ANXIETY AND DEPRESSION IN PRESENT-DAY SOCIETY
A MODERN OUTLOOK ON SPIRITIUAL AND THEOLOGICAL ASPECTS OF COPING

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Abstract

Anxiety and depression have become extremely widespread, with an average rate of anxiety and depression disorders of 7.3% and 4.4% respectively. Such conditions are associated with stress, feeling of emptiness and meaningless of existence, guilt and fear of death. Various mechanisms can be used for coping with stress. In many cases, people suffering from anxiety or depression require assistance of a psychologist, psychotherapist or psychiatrist. Meaning and value psychotherapy is an important element of anxiety and depression treatment. This work overviews the role Theology plays in meaning and value psychotherapy of anxiety and depression disorders. It demonstrates that Psychology and Theology use the same methods for combating anxiety and depression. The first stage of therapeutic effect comes through acceptance, i.e. grace. The second stage involves establishing a value-focused worldview. The final stages of therapeutical and religious influence pursue different goals. Psychotherapy is aimed at helping people realize their place in the society, making their nearest future meaningful and discovering a way out of a certain difficult situation. Religious influence, however, strives for achieving a higher meaning and finding an ultimate pathway.

Keywords: psychotherapy, religion, existentialism, logotherapy, well-being

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1. Epidemiology of anxiety and depression disorders

Anxiety and depression have become epidemics of the modern world. Average rate of all anxiety disorders in human population comprises 7.3%, ranging between 4.8-10.9% [1, 2]. According to the WHO, 3.6% of all people are diagnosed with anxiety disorders: 4.6% of women and 2.6% of men [3]. During their lifespan, 14.5-33.7% of people suffer from anxiety disorders of any kind [4]. Such inequality in anxiety distribution can be explained by multiple data analysis methods as well as by cultural, economic, social and other differences among survey groups.

Anxiety most often occurs among people aged 18-34 and least often among people aged 65-79 - the latter group suffers more commonly from depression disorders [5]. It is worth noting that general anxiety disorder rate is 2.5-3 times higher in developed countries than in developing ones [6, 7]. However, these data can be reasonably disputed due to not providing an adequate explanation of such discrepancy. Besides, anxiety in developing countries mostly affects low-income groups [K. Sheridan, *Rich countries are more anxious than poorer countries*, 2017, https://www.statnews.com/2017/03/15/anxiety-rich-country-poor-country/]. Anxiety treatment costs comprised 41 billion euros in the Eurozone in 2004 [8] and 33.71 billion dollars in the US in 2010 [9]. The risk of depression disorders is similar to anxiety risks and reaches 15-18% [10]. On the contrary to depression disorders, major depression rate in human population is at least 4.4%: 5.1-5.9% among women and 2.6-3.6% among men [11]. It is more commonly diagnosed among people aged 55-74 and affects 7.5% and 5.5% of women and men of this age group respectively [11].

Depression severely limits psychosocial functioning, downgrades quality of life and acts as a major aggravating factor for other diseases. For instance, depression leads to a 50% increase in death rate and is a major early death factor comparable to smoking [12]. Moreover, people diagnosed with anxiety/depression die 7.9 years earlier than those who do not have such disorders [13]. Depression is accompanied by anxiety in 50% of cases, by usage of psychoactive substances in 12-20% of cases [14] and is associated with personality disorders in 30-50% of cases [15]. Its health consequences are immense: the WHO claims depression is the largest general disability factor (7.5% of all disability years according to 2015), while anxiety is on the 6th place (3.4%). Depression is also the main cause of suicide for 800 000 people annually [3]. The evidence shows that depression is more frequently found in countries with average Human Development Index rates [16]. Depressed people are 20-60% more often diagnosed with cardiovascular (hypertonia, IHD) and endocrine (diabetes, obesity) diseases as well as with musculoskeletal pathologies (LBP, cervicalgia) [15].

Stress and life problems are the main cause of depression and anxiety disorders [17], while an important factor of overcoming them is spiritual health [18]. Meanwhile, an essential component of spiritual well-being is transcendence.

The aim of this overview is to determine the role of Theology in meaning and value psychotherapy of anxiety/depression disorders.

2. Spirituality, spiritual health and religion

Spiritual health can be considered a synonym of spiritual well-being. The broadest interpretation of spiritual health (well-being) introduces the combination of 4 complementing synergic domains: relations with oneself (the personal domain of life meaning and value), other people (the social domain), the environment (nature) and divine/higher reality (the transcendent domain) [19-22]. Transcendence is linked to religion but is not limited by it. As religion focuses more on connection with God, transcendence involves the relation between 'self' and the Universe or some higher power that stretches beyond human limits [22]. Transcendence is the key component of spirituality [23]. The environmental domain covers human-nature relations. The social domain includes close relations among people. The personal domain regulates our attitude to ourselves, our strengths and weaknesses. Spiritual health and ability to overcome difficulties is a dynamic condition that brings the four domains together and demonstrates the quality of relations within them [21].

Spirituality can be described as a personal need to find answers for questions on ultimate values of life, illness and death [24]. Five spirituality attributes can be distinguished: meaning (the purpose and significance of life); value (beliefs and standards held dear); transcendence (acknowledging and caring about dimensions beyond oneself, such as cosmic powers, transcendent reality, God, devotion and love for the sacred); connection (relations to oneself, others, God, higher power shown through love, forgiveness, trust, hope and faith in humanity and higher reality); becoming (development and life progress that require contemplation, experience and understanding personal place in life) [25]. Meanwhile, spiritual health is related to positive changes in said spirituality attributes [26]. The introduction of becoming (also known as progressive) synergism attribute as another spiritual health domain is nowadays under consideration. Progressive synergism ensures integration of other spiritual health domains and reveals their potential [22].

Spiritual health is a powerful buffer that helps to cope with stress and find a way out of a difficult situation [18]. Science still has no consensus on the role religion plays in maintaining physical and mental health. However, it has become evident that religious worldview is connected to spiritual well-being, the one of four health components [27-29].

3. Spiritual approach to anxiety and depression problems

Lack of spiritual health leads to loss of life meaning and value. In this case, people focus only on personal issues, expressing envy and hostility towards others and thus damaging the communication domain. The Nature is perceived as something insignificant, hostile or making life more complicated; this results

in irrational use of natural resources. On the transcendental level, such people consider God to be a formal entity aimed solely at punishing wrongdoers. This is why the blame for any misfortunes is laid on the higher power [30].

According to M. Heidegger, Dasein, the internal being, is an existential matrix, with its modes determined by existentialia [31]. Concern is the existentiale that forms other Dasein existentialia, while care unifies them. Having analysed the notion of concern, M. Heidegger concluded that concern is associated with the fear of death. Meanwhile, death is a possibility of Dasein ('being there') that excludes other possibilities. Thus, M. Heidegger defines human existence (Dasein) as being-toward-death. Fear of death is an existential anxiety or concern related to our fear of making wrong choices and of non-existence that limits human potential [31]. Existential anxiety is an attribute of finite human nature and is associated with freedom, imminence of death and fundamental loneliness [32].

Anxiety is primarily the concern over existence of some objects or events. Anxiety can be related to concern over our actions that may devoid us of certain opportunities. Horror is the fear of the unknown. Its phenomenon can be so intensive that it can lead to disintegration of the observer. The subject who experiences horror can turn away from it to maintain integrity of consciousness. But the subject is also capable of overcoming horror and reaching authentic existence.

Thus, existential anxiety has a positive side because by experiencing horror, the human presence - Dasein - can rise above everyday worries and achieve the true value of existence. Recognizing the phenomenon of death enables to shift to authentic being from unauthentic existence that avoids the ontological question 'What does it mean to exist?' and makes people dissolve in everyday concerns. Authentic existence is possible only when people realize their finiteness, historicity and freedom and make questions about personal being beyond social 'self' and its categories [31, 33].

M. Heidegger was the proponent of atheistic existentialism, according to which the authentic being can be achieved through personal efforts, with unauthentic existence being the pre-condition. However, courageous atheistic acceptance of making a personal choice to face owns finiteness bears the burden of unresolvable despair in its highest form, the one impossible to overcome. This is the demonic, or absolute, despair [34]. S.A. Kierkegaard called despair the sickness onto death. The sin is opposed not to good behaviour but to faith. Despair is primary and exists even when people do not realize it. The overwhelmingness of despair is ontologically rooted in God and alienation from God. Only despair gives a chance to find a pathway to God, unite with God and achieve hope [34].

Existential anxiety is related to the threat of non-existence and can be divided into anxiety of fate and death, anxiety of emptiness and meaninglessness and anxiety of guilt and condemnation [35-37]. Fear may have a specific object, e.g. death, while existential anxiety is a response to the threat of non-existence, unrelated to any object. Fear of death is objectification of the threat of non-

existence. Realizing the finiteness of being induces ontological or existential anxiety. Fear can be dealt with but anxiety cannot due to inability of overcoming this finiteness. However, fear of death and existential anxiety are often intertwined and inseparable. According to P.J. Tillich, the fear of death is ultimate because it contextualizes seriousness of all fears. Anxiety of fate represents more limited, relative concern over accidental nature of life and our role in it [35]. P.J. Tillich claims that fear as a source of anxiety and depression can be dealt with by overcoming alienation through reconnecting with the source of being, i.e. God [36, p. 79; 38].

4. Correlation analysis of fear, anxiety, depression and spirituality

Nowadays, various scales are used for assessing death-related fear, anxiety and concern [39, 40]. Death anxiety questionnaires often mention fear of graves, dead or dying people; fear of post-mortem events and dying [41]. Results of death anxiety surveys among man and women of different age groups are often contradictory. However, the overwhelming majority of studies demonstrate that most points on death anxiety scales are scored by women, aged people, persons with mental disorders (anxiety, depression, traumatic stress) and somatic diseases [42]. It has been revealed that spiritual well-being and religiousness have negative correlations with death anxiety on D. Templer's scale (DAS) [41, 43]. Despite the importance of death anxiety research, currently used scales do not fully reflect the notion of existential anxiety described by P.J. Tillich and M. Heidegger [33, 38].

The Existential Anxiety Questionnaire (EAQ) is based on P.J. Tillich's theory and distinguishes three types of existential anxiety: anxiety of fate and death [36, p. 42-44, 162-163], anxiety of emptiness and meaninglessness [36, p. 41, 172-173], anxiety of guilt and condemnation [36, p. 41, 164]. American scientists C.F. Weems have conducted 2 surveys [44]. The first survey involved 225 university students aged 18-44, with average age of 21 years and average family income of 20,000-50,000 USD. 64% of the respondents were female. Existential anxiety was estimated by calculating the percentage of people who positively responded about having concerns over each of 6 existential anxiety aspects defined by P.J. Tillich [38]. The study had the following results: 28% of respondents had anxiety of death, 44% - anxiety of fate, 25% - anxiety of meaninglessness, 40% - anxiety of emptiness, 14% - anxiety of condemnation and 33% - anxiety of guilt. 75% of respondents reported having one or several existential anxieties. The second survey involved 326 students aged 18-59, with average age of 21 years and 50,000-100,000 USD family income (82% of the respondents were female). The survey demonstrated that anxiety of fate and death correlated with anxiety of emptiness and meaninglessness ($r = 0.63$) and guilt and condemnation ($r = 0.56$). Anxiety of guilt and condemnation correlated with emptiness and meaninglessness ($r = 0.62$). 86% of respondents had at least one existential anxiety. Death anxiety was experienced by 43% of participants, fate anxiety - by 61%, anxiety of meaningless - by 22%, anxiety of emptiness -

by 64%, condemnation anxiety - by 52% and anxiety of guilt - by 53%. This research proved that existential anxiety can be followed by clinically relevant depression and anxiety disorders and lead to maladaptive thoughts on oneself, the world and personal future [35]. Another study surveyed 386 people aged 18-36 (average age - 33) who lived in areas affected by Hurricane Katrina. The participants responded having anxiety related to death (50%), fate (711%), meaninglessness of life (25%), emptiness (74%), condemnation (60%) and guilt (62%). 94% had at least one of 6 signs of existential anxiety. Furthermore, 5.2% admitted having suicidal thoughts. The predictors of suicidal thoughts included posttraumatic disorder ($p < 0.001$), emptiness of life ($p < 0.001$) and feeling of guilt ($p < 0.005$) [44].

D.B. Feldman pointed out that hope is an important element shaping meaning of life and providing cognitive basis for successful goal attainment [45, 46]. To verify this hypothesis, they surveyed students using scales of hope, meaning of life, depression and anxiety. The respondents were 139 college students, 74 men and 65 women, aged 18-24 (average age - 19.20, SD = 0.92). Three different scales were used for meaning of life assessment (Purpose in Life Test, Life Regard Index, Sense of Coherence Scale). All the scales strongly correlated with each other ($r = 0.81$-0.82, $p < 0.01$). Besides, all three meaning of life indicators significantly correlated with the hope scale ($r = 0.70$-0.77, $p < 0.01$). The factor analysis of survey results showed that hope can be included in the expanded meaning of life definition. Hope also had a negative correlation with both anxiety ($r = -0.67$, $p = 0.01$) and depression ($r = -0.59$, $p = 0.01$) [45]. Later, the researchers surveyed 162 college students (93 men and 99 women, aged 18-33) and found a significant correlation between hope and goal attainment [46]. The study reported that people with high levels of hope were capable of coping with stress factors more effectively than those with low hope potential [47]. Besides, people with lower levels of hope were more prone to maladaptive coping behaviour [48]. Among the respondent students, hope correlated positively with adaptive coping and negatively with depression symptoms and maladaptive coping [49, 50]. 46 respondents that preformed spiritual practices demonstrated higher levels of hope than the control group (23 people). The study assumes that spiritual practices raise hope, which can be explained by stress reduction [51].

According to the scientific data, coherence positively correlates with hope ($r = 0.34$, $p < 0.001$) [52]. The meta-analysis of 850 studies demonstrated that 80% of them indicate a correlation between life satisfaction, faith and religious practice. Two thirds of studies pointed out religious people have lower depression and anxiety levels [53]. Another meta-analysis that covered 35 studies found a positive correlation between religiousness and mental health ($p < 0.0001$). The analysis demonstrated positive correlations between religious faith, life satisfaction ($p < 0.0001$) and self-realization ($p < 0.0001$) as well as a negative correlation between belonging to an institutional religion and stress level ($p < 0.001$) [54].

These results cannot provide a definitive answer whether mental health or religiousness is the primary factor of such outcome. This ambiguity is caused by the correlation-focused approach taken by the analysed studies. Besides, the survey groups were heterogeneous and the studies did not consider social status, ethnicity, area of residence and medical history of the respondents.

5. Coping strategies and stress

Coping behaviour is a human mechanism of overcoming stress. There are five main types of coping behaviour: solving problems, seeking support, avoidance, distraction and positive cognitive restructuring [55]. Strategies of overcoming stress can also be divided into active, passive and intermittent [56]. In stressful situations, people usually use several strategies simultaneously [57]. Much attention in overcoming anxiety and depression disorders in currently given to active coping strategies aimed at eliminating or diminishing stressful situations and reducing stressful connections with the environment. Several studies demonstrated that cognitive coping strategies focused on searching information are related to positive emotions and better adaptation to the surrounding environment, while emotional coping leads to feeling of guilt, maladaptation and reduced self-esteem [58, 59]. It is worth mentioning that people suffering from anxiety/depression generally use emotion-focused coping strategies thus limiting their ability to adapt to the environment [60].

Other coping categories distinguished nowadays are spiritual and religious coping. Positive spiritual coping is represented by cognitive and behavioural measures related to four domains. On the personal level, people can follow their life goals, search for meaning of life or discover their weaknesses and work on them. Some may turn their attention to others showing care, love or compassion on the social level. As for the environmental domain, people may turn to the nature for relaxation or, for example, become vegetarians and try to reduce harmful impacts on the environment. On the transcendental level, relations with God or higher power and feeling of belonging to the Universe may provide support in times of stress or life difficulties [30]. Consequences of negative spiritual coping are opposite to positive coping: eventually, people may deny that life has any meaning, concentrate on personal weaknesses and disadvantages, treat others and the nature with hostility, reject divine love and become unable to address life issues.

There is a positive correlation between age and positive spiritual coping ($r = 0.20$; $p < 0.001$). Also, it has been proved that the more educated people are, the less they are prone to negative spiritual coping ($r = -0.19$, $p < 0.001$). The survey of 352 respondents revealed a negative correlation between positive and negative spiritual coping ($r = -0.52$, $p > 0.05$). Positive coping was related to spirituality ($r = 0.28$-0.68), positive religious coping ($r = 0.27$-0.83), gratitude ($r = 0.22$-0.42) and forgiveness ($r = 0.24$-0.39). Negative spiritual coping had a negative correlation to all these variables. Furthermore, positive spiritual coping negatively correlated to negative coping (r = from - 0.10 to - 0.26), while

negative spiritual and religious copings had a positive correlation ($r = 0.34$-0.44). Adequate mental functioning positively correlated with positive personal spiritual coping ($r = 0.16$, $p = 0.003$), social spiritual coping ($r = 0.23$, $p < 0.001$) and positive spiritual interaction with the environment ($r = 0.21$, $p < 0.001$). On the contrary, negative spiritual coping had negative correlations both with personal ($r = -0.46$, $p < 0.001$) and social ($r = 0.20$, $p < 0.001$) spiritual health domains. These results demonstrated that spiritual, non-religious coping was an independent component of physical and mental health [30].

Harmful consequences of negative spiritual coping were found among women diagnosed with cancer (in terms of sexual activity) [61], earthquake survivors [62] and patients undergoing dialysis [63]. Damaged relations with one or all four domains can cause even greater stress, thus exacerbating both mental and somatic problems [64].

Positive and negative spiritual coping are different but interrelated concepts. Although it is possible to consider them to be two sides of the same continuum, this approach raises certain objections [30]. Negative spiritual coping is related to psychopathology in the short-term perspective and to growth and well-being in the long-term perspective [65]. A 30-week study was conducted in the Netherlands involving 651 participants aged 18-80 (average age - 45). It demonstrated that negative spiritual coping can damage mental health, increase stress and vulnerability. On the contrary, positive spiritual coping is capable of reducing stress and boosting resilience. The study also emphasized that positive religious coping is significantly related to positive spiritual coping, while negative spiritual coping correlated with negative religious coping, albeit to lesser extent [66].

Religious people have 3 coping options: cooperative, delegated and self-regulating. In case of cooperative coping, people and God are acting together and share responsivity for solving problems. Delegated coping involves taking a passive stance and making God responsible for dealing with problems. People who use self-regulating coping are addressing their issues themselves believing that God will grant them power and opportunities to succeed. The survey of 175 respondents demonstrated that only the first option had a positive effect on mental health and stress adaptation and was consequently declared positive religious coping [67]. The meta-analysis of 13,512 respondents and 47 studies revealed that positive religious coping is associated with positive psychological adaptation (total effect 33%, CI 30-35, $p < 0.01$), while negative religious coping is linked to non-adaptive behaviour (total effect 22%, 95% CI 19-24, $p < 0.01$) [68]. It was proved that negative religious coping (feeling abandoned by God, questioning divine love and care, considering disease to be caused by the devil) among aged patients increased death rate by 19-28% [68]. There is evidence that the higher stress is, the better religious coping protects people from its influence [69]. The group of respondents comprised of 251 college students demonstrated that self-absorption (attentiveness), hope, meaning of life, positive emotions have a reliable correlation with adaptive coping (adapting skills of overcoming difficulties) ($p < 0.01$) and, on the contrary, negatively correlated with

maladaptive coping ($p < 0.01$). Existential thinking had a reliable positive correlation with Purpose in Life indicators ($p < 0.05$). It is worth noting that existential thinking showed no correlation with adaptive coping but demonstrated correlation with searching ($p < 0.05$) and presence ($p < 0.01$) of meaning of life. Finding meaning of life is mostly related to existential thinking and self-absorption ability [52, p. 73].

Science confirms that positive religion-based coping strategies can play an important role in overcoming various mental disorders. Positive religious coping strategies are able to improve all quality of life parameters among patients with mental and somatic disorders [70, 71]. Meanwhile, negative religious coping is often associated with lower quality of life and worse indicators of mental and somatic health than compared to non-religious persons' activities [72, 73]. Several studies proved that religious worldview coupled with looking for support and predominantly passive coping behaviour is associated with higher stress levels and lower indicators of physical and mental health [74]. However, some works indicate that search for spiritual support can be a part of positive religious coping if accompanied by proactive behaviour aimed at cooperating with God and being sure of His love and care [65, 75, 76]. K.I. Pargament distinguished positive and negative coping. Positive religious coping involves recognizing stress as a beneficial factor promoting spiritual growth, acknowledging God as a good-intended partner, acknowledging divine support and love. This is represented by safe relations to transcendental forces, spiritual unity with other people and the world. Negative religious coping is associated with reinterpreting stress as divine punishment, becoming passively dependent on God's will to solve problems or attempting to face problems without relying on God's help. Such religious coping involves some sort of spiritual conflict, failure to accept oneself, the world, other people and divine essence [65].

There is a correlation between positive religious coping and best indicators of health, well-being, spiritual growth [75, 76]. People applying positive coping strategies are characterized by adequate acceptance of their problems, feelings of joy, optimism, meaningfulness. Apart from these three components, some studies also distinguish pleading religious coping, during which people do not accept their situation and ask God for miraculous intervention. The meta-analysis of 49 studies concluded that this fourth coping type cannot be considered adaptive. People using negative coping strategies are characterized by increased anxiety, bad mood, lack of purpose and tiredness with life [68]. It is necessary to keep in mind that the overwhelming majority of people apply positive religious coping for fighting stress [77]. As stated by P.T.P. Wong and P.S. Fry, "there is now a critical mass of empirical evidence and a convergence of expert opinions that personal meaning is important not only for survival but also for health and well-being" [78]. Thus, meaning is an important attribute of spiritual well-being.

6. Ways to religious coping in the post-secular society and potential for development of therapeutical strategies

The notion of desecularization became widespread in 1999, when P.L. Berger claimed in his book that religion was undergoing the process of resurgence. Furthermore, according to him, the modern world is becoming predominantly religious, as the concept of secularization got unable to justify itself. P.L. Berger believes that desecularization is reactionary to a prior period of secularism [79]. The process of religious resurgence and its social expansion can be defined as counter-secularization. Such processes can nowadays be witnessed in the Russian Federation and other former Soviet territories [80]. Formerly secular structures and religious norms are drawing closer, religious beliefs and practices are resurging and religion is being reinstated in the public sphere. However, it is the cultural aspect that becomes the key counter-secularization component: counter-secularization in Philosophy, literature and art leads to changes in the worldview [81]. This is extremely important, as the same religion can be used in different cultural aspects with opposite results [82]. Religion needs culture to shape its expression. At the same time, without religion, culture loses its limitless profoundness. According to P. Tillich, religion in its broadest and fundamental meaning is the ultimate concern [37, p. 21]. This ultimate concern can be found in all creative functions of human spirit: as ultimate seriousness of ethic requirements in morale, as desire for ultimate clarity in scientific knowledge or as infinite urge to express ultimate meaning in aesthetics. Thus, those who reject religion for the sake of morale, science or aesthetics, actually reject religion for the sake of religion. This situation is absurd because it is impossible to reject religion with ultimate concern, as religion itself is the state of ultimate concern, or interest. P.J. Tillich claims that the problem of secularization is rooted in alienation of spiritual life from its own origin and depth, i.e. from God. Without alienation, religion would be the all-defining reason and substance of spiritual life. Religion reveals the profoundness of spirituality that is usually hidden under the dust of daily routine and lost in the noise of secular activities. It grants us the experience of the Sacred (that cannot be perceived otherwise) and the ultimate meaning, becoming the source of ultimate courage [37, p. 62].

Development of depth psychology provides the opportunity for cooperation between religion, medical psychology and Psychiatry [83]. Depth psychology studies unconscious processes and is inseparable from existential philosophy and Theology. On the other hand, depth psychology helped to expand knowledge on mentality-influenced psychosomatic disorders and consequently contributed to medical psychology and Psychiatry. Thus, mental health recovery is the objective of several disciplines: Theology, Psychology, Philosophy and even Psychiatry in case spirituality-related anxiety or depression disorders are clearly expressed and require both psychological intervention and medical treatment.

Existential psychology and Philosophy consider depression and anxiety disorder to be caused by feelings of meaninglessness, constant loneliness and emptiness. According to existentialism, such emotions stem from realizing finiteness, self-alienation, disassociating from personal activities, other people and the Nature. From the existentialist standpoint, this problem is universal for all people regardless of their health condition. It can be reduced but not fully dealt with. Negative coping with alienation leads to neurosis and, in some cases, to psychosis. Neurosis is a way of shielding from alienation and external hostility. Christian theology is based on three main concepts: the bliss of being, the universal fall (when people fall from the blissful being), the possibility of healing or salvation from alienation. That means human existence is teleological – it must have a purpose of being and the whole life is directed at achieving this purpose [37, 38]. Given this aspect, any guilt, alienation or emptiness require salvation, as alienating from the existential being is a sin. In such case, salvation can be given by psychologists, theologians or doctors and their assistance should be based on the notions of grace or acceptance. Consultants or priests acknowledging the complexity of human situation are expected to provide grace. Grace consists of two elements: overcoming guilt and overcoming alienation. The former involves accepting the unaccepted ones ('forgiveness of sins') and the latter means achieving a new state of being by closing the divide between who we are and who we should be. For fulfilling these two tasks, psychotherapy and religion use similar methods - however, they have one fundamental difference. Psychotherapy can set people free from a specific difficulty, while religion shows the ultimate pathway to those already freed from difficulties and facing a decision about purpose and meaning of their lives. It is the basic distinction that ensures mutual cooperation and independence of religion and psychotherapy [37, 38, 84, 85]. This concept was supported by the founder of existential intervention logotherapy V.E. Frankl, who stood for transforming spiritual crises into spiritual revival [86] and by clinical psychologist P. Wong, who made a major contribution to logotherapy by introducing four components of meaning: Purpose, Understanding, Responsible action and Enjoyment/Evaluation (PURE model) [87]. According to P. Wong, therapeutic intervention must focus on positive reconsidering of negative situations, finding purpose of life and pursuing it. Such purpose of life must reach beyond individual limits and give people the ability to serve each other. He defined this concept as self-transcendence [88]. Currently, he is a member of a working group researching virtue, happiness and meaning of life [P. Wong, *Register now for 'Courage, Faith, and Meaning: Existential Positive Psychology's Response to Adversity'*, Vancouver, 2018, https://thevirtueblog. com/tag/paul-wong/].

7. Conclusion

Anxiety and depression disorders are an important medical and social issue. In many cases, their presence is caused by lack of spiritual health accompanied by negative spiritual coping, in particular, by negative religious

coping. There is significant evidence that spiritual health is impossible without finding the meaning of life and following it. While logotherapy helps people to find the meaning of their nearest future and a way out of a specific difficulty, theology enables to achieve the higher meaning of being in God and choose the ultimate path. People lost in secular everyday issues must be reminded that beyond despair, abandonment, anxiety, loneliness, fear and need there are also positive existentialia of human life. The essential psychological objective of theology is to form such positive existentialia as being-in-God, freedom, hope, faith and love. In this context, it is worth quoting the Saviour: "For whoever wants to save their life will lose it, but whoever loses their life for me will find it" (Mark 8.35). Thus, treatment of anxiety and depression disorders may require consolidation of logotherapy, Theology and Psychiatry.

References

[1] A.J. Baxter, K.M. Scott, T. Vos and H.A. Whiteford, Psychol. Med., **43(5)** (2013) 897-910.
[2] A.J. Baxter, T. Vos, K.M. Scott, R.E. Norman, A.D. Flaxman, J. Blore and H.A. Whiteford, Int. J. Meth. Psych. Res., **23(4)** (2014) 422-438.
[3] ***, *Depression and Other Common Mental Disorders: Global Health Estimates*, World Health Organization, Geneva, 2017, online at https://apps.who.int/iris/bitstream/handle/10665/254610/WHO-MSD-MER-2017.2-eng.pdf?sequence=1&isAllowed=y.
[4] B. Bandelow and S. Michaelis, Dialogues in Clinical Neuroscience, **17(3)** (2015) 327-335.
[5] F. Jacobi, M. Höfler, J. Strehle, S. Mack, A. Gerschler, L. Scholl, M.A. Busch, U. Maske, U. Hapke, W. Gaebel, W. Maier, M. Wagner, J. Zielasek and H.-U. Wittchen, Nervenarzt., **85(1)** (2014) 77-87.
[6] S. Lee, A. Tsang, A.M. Ruscio, J.M. Haro, D.J. Stein, J. Alonso, M.C. Angermeyer, E.J. Bromet, K. Demyttenaere, G. de Girolamo, R. de Graaf, O. Gureje, N. Iwata, E.G. Karam, J.-P. Lepine, D. Levinson, M.E. Medina-Mora, M.A. Oakley Browne, J. Posada-Villa and R.C. Kessler, Psychol. Med., **39(7)** (2009) 1163-1176.
[7] D.J. Stein, C.C. W. Lim, A.M. Roest, P. de Jonge, S. Aguilar-Gaxiola, A. Al-Hamzawi, J. Alonso, C. Benjet, E.J. Bromet, R. Bruffaerts, G. de Girolamo, S. Florescu, O. Gureje, J.M. Haro, M.G. Harris, Y. He, H. Hinkov, I. Horiguchi, C. Hu, A. Karam, E.G. Karam, S. Lee, J.-P. Lepine, F. Navarro-Mateu, B.-E. Pennell, M. Piazza, J. Posada-Villa, M. Ten Have, Y. Torres, M.C. Viana, B. Wojtyniak, M. Xavier, R.C. Kessler and K.M. Scott, BMC Med., **15(1)** (2017) 143.
[8] P. Andlin-Sobocki and H.-U. Wittchen, Eur J Neurol., **12(Suppl 1)** (2005) 39-44.
[9] E. Shirneshan, *Cost of Illness Study of Anxiety Disorders for the Ambulatory Adult Population of the United States*, Doctoral Thesis, University of Tennessee Health Science Center, Memphis, 2013, 370.
[10] G.S. Malhi and J.J. Mann, Lancet, **392(10161)** (2018) 2299-2312.
[11] GBD 2017 Disease and Injury Incidence and Prevalence Collaborators, Lancet, **392(10159)** (2018) 1789-1858.
[12] R. Péquignot, C. Dufouil, K. Pérès, S. Artero, C. Tzourio and J.-P. Empana, J. Am. Geriatr. Soc., **67(3)** (2019) 546-552.

[13] L.A. Pratt, B.G. Druss, R.W. Manderscheid and E.R. Walker, Gen. Hosp. Psychiat., **39** (2016) 39-45.
[14] A. Steffen, J. Nübel, F. Jacobi, J. Bätzing and J. Holstiege, BMC Psychiatry., **20(1)** (2020) 142.
[15] O. Friborg, E.W. Martinsen, M. Martinussen, S. Kaiser, K.T. Overgård and J.H. Rosenvinge, J. Affect. Disorders, **152-154** (2014) 1-11.
[16] G.Y. Lim, W.W. Tam, Y. Lu, C.S. Ho, M.W. Zhang and R.C. Ho, Sci. Rep.-UK, **8(1)** (2018) 2861.
[17] N. Salari, A. Hosseinian-Far, R. Jalali, A. Vaisi-Raygani, S. Rasoulpoor, M. Mohammadi, S. Rasoulpoor and B. Khaledi-Paveh, Globalization Health, **16(1)** (2020) 57.
[18] S.S. Lee and C. Waters, Journal of Prevention & Intervention in the Community, **26(1)** (2003) 39-47.
[19] I. Jirásek, Quest, **67(3)** (2015) 290-299.
[20] A. Jaberi, M. Momennasab, S. Yektatalab, A. Ebadi and M.A. Cheraghi, J. Relig. Health., **58(8)** (2019) 1537.
[21] A. Ghaderi, S.M. Tabatabaei, S. Nedjat, M. Javadi and B. Larijani, Journal of Medical Ethics and History of Medicine, **11** (2018) 3.
[22] J. Fisher, Religions, **2(1)** (2011) 17.
[23] P.C. Hill, K.I. Pargament, R.W. Hood, J.M.E McCullough, J.P. Swyers, D.B. Larson and B.J. Zinnbauer, J. Theor. Soc. Behav., **30(1)** (2000) 51-77.
[24] E. Benzein, A. Norberg and B. Saveman, J. Adv. Nurs., **28(5)** (1998) 1063-1070.
[25] D.S. Martsolf and J.R. Mickley, J. Adv. Nurs., **27(2)** (1998) 294-295.
[26] R.J. Bensley, Health Educ. J., **22(55)** (1991) 287-290.
[27] ***, *The European Health Report 2012: Charting the Way to Well-Being*, World Health Organization, Copenhagen, 2012, 161, online at https://www.euro.who.int/__data/assets/pdf_file/0004/197113/EHR2012-Eng.pdf.
[28] M. Tanatsugu, Journal of Kyoto Prefectural University of Medicine, **112(9)** (2003) 651-661.
[29] R.J. Fehring, J.F. Miller and C. Shaw, Oncol. Nurs. Forum., **24(4)** (1997) 663-671.
[30] E. Charzyńska, J. Relig. Health., **54(5)** (2015) 1629-1646.
[31] J. Magrini, *'Anxiety' in Heidegger's Being and Time: The Harbinger of Authenticity*, Philosophy Scholarship, College of DuPage, Glen Ellyn, 2006, 15.
[32] R.M. Shockey, Bulletin d'Analyse Phénoménologique, **12(1)** (2016) 27.
[33] M. Heidegger, *The Concept of Time*, Wiley-Blackwell, Hoboken, 1992, 76.
[34] S. Kierkegaard and A. Hannay, *The Sickness unto Death: A Christian Psychological Exposition of Edification & Awakening by Anti-Climacus*, Penguin Classics, London, 1989, 168.
[35] C.F. Weems, N.M. Costa, C. Dehon and S.L. Berman, Anxiety, Stress, & Coping, **17(4)** (2004) 383-399.
[36] P. Tillich, *The Courage to Be*, Yale University Press, New Haven, 1961, 252.
[37] P. Tillich, *Theology of Culture*, C. Kimball (ed.), Oxford University Press, Oxford, 1959, 213.
[38] P. Tillich, Rev. Existent. Psychol. PS., **1** (1961) 8-16.
[39] A.M. Abdel-Khalek, Death Stud., **28(9)** (2004) 889-898.
[40] W. Cai, Y.-L. Tang, S. Wu and H. Li, Front. Psychol., **8** (2017) 858.
[41] D. Lester, D.I. Templer and A. Abdel-Khalek, OMEGA - J. Death Dying., **54(3)** (2006) 255-260.
[42] M. Dadfar, D. Lester and F. Bahrami, Journal of Aging Research, **2016(54)** (2016) 2906857.

[43] C.H. Rasmussen and M.E. Johnson, OMEGA - J. Death Dying., **29(4)** (1994) 313-318.
[44] B.G. Scott and C.F. Weems, J. Humanist. Psychol., **53(1)** (2013) 114-128.
[45] D.B. Feldman and C.R. Snyder, J. Soc. Clin. Psichol., **24(3)** (2005) 401-421.
[46] D.B. Feldman, K.L. Rand and K. Kahle-Wrobleski, J. Soc. Clin. Psichol., **28(4)** (2009) 479-497.
[47] C.R. Snyder, Psychol. Inq., **13(4)** (2002) 249-276.
[48] H. Gustafsson, T. Skoog, L. Podlog, C. Lundqvist and S. Wagnsson, Psychol. Sport Exerc., **14(5)** (2013) 640-649.
[49] E.C. Chang and S.L. DeSimone, J. Soc. Clin. Psichol., **20(2)** (2001) 117-129.
[50] M.W. Gallagher, S.C. Marques and S.J. Lopez, J. Happiness Stud., **18(2)** (2017) 341-352.
[51] R.T. Munoz, S. Hoppes, C.M. Hellman, K.L. Brunk, J.E. Bragg and C. Cummins, Res. Social Work Prac., **28(6)** (2018) 696-707.
[52] I. Le Sueur, *An Investigation of Existential and Positive Psychological Resources in College Students*, Doctoral Thesis, Seton Hall University, South Orange, 2019, 129.
[53] H.G. Koenig and D.B. Larson, Int. Rev. Psychiatr., **13(2)** (2001) 67-78.
[54] C.H. Hackney and G.S. Sanders, J. Sci. Stud. Relig., **42(1)** (2003) 43-55.
[55] E.A. Skinner, K. Edge, J. Altman and H. Sherwood, Psychol. Bull., **129(2)** (2003) 216-269.
[56] K. Wijndaele, L. Matton, N. Duvigneaud, J. Lefevre, I. De Bourdeaudhuij, W. Duquet, M. Thomis and R.M. Philippaerts, Psychol. Sport Exerc., **8(4)** (2007) 425-440.
[57] G.D. Sideridis, Stress Health, **22(5)** (2006) 315-327.
[58] B.J. Felton, T.A. Revenson and G.A. Hinrichsen, Soc. Sci. Med., **18(10)** (1984) 889-898.
[59] B.J. Felton and T.A. Revenson, J. Consult. Clin. Psych., **52(3)** (1984) 343-353.
[60] T.L. Newton and R.J. Contrada, Psychosom. Med., **56(5)** (1994) 457-462.
[61] N. Boscaglia, D.M. Clarke, T.W. Jobling and M.A. Quinn, Int. J. Gynecol. Cancer, **15(5)** (2005) 755-761.
[62] C. Carmassi, P. Stratta, E. Calderani, C.A. Bertelloni, M. Menichini, E. Massimetti, A. Rossi and L. Dell'Osso, J. Relig. Health., **55(2)** (2016) 641-649.
[63] L.M. Vitorino, R. de C.E.S. Soares, A.E.O. Santos, A.L.G. Lucchetti, J.P. Cruz, P.J. O. Cortez and G. Lucchetti, Journal of Holistic Nursing, **36(4)** (2018) 332-340.
[64] S.-A. Lee, E.-J. Choi and H.U. Ryu, Epilepsy Behav., **90** (2019) 57-60.
[65] K. Pargament, M. Feuille and D. Burdzy, Religions, **2(1)** (2011) 51-76.
[66] L. Jans-Beken, Spiritual Psychology and Counseling, **4(2)** (2019) 93-108.
[67] A.N. Fabricatore, P.J. Randal, D.M. Rubio and F.H. Gilner, Int. J. Psychol. Relig., **14(2)** (2004) 97-108.
[68] G.G. Ano and E.B. Vasconcelles, J. Clin. Psychol., **61(4)** (2005) 461-480.
[69] K.I. Pargament, *The Psychology of Religion and Coping: Theory, Research, Practice*, Guilford Press, New York, 1997, 548.
[70] P.M. Kasi, H.A. Naqvi, A.K. Afghan, T. Khawar, F.H. Khan, U.Z. Khan, U.B. Khuwaja, J. Kiani and H.M. Khan, International Scholarly Research Notices, **2012** (2012) 128672.
[71] J. Doron, R. Trouillet, K. Gana, J. Boiché, D. Neveu and G. Ninot, J. Pers. Assess., **96(5)** (2014) 567-575.

[72] H. Zamanian, H. Eftekhar-Ardebili, M. Eftekhar-Ardebili, D. Shojaeizadeh, S. Nedjat, Z. Taheri-Kharameh and M. Daryaafzoon, Asian Pac. J. Cancer P., **16(17)** (2015) 7721-7725.
[73] E. Talik and B. Skowroński, J. Relig. Health, **57(3)** (2018) 915-937.
[74] J. Doron, R. Trouillet, A. Maneveau, G. Ninot and D. Neveu, Health Promot. Int., **30(1)** (2015) 88-100.
[75] K.I. Pargament, *The Oxford Handbook of Stress, Health and Coping*, S. Folkman (ed.), Oxford University Press, Oxford, 2011, 269-288.
[76] J. Xu, Brit. J. Soc. Work, **46(5)** (2016) 1394-1410.
[77] D. H. Grossoehme, J. Ragsdale, S. Cotton, J. L. Wooldridge, L. Grimes and M. Seid, Journal of Health Care Chaplaincy, **16(3-4)** (2010) 109-122.
[78] P.T.P. Wong and P.S. Fry, *The Human Quest for Meaning: A Handbook of Psychological Research and Clinical Applications*, Routledge, New York, 1998, 462.
[79] P.L. Berger, *The Desecularization of the World: Resurgent Religion and World Politics*, WB Eerdmans. *Michigan*, 1999, 135.
[80] E. Lisovskaya and V. Karpov, Polit. Relig., **3(2)** (2010) 276-302.
[81] V. Karpov, J. Church State., **52(2)** (2010) 232-270.
[82] J.P. Bjorck, Y.S. Lee and L.H. Cohen, Am. J. Commun. Psychol., **25(1)** (1997) 61-72.
[83] H.F. Ellenberger, *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*, Basic Books, New York, 1970, 932.
[84] V.E. Frankl, *The Will to Meaning: Foundations and Applications of Logotherapy*, Plume, New York, 1988, 208.
[85] V.E. Frankl, *Man's Search For Ultimate Meaning*, Basic Books, New York, 2000, 208.
[86] V.E. Frankl, M. Edgardh and H. Åkerberg, *Gud Och Det Omedvetna: Psykoterapi Och Religion (God and the Unconscious: Psychotherapy and Religion)*, Natur och kultur, Stockholm, 1987, 130.
[87] P. Wong, *From Logotherapy to Meaning-Centered Counseling and Therapy*, P.T.P. Wong (ed.), 2nd edn., Routledge, New York, 2012, 665-694.
[88] P.T.P. Wong, International Journal of Existential Positive Psychology, **6(1)** (2016) 9.