kinds of research or mass screening operations rapidly, objectively and in a standard manner. The reported test-retest reliability of the scale is +0.93 and its construct validity is estimated at +0.85 to +0.90 (Cattell & Scheier, 1963).

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3. Semi-Structured Interview was conducted on each subject to get some personal and demographic information and some facts about the nature, history, duration and intensity of the problem.

Procedure

The research was conducted in two phases. In phase I, after taking formal permissions from the management of Khyber Teaching Hospital and Lady Reading Hospital, Peshawar, those subjects were approached in the out-patients departments of the hospitals who were diagnosed by the psychiatrists as suffering from generalized anxiety disorder. The diagnosis was also confirmed by using the criteria of generalized anxiety disorder given in DSM IV (1995). The subjects were approached individually and rapport was developed with them. They were

assured about the confidentiality of their responses. A semi structured interview was conducted on each subject to get information about demographics, nature, history, duration and intensity of the problem.

After this, two tests were administered on each subject. Before administering each test, the standard instructions mentioned in the tests were made clear to them. The first test was IPAT Anxiety Scale which was used to measure the level of anxiety of the subject. Then the Index of Religiosity was administered which was used to measure the degree of religiosity of the subject. After administering each test, it was made sure that every question had been answered by the subject.

In phase II, those subjects were assessed who were not suffering from any psychological disorder. They were selected from different areas of Peshawar city. They were also approached individually. Rapport was established with them and they were assured about the confidentiality of their responses. In order to get some relevant personal and demographic information, a semi structured interview was conducted on them. Two psychological tests were administered on each subject. Each test was administered after the standard instructions mentioned in the tests were given clearly to them. IPAT Anxiety Scale was administered to assess the subject's level of anxiety, following which their degree of religiosity was measured through the Index of Religiosity. After administering each test, it was made sure that every question had been satisfactorily answered by the subject. In the end, all the subjects were thanked and their cooperation was acknowledged.

Results

Table 1

Mean, standard deviation and t-value of degree of religiosity of anxious and non-anxious groups on index of religiosity

Group	*N*	*M*	*SD*	*t value*
Anxious	40	53.48	10.66	7.718*
Nonanxious	40	70.20	8.61	

The above table shows highly significant difference (p<.001) between anxious and non-anxious groups on Index of Religiosity. The figure shows that the anxious group has lower religiosity as compared to non-anxious group.

Table 2

Mean, standard deviation and t-value of degree of religiosity of anxious and nonanxious males on Index of Religiosity

Group	*N*	*M*	*SD*	*t-value*
Anxious	20	54.25	10.25	7.123**
Nonanxious	20	72.80	5.53	

The above table shows a highly significant difference (*p*<.001) between anxious and nonanxious males on Index of Religiosity.The figures show that anxious males have lower religiosity as compared to the nonanxious males.

Table 3

Mean, standard deviation and t-value of degree of religiosity of anxious and nonanxious females on Index of Religiosity

Group	*N*	*M*	*SD*	*t-value*
Anxious	20	52.70	11.27	4.352**
Nonanxious	20	67.60	10.36	

The above table shows a highly significant difference (*p*<.001) between anxious and nonanxious females on Index of Religiosity. The figures show that anxious females have lower religiosity as compared to the nonanxious females.

Table 4

Mean, standard deviation and t-value of level of anxiety of anxious males andfemales on IPAT Anxiety Scale

Group	*N*	*M*	*SD*	*t-value*
Males	20	8.95	1.05	.620
Females	20	9.15	0.99	

The above table shows the difference between anxious males and females on IPAT Anxiety Scale. The figures show that anxious females have a higher level of anxiety as compared to the anxious males but this mean difference is not significant.

Table 5

Means, standard deviations and t-value of degree of religiosity of anxious males and females on Index of Religiosity

Group	*N*	*M*	*SD*	*t- value*
Males	20	54.25	10.25	.455
Females	20	52.70	11.27	

The above table shows the difference between anxious males and females on Index of Religiosity. The figures show that anxious males have higher religiosity as compared to the anxious females but this mean difference is not significant.

Discussion

The findings of the study supported our main hypotheses and it was indicated that the males and females suffering from generalized anxiety disorder had a lower degree of religiosity as compared to those males and females who were not suffering from any psychological disorder. The study also found that there are some gender differences in the level of anxiety, degree of religiosity and the symptomatic profile of generalized anxiety disorder; however, these differences are not very high.

The results of this study demonstrated that the subjects suffering from generalized anxiety disorder showed a significantly lower degree of religiosity as compared to thosewho were not suffering from any psychological disorder (t = 7.718, p<.001) as shown in table 1. The mean difference between the scores of anxious and non- anxious groups on Index of Religiosity is highly significant (p<.000). This strongly supports our hypothesis no 1, i.e., "the subjects suffering from generalized anxiety disorder will have a lower degree of religiosity as compared to those who are not suffering from any psychological disorder".

Several studies show that people suffering from some psychological disorder report lower degrees of religious affiliations. For example, Harris et al. (2002) found that strong religious faith, regular prayers and connecting to others in the religious reference group have a negative relationship with trait anxiety.

Kendler et al. (2003) analyzed the role of religiosity in psychological disorders and found that some aspects of religiosity, such as social religiosity, unvengefulness and thankfulness relieved disorders like phobias, panic and generalized anxiety disorders.

A study, "Religion and Immune Function" by Koenig et al. (1997) found that regular worshippers enjoy better health as compared to less frequent worshippers, possibly because of better and stable immune systems.

The findings of our study did not differ when males and females were taken separately. The results indicated that anxious males showed a significantly lower degree of religiosity as compared to non-anxious males, table 2, ($t = 7.123$, $p<.001$), thus firmly supporting our hypothesis no 2, i.e., "males suffering from generalized anxiety disorder will have a lower degree of religiosity as compared to those males who are not suffering from any psychological disorder". Similarly, it is also indicated that anxious females showed a statistically significant lower degree of religiosity as compared to non-anxious females, table 3, ($t = 4.352$, $p<.001$). These findings strongly supports our hypothesis no 3, i.e., "females suffering from generalized anxiety disorder will have a lower degree of religiosity as compared to those females who are not suffering from any psychological disorder".

Religious thoughts and sentiments are closely related with a person's attitude and outlook and spirituality can act as a buffer or cushion for a person in the time of agony (Garroutte et al., 2003).

The difference in the degree of religiosity between anxious and nonanxious groups in our sample can be attributed to the fact that religious people base their lives on faith, with belief in the existence of God and His care for them. They believe that God will help them in the time of suffering. They see worship as essentially an expression of reliance, confidence and connectedness to God. They trust the Creator as being the ultimate savior. This confidence in God may improve self confidence. Without this confidence, people may feel fear, apprehension and helplessness because of a perceived inability to predict, control, or obtain desired results or outcomes in certain upcoming situations or contexts. This fear and uncertainty is the basic characteristic of anxiety which, if gets severe, may ultimately lead to anxiety disorders.

The results of the study demonstrated that females suffering from generalized anxiety disorder had a higher level of anxiety as compared to the anxious males thus supporting our hypothesis no 4, i.e., "females suffering from generalized anxiety disorder will show a higher level of anxiety as compared to the males suffering from generalized anxiety disorder". Though the statistical difference between these females and males is found to be non-significant, ($t = .620$, $p = .539$), but the mean anxiety level of females is higher than that of the males as shown in table 4 (mean males: 8.95, mean females: 9.15).

Generalized anxiety disorder and other anxiety disorders, are found to be associated with depressive feelings and thinking that affect women. Statistics prove that girls develop anxiety disorders in younger age and at a faster rate than boys. By age 6, twice as many girls have experienced an anxiety disorder (Hankin and Abramson 2001).

According to a study conducted by Simonds, and Whiffen (2003), women are expected to suffer from anxiety more than men. Women are also more apt to be diagnosed with either anxiety disorder alone or co-morbidly with depression.

Different aspects of anxiety have been studied by different researchers, such as Frot, Feine, and Bushnell (2004) studied the gender differences in pain anxiety and found that women rate pain higher than men, but despite their lower pain ratings, males have more anxiety related to pain.

The findings of a community survey of adolescents of rural origin suggested that women scored higher on a self-report anxiety instrument not only for total anxiety, but also for some subtypes of anxiety, such as generalized anxiety disorder, separation anxiety disorder, panic disorder, social phobia, and school phobia (Puskar, Sereika, and Haller, 2003).

The results of the study revealed that females suffering from generalized anxiety disorder had a lower degree of religiosity as compared to the anxious males, table 5, ($t = .455$). This does not support our hypothesis no 5, i.e., "the females suffering from generalized anxiety disorder will have a higher degree of religiosity as compared to the males suffering from generalized anxiety disorder". However, this difference between the genders is statistically non significant ($p = .652$).

McCartney and Hetrick (2001) found that gender could not always predict religiosity. However, Stark (2002) in his article, "Physiology and faith: Addressing the universal gender difference in religious commitment", argues that men are less religious than women and this fact can be generalized around the world. He broadens his argument by saying that this difference is quite apparent and understandable because it seems to be the result of differential sex role socialization.

Mirola (1999) also finds that women are not only more religious but also prone to depressive disorders at rates significantly higher than men. In "The religiosity of women in the modern West", Walter and Davie (1998) put forward the premise that as women's bodies are more vulnerable women should be more religious. They also note the dearth of research in the area.

The results of the present study demonstrate that males and females in both anxious and nonanxious groups do not differ much regarding their degree of religiosity. This may be attributed to many factors. It is a well known fact that in our society, women lag behind men in knowledge and exposure. The literacy rate of women is far less than men. Women may pray, fast and perform many other rituals b ut lack in sufficient knowledge about Islam. Consequently, they score low on the items based on religious knowledge as compared to men. The society of NWFP is thought to be quite religious and the men too perform rituals quite regularly. Thus they score hi gh on those items as well, which are related to the ritualistic aspects. As a result, males show an overall higher degree of religiosity as compared to females.

Conclusion

Results of the present study demonstrated that in the general population of Peshawar, people suffering from generalized anxiety disorder had a lower degree of religiosity as compared to those who were not suffering from any psychological disorder.

Implications

In Pakistan, religion is integral to every part of life includ ing psychotherapy. The low literacy rate, general social structure of the society with a loose hierarchical family system and a lack of awareness together make it difficult to expose people to the knowledge and treatment of psychological disorders. Psychology, which came to Pakistan in 1960s, is in itself a relatively new exposure. It is quite understandable that people have very little knowledge about psychological disorders and their treatments.

There is still a general belief in “occupation” by demons and evil spirits. For the treatment of such “occupied” persons, the patients are taken to the so-called spiritual healers. Moreover, a variety of strata of mystics or Sufis exist, to whom the sufferers go in a hope that their worries would be alleviated.

The social psychology of people complicates the issue if the suffering person is somehow brought to the psychotherapist. The patient usually does not reveal himself and does not even expect the therapist to intrude deeply into his personal life, a nd western mode of treatment may become quite unentertaining for the patient. It is, therefore, conceivable that the Muslim clients of Pakistan will identify more with an Islamic mode of treatment instead of a therapeutic strategy based on western principles.

To embody this idea, some evidence of scientific studies was needed. Since anxiety disorders are the most prevalent class of mental disorders (Barlow 2002), the role of religiosity in these disorders in the context of Pakistani society was chose n for this study.This research proved that religiosity does have a relationship with generalized anxiety disorder. So this study may be of some benefit and help the clinicians to identify an avenue for treating the patients.

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Received: November 11, 2011
Revision Received: April 6, 2012