“Be Not Afraid”: A Statement of Fact and a Statement of Faith

LAWRENCE ONWUGBUCHUNAM, (Ph.D., RN)¹.
Alberta Health Services.
Columbia College

Abstract
The reality of ambivalence and resistance around the incorporation of spirituality and religious beliefs in the treatment of fear and anxiety disorders and other mental health conditions cannot be denied. The overall purpose of this scholarly article is to advance thoughtful deliberations and discussions around the possibility that healthy spirituality and healthy religious practices, together with psychotherapy and pharmacologic interventions, could be effective in the treatment of anxiety disorders and other mental health conditions. Through a review of scholarly articles and reflections on his experience in clinical nursing practice, the author demonstrates with clarity of thought, acute insight, and academic rigor the necessity and relevancy of including healthy spirituality and healthy religious beliefs, together with psychotherapy and pharmacology, in the management of fear and anxiety disorders and other mental health conditions. The article is a call for engagement in this issue, not a conquest.

Keywords: spirituality, religious beliefs & practices, mental health, addictions recovery, nursing

¹Lawrence Onwuegbuchunam has degrees in philosophy, theology, and nursing, and a PhD in leadership studies from Johnson University School of Business and Public Leadership (Kimberlin Heights, TN). He is a registered nurse with passion and extensive years of experience and clinical practice in the areas of mental health and addictions. He is a sessional instructor of courses: Mental Health Nursing and Human Growth and Development Across the Lifespan at Columbia College (Calgary, AB). Lawrence is the author of two books: Servant Leadership and Moral Courage in Canadian Nursing (Friesen, 2020) and Useful Admonitions to the Christian Nurse: A Pragmatic, Theological, and Empirical Equipoise (Friesen, forthcoming August 2021). For correspondence email ndulaw@yahoo.com
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Evident in most religious worldviews including Judaism, Buddhism, and Christianity is the admonition not to be afraid. This scholarly article examines this admonition and its relation to anxiety and other mental health disorders through the lens of Christian worldview. The assertions made here are informed and influenced by both a Christian and an empirical worldview.

Fear and anxiety often manifest simultaneously and frequently overlap in the ways we describe them and how we perceive their presentations, but there is a distinction between fear and anxiety. Fear is the emotional and cognitive reactions to anticipated or real threat or danger, while anxiety is the prediction, expectation, and anticipation of future threat or danger (American Psychiatric Association, 2013). More often than not, fear triggers the autonomic response in a human person to fight or to run away from a threat or a danger, whether the danger is perceived or real. Anxiety, on the other hand, is often associated with symptoms such as rigidity of the muscles, hypersensitivity, and hypervigilance with regard to future perceived danger, as well as self-seclusion and avoidant behaviours (American Psychiatric Association, 2013). Often, an anxious and fearful person tends to withdraw from or pervasively avoid the thoughts or events that they associated with fear and anxiety as a way to escape or to mitigate their disturbances.

People do not have to practice being afraid because it is an automatic response. Fear and anxiety are autonomic responses that manifest in the very nature of human person in response to danger or threat. Through cognitive process such as discernment, human beings could gain insight into what or how to respond to fear and anxiety. The insight could come from their value system, spirituality, belief system, ethics, and morals (Dreyer, 2018). The Christian nurse could tap into the empirical knowledge of how fear and anxiety manifest, including how they are
managed. The Christian nurse in particular can also could draw from the biblical worldview on how to respond to fear and anxiety. Insights about fear and anxiety from both the biblical worldview and the empirical worldview could translate to healthy responses to and management of anxiety and fear.

Based on my professional experience and significant years of work in adult in-patient mental health and addictions programs, using avoidance techniques such as self-isolation, self-seclusion, and withdrawing from the object or thought that triggers fear may be convenient for the fearful person, but do not translate to effective coping skills for long-term management of anxiety disorders. The reality is that addressing anxiety through self-seclusion, self-isolation, and avoidance can trigger depression and loneliness. There is a critical relationship evident in the psychopathology of these illnesses. Anxiety and depression often present together, and their symptoms are usually inseparable (Kaitlin, 2020). From my clinical practice, depression often presents with emptiness and a sense of failure while anxiety presents as fixation on and preoccupation with that emptiness and failure through worrying.

**Insight From Different Religions**

Religion has been perceived by many scholars as a meaning-making system that provides people with meaning and purpose in their lives (Xu, 2018), especially when people are confronted with realities of sickness, anxiety, hopelessness, and acute stress. For some people, religion provides hope in the midst of doubt and hopelessness, sheds light in the midst of darkness, and serves as a coping mechanism and meaningful survival strategy.

Different religions have explored, taught, and elaborated on the dangers of succumbing to fear and anxiety. Eastern religions such as Buddhism underscore the usefulness of mindfulness, a
practice similar to cognitive behavioural therapy (CBT), a psychotherapy that is commonly used by professionals in the treatment of fear and anxiety disorders. CBT helps individuals to be aware of distressing thoughts that bring fear and anxiety in order to regulate them. Mindfulness teaches individuals to shift awareness from distressing thoughts and emotions and “adopt a perspective that distressing thoughts and sensations contributing to anxiety and stress are merely events that come and go in human experience that is constantly in flux” (Davis et al., 2007, p. 24).

The idea of interconnection and interdependence between human thoughts, human emotions, and human actions is not strange to Judaism. Judaism underscores a significant correlation between and puts strong emphasis on the impact of human actions on human thoughts and feelings. This is consistent with the philosophy of CBT. Jewish traditions and teachings acknowledge the reality of struggles in human life, including struggles with fear and anxiety, but maintain that, despite these realities, one should develop both the strength and the fortitude to engage in positive adaptive behaviours (Shabtai et al., 2016).

There are several instances in the Christian bible where Christians were advised not to be afraid or anxious. Evident in the synoptic gospels, and in the gospel of John, are examples of the admonition: “Be not afraid” (King James Bible, 2002, Mk. 5:36); “Let not your heart be troubled” (Jn. 14:1). In the gospel of Matthew in particular, the apostles of Jesus were afraid when they saw Jesus walking on the lake, and Jesus spoke out to them and said: “Take courage. It is I. Do not be afraid” (Matt. 14:27). Peter, one of the apostles, replied: “Lord if it be thou, bid me come unto thee on the water” (Matt. 14:28). And Jesus replied: “Come” (Matt. 14:29). Peter was able to walk on the water, but started to sink as soon as he became afraid and began to worry.
As a matter of fact, we have different types of anxiety disorders that disturb the functions of the brain, triggering disturbances to one’s activities of daily living and affecting one’s level of functioning (American Psychiatric Association, 2013). The reality is that fear and anxiety can interfere with an individual’s day-to-day functioning (e.g., at school and work), can negatively affect their level of functioning, and can rob them of their internal and external peace.

The Christian nurse should be aware that fear and anxiety are automatic responses that people experience when faced with real or perceived danger, and that it is both normal and natural, despite the biblical admonition to “not be afraid.” Interpreting this biblical statement in the context of today, drawing on what we know about human nature, we can understand that despite the fear and the anxiety we encounter, we should neither succumb nor surrender to fear and anxiety. There is hope. There is treatment. This assertion is similar to the definition of moral courage: despite the fear and the anxiety we may encounter in the process of doing the right thing, we overcome the fear and the anxiety, and we still do what we know is morally right.

**Therapeutic Interventions for the Management of Fear and Anxiety**

There are interventions that help with the management of anxiety disorders. These include psychoeducation and psychotherapy, pharmacologic interventions, self-help, and genuine and constructive spirituality and religious beliefs.

In his seminal book *Man’s Search for Meaning*, Viktor Frankl (1946/2006), a psychiatrist and the founder of logotherapy, which underscores the importance of finding meaning in life, introduces, while elaborating on how fear and anxiety affect patients, the concept of anticipatory anxiety: an anxiety that produces or brings to fruition that which one is afraid of. In other words, hyperfixation or excessive focus on and anticipation of the event of which one is afraid gives rise
to that event. Frankl further introduced paradoxical intention in the context of attitude reversal as a possible treatment technique for this type of anxiety: the object of fear is replaced by a paradoxical wish and, with humor, one attempts to ridicule it, to do the opposite, or to minimize the object of fear to the point that it loses its grip on the individual. This treatment approach encourages individuals to deal with the object of fear and anxiety, not by avoidance or by fighting with it, but by addressing the fear and anxiety in an ironical way through paradoxical intention. This causes the fear to slowly diminish and dissipate. Frankl used this technique to effectively treat patients who had fear and anxiety issues, as well as other mental health conditions.

The Psychotherapeutic approach CBT is also an effective treatment for anxiety disorders. The philosophy of CBT is grounded in the knowledge that our thoughts, feelings/emotions, and behaviours are all interconnected. CBT emphasizes cognitive restructuring and underscores self-monitoring of emotions in order to identify the cognitive distortions that trigger anxiety and replace them with realistic and balanced thinking (Simos & Hofmann, 2013).

There are pharmacologic options for the treatment of anxiety disorders. Selective serotonin reuptake inhibitors (SSRIs), and serotonin norepinephrine reuptake inhibitors (SNRIs), although classified as antidepressants, are very commonly used as the first line of treatment for anxiety disorders, and are believed to be effective (Garakani et al., 2020).

Tricyclic antidepressants (TCAs) are also used in the treatment and management of anxiety disorders. This class of medications, although efficacious in the treatment and management of anxiety disorders, are less frequently prescribed due to potential side-effects such as weight gain, arrhythmias, urinary urgency or retention, and others (Garakani et al., 2020).
Incorporating Healthy Religious and Spiritual Practices in Therapy

Healthy, genuine, rational, and constructive faith, spirituality, and religious beliefs, could help with the management of anxiety, in combination with openness to other treatment options such as pharmacologic intervention when necessary. A study conducted by Zagozdon and Wrotkowska (2017) concluded that the incorporation of religious beliefs in some patients with anxiety and depression translated to better medication compliance among the participants, resulting in better treatment outcome. The study also found that spiritual orientation played an important role in recovery from addictions and in treatment adherence in people with substance and addiction issues. Indeed, several scholarly works show modest but positive correlation between spirituality and religiosity on psychological health, especially, but not exclusively, in the areas of anxiety and depression (Reuter & Bigatti, 2014).

There are significant empirical studies that have suggested a positive impact, and a strong correlation between spirituality and religious beliefs on mental health (Kennedy et al., 2015). A study done by Rosmarin et al. (2013) found that, in 159 patients who participated in a CBT day-hospital psychiatry program, belief in God played a positive role in the improvement of their mental health—especially, but not exclusively, in reducing depression.

However, there seems to be a rocky relationship between spirituality and psychiatry. Some mental health professionals often perceive spirituality and religious beliefs as barbaric or primitive and lacking empirical justification. Some believe, too, that spirituality and religion induce guilt that negatively impacts patients’ mental health. As such, spirituality and religion are often ignored as viable treatment options (Dein, 2018). Kahle and Robbins (2014) perceive the dismissal of spirituality and religion as therapeutically relevant as a fundamental flaw and bias that renders therapy rarely effective in those for whom religion and spirituality already play a
central role. The authors argue for the inclusion of spirituality in psychotherapy. It is a fact worth mentioning that unhealthy or distorted religious faith and spirituality, devoid of human reason, could exacerbate anxiety disorders and add to the struggles of those already afflicted with anxiety (Huguelet & Koenig, 2010). However, I believe that healthy religious beliefs and healthy spiritual practices could help to mitigate the symptoms of fear and anxiety.

**Practical, Hypothetical Case Studies for Illustration**

The following two hypothetical case studies are anchored in my clinical practice experience. They do not reproduce any one person’s personal experience. The case studies are meant to illustrate how spirituality and religious beliefs can be both constructive and destructive depending on the circumstances of an individual’s illness trajectory and recovery.

**James**

James, a 19-year-old, first-year university nursing student, was born and raised in a strong Christian Roman Catholic family. He considers himself a practicing Christian, and perceives his Christian faith as his protective factor, coping skill, and support system. During his first year of university, James became sick. He was fearful and anxious due to the significant stress of his school work. This negatively impacted his level of functioning and interfered with his activities of daily living. James resorted to prayer alone. He prayed without ceasing, asking God to heal him. James wondered why God has allowed him to go through this awful experience. He avoided going to classes due to his poor performance. He was anxious about meeting students he didn’t know. He had poor concentration, thought blocking, and flight of ideas when expressing himself at school due to his anxiety. He believed that he was a loser and
that God has abandoned him. He became angry at God and was struggling with his faith. He ignored the suggestions from his professors and colleagues to seek professional help through the counselling services in the school. His anxiety disorder translated to depression and suicide attempts. He was hoping for a miracle to happen, waiting for God to heal him and make him whole again, and believing that seeking professional help was a sign of lack of faith in God—but the fear and the anxiety persisted. Finally, he withdrew from everyone, dropped out of school, and refused to seek professional help. He abandoned his faith and is currently struggling alone without support.

A nurse working with James would have the professional obligation in the context of patient teaching, using therapeutic communication skills and through the establishment of therapeutic relationship and rapport, to provide James with right information and credible resources that could facilitate his seeking evidence-based professional therapy and pharmacological intervention in combination with the application of genuine spirituality and constructive religious practices.

**Sara**

Sara is a newly graduated nurse who is currently in her first year of nursing practice. Sara is a practicing Christian whose faith in God informs and influences her nursing practice. Sara works in the in-patient mental health and addictions unit in a fast-paced acute care hospital. Until recently, she has felt that experienced staff are not supportive to new staff. Sara described her work environment as “overwhelming, oppressive, and unsupportive.” Thoughts of going to work triggered fear and anxiety in Sara. At work, she sweat profusely, appeared hypervigilant, and
second-guessed herself frequently. She isolated from other staff and was afraid to ask colleagues questions due to fear of being judged.

Through the information, resources, and professional colleagues available to her at work, she was able to recognize the right thing to do. Sara connected with an independent psychiatrist outside of her work who assessed her and diagnosed her with anxiety disorder. Sara was introduced to CBT and psychotropic medication to manage her anxiety disorder.

Through psychotherapy and pharmacologic intervention, Sara realized the cognitive distortions that she had about her colleagues. Sara was able to change her unhelpful thinking styles and thought distortions, which was effective in the management of fear and anxiety at work. Sara complemented her treatments with mental health professional with her faith: she prayed, asking God to heal her, while at the same time accessing other credible resources available to her. Today, Sara has no issues with fear and anxiety at work, and she effectively manages the normal stress in life that everyone experiences.

**Implications for Christian Nurses in Their Practice**

For Christian nurses, it is important to be consciously aware that no one is immune from getting sick. Sickness in this context includes experiencing mental health crises such as, but not limited to, fear, anxiety disorders, and depression. The nurse can become a patient tomorrow, and there is nothing wrong with that. Therefore, in caring for patients, knowledge and empathy are indispensable for competent nursing practice (Onwuegbuchunam, 2020). It is important to understand empathy in the context of role-playing, where nurses put themselves in their patients’ shoes to try to understand patients’ experiences (Onwuegbuchunam, 2020). This immersion of self in other could translate to practical accomplishment and the adherence to the biblical
admonition, “as you would that [people] should do to you, do ye also to them likewise” (King James Bible, 2002, Lk. 6:31). In other words, it encourages nurses to treat their patients the way they would like to be treated.

The Christian nurse could complement empirical knowledge with their Christian belief. They should understand that faith and reason, although distinct, complement one another and should be inseparable in both the nurse’s self-care and in the care of their patients. The two case studies used above for illustration should serve as practical examples of both the positive and negative impacts—the constructive and the destructive components—of spirituality and religious beliefs in illness and recovery journeys. The Christian nurse should not succumb or surrender to fear and anxiety, nor to other mental health and addictions conditions. Instead, they should understand that the biblical admonition “Do not be afraid” (King James Bible, 2002, Mk. 5:36) is both a statement of fact and a statement of faith. They should seek professional help in time of mental health and addiction crises, and should complement professional help with healthy spirituality and healthy religious beliefs.

Despite the ways in which faith can complement and augment therapeutic treatment, the Christian nurse should be aware that some health care professionals are ambivalent about and resistance to the inclusion of spirituality and religious beliefs in their patients’ care. The Christian nurse should, therefore, continue to explore the issue and ask the questions that could lead to answers that address this fundamental flaw.
References


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