6 Anxiety, Compulsions, and Hysteria

We live, they say, in an age of anxiety. In spite of all progress, modern society is full of anxieties and insecurities. They range from worries about ecology to fear of a nuclear catastrophe, from fears that are justifiable in a dangerous world, to groundless anxieties about contracting an incurable illness. Of course, fear has always been around, indeed, it is just part of human existence. Anxiety takes many forms and affects even committed Christians, yet it does not seem to be unconquerable. Although many people suffer from anxiety especially in times of personal crisis, they still manage to find ways of living with the fear and doing, what they have to do. Normally they are open to receive encouragement, and comfort, and after a short time they regain their inner peace.

For a »neurotic« person, it is different. Her thoughts, feelings and behaviour are moulded by fears of an abnormal intensity, which she is unable to put into words. Not without justification, German author Riemann has described the neurotic personality disorders collectively as »basic forms of anxiety«.

Anxiety as an Illness

For many people, fear becomes a disease which overshadows their whole life. When this happens, the doctor will diagnose an »anxiety syndrome«. Often no adequate basis for the anxiety can be found. Even in the

simplest of situations, the afflicted person becomes tortured by overpowering feelings of confinement and threat which at times grow to the level of absolute panic, all with little reason – from the normal point of view. These fears give rise in the process to accompanying physical symptoms, which are as intense as if the afflicted person really was facing immediate danger.

A woman described her anxieties to me in the following memorable way: »If I look out of the window, I'm afraid of falling out. I never get into an elevator, because I'm afraid it might get stuck. I'm continually afraid of an accident when I'm in the car, and at work I worry that I may make a mistake and lose my job. For years I've sent my husband to do the shopping. If I go to church, I'm afraid of the crowd, my heart goes into my mouth and I can't catch my breath. If I read my Bible, I get afraid that I'm not saved, or that I'm possessed by an evil spirit, even though I really know I'm in God's hands. I simply can't fight against these fears. Things do improve when I take medication ... but even then I'm afraid of becoming addicted.«

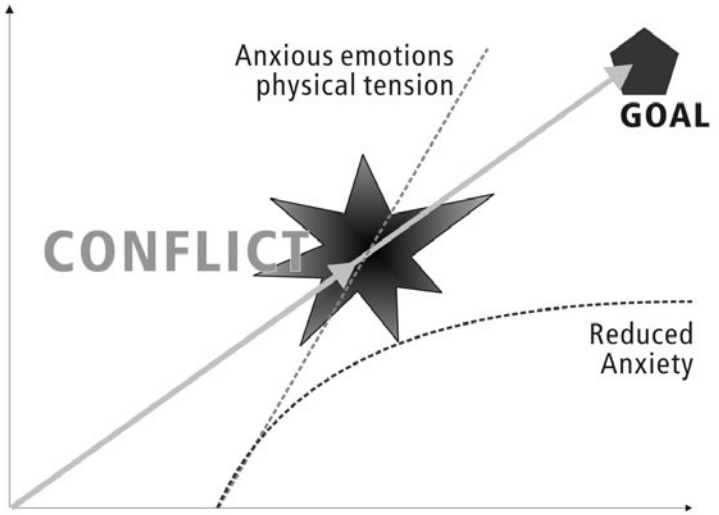
Imprisoned by Fear

People who are afflicted in this way often live in a panicky fear of fear. For this reason, they avoid everything that provokes fear or increases it. A gifted young man will not dare to accept a further promotion because every time he has to take on increased responsibility, he is attacked by massive anxieties and headaches. A housewife will prefer to stay in the security and peace of her home, rather than go shopping and be constantly plagued by the fear of fainting and falling down in public. Every heartbeat, every feeling of nausea, increases her fears and drives her more and more into isolation.

People with anxiety syndromes suffer enormously as a result of their limitations, but they would rather live alone and withdrawn than set in motion the terrible feelings of anxiety which they remember from previous experiences.

Quite often a patient with an anxiety syndrome will find enough resolve to gradually allow himself to face situations which would previously have caused him to be afraid. He dares, perhaps with the help of a pastoral counsellor or a therapist, to try to make the first few steps. To begin with, he is able to suppress the slight unease which rises up inside him, but then the old fears begin to surface once more. In the end he reaches a point where he is no longer able to blot out the distressful inner tension. Time after time, he gives up in resignation and draws back into the security where he still feels reasonably comfortable. Figure 6.1 represents this state of affairs in the form of a diagram.

Figure 6.1: Fear as a hindrance on the path towards a goal
The thick line shows the path to the goal (e.g. going shopping alone). After a few steps the fear level rises (broken line) and becomes stronger and stronger until the sick person decides to withdraw from her intention. The dotted line shows the fear suppressed (e.g. through medication), making the attainment of the goal possible.



Help With Anxiety Syndromes

Is there then any way of suppressing this anxiety far enough to allow the afflicted person at least the possibility of reaching simple goals with a tolerable level of anxiety? Could they not relax, if they really wanted to? Perhaps they could become free of their anxieties, if they worked through their childhood experiences or received »inner healing«?

I would be really glad to answer with a simple »yes«. But anyone who has shared the pain and futile search for healing of a person with a severe anxiety syndrome will be more cautious and compassionate. With less se-

vere anxieties, relaxation techniques of various kinds can certainly be of great help, yet they have no effect with severe anxiety syndromes. In fact, the experience of getting only marginal alleviation by their conscious effort to relax, leads patients into new fears of never finding relief at all. The same kind of frustration is experienced by people with anxiety neuroses with regard to those forms of psychotherapy which try to use strong emotions as a way to change a person. These often achieve exactly the opposite of the desired effect, namely increase of fear, and further withdrawal into resignation.

There then remains the question of directly influencing the biochemistry of the brain through medication. Today we know that there are receptors in the brain which bind with tranquillising drugs such as Valium, but also with alcohol, and lead to an obvious relaxation. Against this background it can more readily be understood why alcoholism and misuse of tranquillisers is so widespread.

Although the risk of addiction is a factor which should not be overlooked, professional support and the right choice of medication minimize this risk in patients with anxiety disorders. Medication can bring enough relief to the patient to keep the fear at a bearable level. Recent studies in the development of addiction have shown on the whole that the problem has been exaggerated. Many patients do not increase their dose, and use the drugs very responsibly.

This reduction of fear by medication can be achieved much more easily, if those afflicted feel themselves to be accepted by their doctor, and are encouraged to live within the limitations which are imposed on them by their fears. Herein lies an important role for the pastoral counsellor. The Bible describes human fear with sympathy and yet realism in a way that no other book does. Jesus does not always promise his disciples complete freedom from anxiety, but says to them: »In the world you will have tribulation, but be of good cheer, I have overcome the world.«

Obsessive Compulsive Disorder (OCD)

The 25-year old bank employee looked in the peak of health. Yet he had been incapable of work for the last six months. His suffering had begun several years earlier. When he was counting money, he began to be plagued with the thought that he had made a mistake. Often he had to fight to make sure he had counted the bank notes correctly.

He was weakened further by an attack of influenza. He didn't dare to

go to work, for fear that other people would notice his problem. If he was putting a piece of paper in the typewriter he had to repeat the process ten times. If he received post addressed to him, he had to check every letter typed on the envelope. Often it would take him half an hour to open it. If he went to the toilet, his family knew it would be occupied for an hour.

The compulsion spilled over into his spiritual life. He had to kneel to confess every little sin straight away (with his knees in line with the pattern on the carpet and his face in his hands). He often had to repeat the prayer several times, because he wasn't sure he had done it right.

His day became full of complicated rituals and agonising mental compulsions. Only when he was asleep did he find a few hours respite. He knew well enough that his thoughts were irrational and his behaviour unnecessary, but if he tried to resist them, an uncomfortable tension and fear surged within him, which only subsided when he gave way to the impulses.

This example illustrates the suffering which can be caused by obsessive-compulsive disorder (OCD). This syndrome is fortunately rare (around 0.5 % of the population) and does not always take such a dramatic form as the case I have just described.

We distinguish between obsessive thoughts, compulsions, and compulsive behaviour. *Obsessive thoughts* are determined by fears (for example, that something will happen to you or someone else) or by feelings of guilt (you might do something wrong, or be responsible for someone else's misfortune). *Compulsions* are often ruled by the pressure to do something dangerous or improper (for e.g. sticking out your tongue) or – especially tormenting for Christians – to say something obscene or blasphemous. Of course, the sick person does not act on the impulse, but suffers enormously as a result of her oversensitive conscience.

Compulsive actions, finally, manifest themselves in repeated acts, for instance to do with counting, controlling or washing.

The causes of obsessive compulsive disorder have long been in the dark, and we still do not have all the answers. However, recent research has brought fourth exciting new evidence that there are biochemical processes in the brain involved with OCD . In these patients, the brain is obviously not capable of properly processing and containing information (for instance concerning the cleanliness of the hands), thus repeating behavioural and thinking impulses outside the control of the conscious will.

How these compulsions come about has so far been only inadequately explained. There is mounting evidence that there is a complicated functional disturbance of the brain. In these cases the brain is obviously not ca-

pable of properly holding a piece of information (for instance concerning the cleanness of the h hands) in such a way that it sends out new behaviour and thought impulses regularly and without the control of the will.

Therapy for OCD

To date therapy for the obsessive compulsive disorder syndrome is limited. Release from compulsions cannot be forced. Throughout the decades all the great psychotherapists have advanced theories about the causes of obsessions and compulsions yet the success of the therapies has been modest. »Compulsion«, so it is said, »is the favourite, but most difficult, child of psychoanalysis.« The same holds true for the attempts of pastoral counsellors to help with severe compulsions. Antidepressant medication, such as Clomipramine or Fluoxetine (Prozac), can bring about substantial relief in about 40 per cent of the patients. Thus, even if success is only limited, treatment should be attempted in order to make the inner tension bearable. In addition, cognitive-behavioural therapy can be very helpful to stop the obsessive circle of thoughts and compulsions.

There is hope especially for those patients who suffer from passing obsessive compulsive symptoms, which can occur under stress in a fragile person. In these cases the distressing compulsions can abate in the course of weeks or months without any specific treatment being given.

What can the doctor and the pastoral counsellor do for the person suffering from OCD and for his or her relatives? To start with, it is of immense value for them to be just *accepted* with their affliction. Because of their healthy appearance, the afflicted person often experiences little understanding. People find it hard to believe that they are unable to stop those thoughts and actions. An important task for the carer is therefore to take the sick person seriously and to strengthen the healthy aspects of life (e.g. encouraging to work or occupy herself with activities which are distracting the person from her impulses). The afflicted person will find real relief in being able to talk openly at regular intervals, even if the problem of the compulsion remains.

The Histrionic Personality

While people with neurotic fears, compulsions and depressions withdraw from others, »hysterical« personalities try to gain the attention of the world around them. Doctors and pastoral counsellors encounter here not sad and inhibited »wallflowers« but attractive, spirited and articulate personalities, for the most part women.

Before we continue to describe their emotional and behavioural patterns, a note on terminology has to be made: Until the 1980s the term for this disorder was *»hysterical«*, derived from the female uterus (greek: hysteros), as these persons often suffer from lower abdominal complaints. However, there is another feature: the dramatic expression which can be found in men and women. Thus the new term is *»histrionic personality disorder«* (from latin: histrio = actor).

Histrionic persons have anxieties too, but unlike the disorders described so far, they are afraid of »the final, the inevitable, of the urgency and the finiteness of our craving for freedom.« *(Riemann)*. They show a pattern of excessive emotionality and attention seeking. Even minor events are met with intense, yet superficial feelings, ranging from rapturous enthusiasm to deep disappointment and temper tantrums.

Nothing bores them more than the routine of an ordered life. They are easily impressed, often responding in an overly trusting way to any strong authority figure. They tend to accept new convictions and beliefs strongly and readily, but without being firmly rooted, often changing their minds after a disappointment.

These characteristics lead to great problems in relationships with other people. Histrionic personalities, as they are called in the DSM-IV, make a charming impression to begin with and make friends easily. But once a relationship has been built, they become demanding, self centred and inconsiderate. In their longing for unconditional acceptance and recognition they make themselves excessively dependent on others. However, if the other person tries to create more space there will be reproaches and dramatic demonstrations of emotion. Helpless clinging to people can reach such a level that it leads to attempts of suicide, just to demonstrate the dependence. By their immature behaviour they destroy the very relationships they long for so intensely.

Sexual problems occur frequently in this context. Histrionic people often suffer from excessive expectations of themselves and their partners and tend to escape into sexual fantasies. The reality is usually quite different

and disappointments are inevitable.

Often they also complain of bad health, general weakness and headaches. In times of great stress this can include uncanny experiences which resemble psychotic symptoms. One lady complained to me during a breakdown that she saw the world around her completely distorted, as if seen through warped glass. Often she felt like a spectator in the theatre of life. When she recovered, these disturbances receded.

It is not surprising that histrionic people often suffer from intense disturbances of mood, especially when external circumstances change and as a result relationships are broken. Depression can be the result.

In some cases, so called *conversion symptoms* can occur, where, for example, afflicted people express their inner helplessness in such a way that motoric weakness develops in the legs which cannot be explained organically. These syndromes have been termed »hysterical neurosis« in older textbooks.

Setting Boundaries

Histrionic patients are a particular challenge for the doctor and the pastoral counsellor. Frequently it is hard to tell what is genuine and what is acted out. The pastoral counsellor often has to experience for himself how the person normally behaves with other people. They are often unpredictable, even for the carer.

Initially, one is overwhelmed with compliments: »You are the first person who has taken me seriously and listened to me. You understand my problems and sympathise with them. You are a wonderful pastor!« But gradually, more and more is demanded: frequent phone calls, often at unusual times, the wish for home visits and other signs of special interest. They often present their complaints in a dramatic form during the consultation, garnished with elaborate details which always, leave you wondering if there isn't some exaggeration. Yet these people are totally convinced about their experiences and react to probing questions from the pastoral counsellor with complaints and doubts about his ability to understand them.

Christians with histrionic traits will tend to explain their experiences in terms of supernatural influences. Often they introduce occult powers into their presentation, so that they can give the most colourful descriptions of demonic oppression. They then require the pastoral counsellor to deliver them from their »possession«. In the process, dramatic scenes are played out which are intended to demonstrate to those present the demonisation

of the patient. If the minister tries to set limits on the fulfilment of their request, the afflicted person can react in a demonstrative way, going into a »huff« and showing annoyance and exaggerated disappointment. Often they will then turn to a pastoral counsellor who has a »greater anointing«.

This doesn't mean that the role of spiritual help during a hysterical crisis has to be played down. Words of scripture and prayers can lead to an impressive calming and release from inner conflicts. On the other hand the »ordinariness« of conveying comfort and empathy of regular pastoral care often seems »too tame« to the afflicted person because it doesn't lead to the instantaneous change they want to see.

It is wrong to dismiss the behaviour of histrionic women as »theatre« though. Here also, we are dealing with a pattern of behaviour in highly sensitive people, which they are not always able to control. Indeed, in hindsight, they are often appalled themselves at the way they have allowed themselves to be carried away by their feelings. With a general calming of the circumstances of stress there usually comes also a subsiding of the histrionic symptoms.

What these people need amid the tossing waves of their feelings is a rock which can provide them with security, protection, and a haven

... a pastoral counsellor who takes them seriously, but reacts to their feelings with relaxed moderation and sets the necessary bounderies.

... a pastoral counsellor who quietly remains firm in response to their immature, angry reactions without rejecting them, and

... a pastoral counsellor who encourages and helps them to be selfsufficient in spite of their desire for dependence.

Does Faith Make You Neurotic?

Neurotic conflicts and insecurities often lie concealed behind the questions and concerns of faith. The pastoral counsellor is affected in a particularly painful way when someone's spiritual life is controlled by anxieties, compulsions and histrionic behaviours, since these do not only affect people who are hostile to the faith. Even upright and serious Christians can suffer from neurotic symptoms which are coloured by spiritual content. It is no accident then, that in literature one finds the idea of »ecclesiogenic« (church-induced) neuroses or »toxic faith« being put forward.

In a comprehensive study, German theologian and psychotherapist Helmut Hark describes the problem of religious neuroses. He defines the idea of »ecclesiogenic neuroses« in the following way: »The term ‚ecclesio-

genic neurosis' designates those, in the many layered spectrum of mental illnesses, which take on a religious form and are induced by excessive religiosity. Whether piety and faith act like a poison in the mind or work like a medicine to produce happiness, depends on the dose administered, and the religious education received from parents, school and church.« He contradicts the widespread assertion that religion makes people ill, and backs this up statistically. By means of a comprehensive questionnaire, he compared 139 patients who were seeking therapy because of mental difficulties with 234 people from a »healthy« control group. He reached the following conclusions:

»In the group of patients an inverse correlation could be observed between psychoneurotic problems and religious orientation. This can be statistically demonstrated: The more pronounced the psychological problem, the smaller the level of religious orientation and piety. Conversely it can be demonstrated that increased religious orientation reduces psychological difficulties. *Our study confirmed the observation made in individual counseling and psychotherapy, that neurosis disturbs religious life, whereas positive religiosity contributes towards healing.*«

The available data and clinical experience do not allow for the assumption that neurotic disorders are more common in any subcultural group, including religious subgroups. Rather, they seem to be equally distributed in the population. Lower social status and increased marital break-ups seem to be associated with the disorder, as marital failure can serve both functions: as a stressor, contributing to further neurotic development or as a consequence of severe interpersonal dysfunction.

Interestingly enough, there seems to be a reciprocal relation between the severity of mental disorders and the support that a patient experiences through Christian faith. Patients suffering from minor neurotic symptomatology seem to struggle more with religious faith, some of them indicating a negative impact on their well-being, experiencing religion as hindering their inner freedom and self actualization. On the other hand, patients with severe neurotic syndromes such as chronic anxiety syndromes or long-standing depressions seem to find support and understanding through their faith although they are often handicapped in their desire to actively take part in religious activities.

Chances and Limitations of Pastoral Care

What possibilities then are open for the pastoral counsellor to help a person suffering from a neurosis, from a biblical perspective? Much has already been alluded to in the sections on individual illnesses. Acceptance by the counsellor, having the opportunity to talk, and to receive special prayer can have an enormously helpful and calming effect for the sick person. In personal one-to-one conversation, and in pastoral preaching, the pastor has a wealth of biblical examples at his disposal, which demonstrate that God chooses to show his power among the weak with their suffering and their limitations. It is often important to help the enquirer towards a new understanding of God.

Yet in severe cases, the goal is not always so clearly visible for the pastoral counsellor. Ought he to be satisfied in these cases with just comforting and supporting the client? Does he need to confront him with his unconscious conflicts and hidden motives? Should the client not at least give expression to his pent up feelings? Or is he simply lacking a fulfilled spiritual life?

The therapeutic ideas found in the literature of psychiatric and pastoral counselling are legion. Yet is noticeable how many neurotically sick patients eventually abandon their odyssey from therapy to therapy and withdraw once more into isolation without their treatment having brought the healing they desired. These failures are hard for the pastoral counsellor and the secular therapist to cope with. Often they end up blaming either the sick person, the parents, or themselves for their own inability.

Indeed, are people just unwilling to change, or are the therapists perhaps expecting too much? I often ask myself whether a delusion of manageability typical of our technological age is not being carried over into the pastoral care and therapy of neurotic patients even if camouflaged by a thick covering net of Christian and psychotherapeutic jargon.

Empathic Compassion

The empathic compassion of the pastoral counsellor seems to me to be of particular importance in the care of a person who is suffering with a long term neurosis. He should be in a position to recognise the client's overly sensitive personality behind the presenting questions concerning faith and doubt, and to respond appropriately. The following quotati-

on mirrors something of the basic attitude of the pastoral counsellor in dealing with nervously weak people. The author war Johann Christoph Blumhardt, who had a widely respected counseling ministry in Southern Germany, more than 100 years ago:

»As as rule I don't make too many demands on the afflicted person, pressurising them to pull themselves together. For I have already seen bad results from that approach. I stick with the advice: ‚Do what you can, and if you can't manage something easily, leave it and keep calm. And don't be afraid, either, that everything will soon be lost. Don't worry if you feel yourself bound up against your will and in a bad mood with God and the things of God.

Furthermore, I would like to say something more to comfort you. In hard affliction, you must not immediately try to apply yourself to the Bible or some other book for your edification. If sometimes you feel that every word applies to you, I understand, but, if all you find there is strangeness, you will get no blessing, read what you will. So it is when your inclination is set against prayer. What good does it do to force yourself? Then I often say ‚leave it!' If you really have to pray like that because people tell you you must pray on your own, well, you can very easily do it in such a way that the irritation hardly finds a way to hinder it. Think how you have the whole Bible already contained in the simple ‚*Our Father*'. There you will find reference to the Name, the Kingdom and the Will of God, the generous care of God in giving us food, the forgiveness of sins, and as you also forgive, and the prayer against temptation.«

Notice with what obvious sympathy Blumhardt takes up the pressures of the »afflicted« without lapsing into spiritualisation or psychological jargon. He takes up what the client says at the level of his problems of faith and relieves his burden by pointing him to simple basic biblical truths.

This keeps the pastoral counsellor from condemning and rejecting the sufferer as a »miserable sinner« and »doubting Thomas«, even if the desired healing is not achieved for the time being. It helps the counsellor develop the ability to steer the client through his weaknesses with patience and love.

References chapter 6

Knowledge on mental health issues is continually being expanded and updated. The disorders discussed in this chapter are described in many useful internet sites. Thus, instead of quoting literature, I would encourage the interested reader to search further information on symptoms and treatment in the net.

Regarding the question of pathogenic aspects of religion, here are a few articles with additional literature references:

Meissner, W.W. (1991). The phenomenology of religious psychopathology. Bulletin of the Menninger Clinic 55:281–298.

Pfeifer S. & Waelty U. (1995). Psychopathology and religious commitment. A controlled study. Psychopathology 28:70–77.

Pfeifer, S. (1994). Faith-induced neurosis – myth or reality? Journal of Psychology and Theology 22:87–96.