Applying Relational Cultural Theory and Symbolic Interaction Theory to the Analysis of the Relationship between Religion and the Development of Childhood Anxiety in Learning

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Abstract

Childhood anxiety develops partly from environmental factors such as religion. Anxiety is the most common childhood mental health disorder, and 90% of families worldwide claim some type of religion. There is mixed research regarding the relationship between childhood anxiety and religion, but theories can be used to asses and predict how this relationship might work. Relational Cultural Theory proposes that the family and religious community interactions that occur cause a child to develop their relational images in a certain way. If these interactions are not positive connections, then the child may develop struggles with anxiety. On the other hand, Symbolic Interaction Theory looks at these social interactions and focuses on the meaning that the child attributes to objects in their reality. Under this theory, religious beliefs would influence how the child assigns these meanings, and whether the meanings increase childhood anxiety.

Keywords: ***childhood anxiety, religion, relational cultural, symbolic interaction***

Abstrak

Kecemasan masa kecil berkembang sebagian dari faktor lingkungan seperti agama. Kecemasan adalah gangguan kesehatan mental anak yang paling umum, dan 90% keluarga di seluruh dunia mengklaim suatu jenis agama. Ada beragam penelitian tentang hubungan antara kecemasan masa kecil dan agama, tetapi teori dapat digunakan untuk menilai dan memprediksi bagaimana hubungan ini bisa berhasil. Teori Budaya Relasional mengemukakan bahwa interaksi keluarga dan komunitas keagamaan yang terjadi menyebabkan seorang anak mengembangkan citra relasionalnya dengan cara tertentu. Jika interaksi ini bukan koneksi positif, maka anak tersebut mungkin mengalami pergumulan dengan kecemasan. Di sisi lain, Teori Interaksi Simbolik melihat interaksi sosial ini dan berfokus pada makna yang dikaitkan anak dengan objek dalam realitas mereka. Di bawah teori ini, keyakinan agama akan memengaruhi cara anak memberikan makna ini, dan apakah makna tersebut meningkatkan kecemasan masa kanak-kanak.

Kata kunci**: kecemasan masa kecil, agama, relasional budaya, interaksi simbolik**

A. INTRODUCTION

Worldwide, childhood anxiety is the most prevalent disorder our children face (Cooley & Boyce, 2004). The development and treatment of childhood anxiety has a strong relationship with environmental factors such as the religious context of the child's family. Religion is also a prominent factor in children's daily lives (Koenig, 2009). Approximately 90% of people in the entire world are involved in some sort of religious or spiritual practices. There is research examining this relationship, but it tends to be very mixed on whether the relationship is positive or negative. However, it can be analyzed using theoretical propositions.

Relational Cultural Theory (RCT) is an excellent fit for this analysis because it is focused on the relational images (or beliefs) that are developed during childhood throughout interactions with our family and other important people (Rausch, 2014 citing Miller & Stiver, 1997). Symbolic Interaction Theory (SIT) is another excellent fit for this analysis because it is focused on meanings attributed to symbols, which are passed down through interactions with other people (Mead, 1964). Religion plays a significant role in the interactions children have with their primary caregivers (Bengtson, Copen, Putney, & Silverstein, 2009). It also plays a significant role in children's lives through church and other relationships. Since RCT proposes that relational images developed in these childhood relationships have a direct correlation with mental health, and since SIT proposes that these relationships provide for meanings which are associated with mental health, it follows that these theories would be an excellent fit for examining the relationships between childhood anxiety and religion (Rausch, 2014 citing Miller & Stiver, 1997; Mead, 1964).

B. Religion

Out of all 238 countries, only eight claim 25% or more of their inhabitants are non-religious. In the United States, for the 92% of Americans who are religious, religion affects almost every part of life: from politics to education, to family life and work (Bengtson, Copen, Putney, & Silverstein, 2009; Mahoney & Cano, 2014). Historically, religion played a large role in culture including a significant role in understanding mental health issues (Koenig, 2009; Sheikh & Furnham, 2000). There is mixed evidence about the relationship of religion and anxiety with some research stating decreased anxiety, some increased anxiety, and some no relationship

(Koenig, 2009; Green & Elliot, 2010). The prevalence of religion in daily life means that it is important to consider its role in childhood anxiety to support treatment and parenting.

Religion is defined as the beliefs, practices, traditions and rituals people hold about truth and reality that involves a supreme, omnipresent being (Koenig, 2012; Koenig, 2009). These beliefs focus on ideas about morality, life after death, and sacredness, and provide a sense of meaning and purpose**.** These beliefs are connected to behavioral, emotional, and cognitive beliefs people hold on to and act according to. It is a social and individual experience that often connects communities and generations of people (Roebuck Bulanda, 2011). Religious beliefs are often transmitted through family members and traditions (Leonard, et al, 2013).

Religions provide rules both social and individual for people to live by and use in decision-making processes (Etengoff & Daiute, 2014). These rules describe gender roles, age roles, family roles, and community roles. Religions range from conservative to liberal both between religions and within each religion (Roebuck Bulanda, 2011). These roles affect how people make decisions about behavior, and how they react and interpret their environments.

Religion also provides strategies for coping with life stressors and discourages risk taking behaviors (Koenig, 2012). For example, religious beliefs may be protective against mental illness when it provides a someone to blame for struggles (a god or a devil), and thus, individuals do not have to take responsibility for their struggles (Abdullah & Brown, 2011). Koenig (2009) found that religious beliefs can reduce anxiety, increase self-control and feelings of security, and boost confidence. Religions often provide clear cut roles for family members by age and gender. This clarity reduces stress related to role performance, and can help to reduce role conflict between roles such as work and family (Mahoney, 2010; Patel & Cunningham, 2012). These roles also provide frameworks for child-rearing practices (Desrosiers, Kelley, & Miller, 2011).

Religion provides many specific beliefs that support mental health (Koenig, 2012; Mahoney, 2010; Green & Elliot, 2010; Patel & Cunningham, 2012). These values include honesty, forgiveness, patience, altruism, generosity, discipline, humility, optimism, abstinence, love for others, compassion, and dependability. Religious values such as these promote positive social relationships, which are associated with positive mental health outcomes such as social skills, better social support, marital stability, low delinquency rates, and altruistic behaviors.

Finally, religion provides strong psychosocial resources associated with decreased stress including problem solving, looking beyond personal limitations, looking outside themselves for solutions, a formal setting for social relationship building, and providing a moral framework (Patel & Cunningham, 2012). These resources are correlated with interpersonal resources, which provide positive relationships and influence coping behaviors.

In contrast to the above positive associations, religion has also been associated with negative mental health outcomes (Koenig, 2012). For example, religion is often used to promote aggression, violence, prejudice, exclusion, and power and oppression dynamics. Religion also promotes rigidity and excessive guilt and anxiety. Cognitive beliefs that might cause anxiety to increase include ideas that one is being punished by God or that God has abandoned them (Patel & Cunningham, 2012). Negative views such as these have been associated with higher levels of depression, anxiety, and family conflict (Mahoney, 2010; Koenig, 2009).

In addition, religious beliefs can delay diagnosis and treatment for anxiety by blaming external factors (such as demons and the devil) for symptoms rather than recognizing the issue at hand (Koenig, 2012; Mahoney, 2010). Conflicting religious beliefs can cause explosive arguments about treatment and mental health, which increases anxiety in children. These conflicts contribute to role conflict by requiring the child to reconcile expectations of their role as a religious member and their role as a child (Patel & Cunningham, 2012).

Individuals also struggle with cognitive dissonance related to religion (especially conservative religion), when it conflicts with individual attributes, such as the case with Catholic gay men (Etengoff & Daiute, 2014; Roebuck Bulanda, 2011). This dissonance produces anxiety, depression, and other mood disorders. Similarly, individuals with liberal gender beliefs can experience cognitive dissonance in religions that hold traditional gender expectations.

Etengoff and Daiute (2014) also found that while religion can promote social relationships, it can also promote relationally maladaptive behaviors. For example, religion may create or exacerbate social conflict around specific beliefs, and such social conflict with your religious community is more stressful that outside social conflict (Koenig, 2009; Green & Elliot, 2010) For example, Etengoff and Daiute (2014) found that religious beliefs were problematic when families used them during conflict in the coming out process. They also found that parents

use religion to support their views in arguments with children, even when they recognized that this behavior lead to increased verbal aggression and stonewalling from the child. Finally, religious beliefs can promote blind adherence to hateful, aggressive, and even violent expectations such as in the Christian crusades and Isis attacks (Koenig, 2012).

Religion is highly prevalent in the world and in the United States (Koenig, 2009). Religious practices and beliefs are transmitted through families and affect everything from traditions to parenting style and conflict styles (Bengtson, Copen, Putney, & Silverstein, 2009). This is how religion plays an integral role within families (Patel & Cunningham, 2012). Thus, it is important to investigate how religion might affect mental health issues in children, especially anxiety. Many resources found relationships both positive and negative between religion and anxiety (Koenig, 2009; Green & Elliot, 2010). This paper will explore how two theories explain these relationships: Symbolic Interactionism and RCT.

C. **Relational Cultural Theory (RCT)**

Relational Cultural Theory (RCT) is a relatively modern theory that developed out of the feminist theories (Rausch, 2014 citing Miller & Stiver, 1997). It focuses on how relationships and culture influence child development. The primary RCT tenet is that as children interact with others they develop relational images (or ideas) about themselves and the world. This focus on relationship makes this theory perfect to analyze the role of religion in children's anxiety since religion plays a major role in family life and relationships.

RCT holds that children are naturally social, and instinctively seek to connect to people (Rausch, 2014 citing Miller & Stiver, 1997). It also suggests that children learn about the world through their interactions with other people (Rausch, 2014 citing Miller & Stiver, 1997; Surrey, 1991). As they learn about the world they develop relational images.

Relational images are a type of cognitive schema that include information about how to achieve connection with others (Rausch, 2014 citing Miller & Stiver, 1997). Connections are interactions that are mutually beneficial, validating, and authentic (Rausch, 2014 citing Surrey, 1991). If a child experiences connection they will develop positive relational images that will support them in building future relationships.

Disconnection occurs when children do not feel the other person is understanding, authentic, or empathic with their experience. Disconnections lead to relational images that are about a fear of isolation, despair, worthlessness, and hopelessness. Disconnections are inevitable, but in healthy relationships the damage is repaired. Common relational images for disconnection include accommodating, emotional disengagement, role-playing and replication.

Repeated disconnections create a relational image referred to as the Central Relational Paradox (CRP). The CRP states, "that individuals continuously seek connections, but after a series of disconnections they do more and more to keep themselves out of painful connections" (Rausch, 2014). These individuals want and try to connect, but they believe they must do so by ignoring their own experience. Thus, they are constantly being inauthentic, which prevents true connection. In other words, there are two sides to the CRP: both the need for connection and the need for disconnection.

RCT also suggests that the cultural framework of America promotes power and oppression dynamics that limit our ability to develop positive relational images as children (Rausch, 2014 citing Miller & Stiver, 1997). Our culture treats success and approval as a scarce resource meaning that only one person can win. This promotes manipulation not collaboration.

However, RCT also states that if children are provided with a safe and authentic relationship they will begin to develop new, healthy relational images (Rausch, 2014 citing Miller & Stiver, 1997). This means that therapy techniques are focuses more on relationship building between the therapist and client, exploring relational images, and replacing the old images with new ones based on the therapeutic relationship. Similarly, family or religious community members can provide these positive authentic relationships for the child. This relationship requires authentic and responsive engagement with the child.

D. **Symbolic Interaction Theory (SIT)**

Symbolic Interaction Theory (SIT) focuses on how humans develop a complex set of symbols to give meaning to the world (LaRossa & Reitzes, 1993). These symbols develop meaning and are passed down through interactions with other people (Mead, 1964; Wimberley, 1989). Although SIT is commonly used to study dyadic interactions, in today's context, SIT also represents the diverse interactions within a family system and community. This theory fits the

analysis of the relationship between religious beliefs and childhood anxiety because religion provides a societal framework of symbols and meanings that are applied to roles the children are expected to meet. These roles combined with other roles the children hold may create role strain resulting in anxiety.

SIT states that behavior is understood by the meanings of the individual actors (White, 2015). Therefore, if we wish to understand human behaviors, we must know how people define the things— objects, events, individuals, groups, structures—in their environment. An example is that different people have different way of handling their emotional issues such as anxiety when they connect it with their religious beliefs. Going back to Koenig (2009) argument that says religious beliefs are connected to behavioral, emotional, and cognitive behaviors people hold on to and act according to, some people express their anxieties with violent conducts or the opposite, caring and loving behaviors (Patel & Cunningham, 2012; Koenig, 2012). To understand this, it is important to know what the behaviors means to the actors because a lot of human behaviors cannot be simply explained just by looking at the behavior physically, denying the significance of its meaning to the actors.

In relation with that, actors define the meaning and the context of the situation (Hewitt, 1976; Mead, 1934). In a classroom setting, this assumption applies when a student does not do very well because he is very anxious about the test. He may be anxious because he has decided that the meaning of a test is whether he is intelligent or not, and thus, failing it would mean he is unintelligent. His teacher or parents might not understand or even know this unless they ask him and find out what happened.

SIT also states that individuals have minds, which allows them to have a looking glass self (Hewitt, 1976; Mead, 1934). This concept means people can look at themselves as objects assigning meaning to themselves and reflecting on choices. This evaluation is influenced by the fact that society comes before the individual (Mead, 1934). This is the idea that the individual develops within the context of society, and is thus, a product of society. This contradicts the idea of others that suggests humans come first and therefore create society. This is Mead's belief, because humans cannot understand the world or communication if they do not first know the meaning of symbols such as language.

There are several connected propositions within SIT (White, 2015). First is that as a person is better at a specific role within a relationship, that person is more satisfied with that relationship. Second, the clearer the societal expectations of a role are, the better that person will perform the role increasing satisfaction (Mead, 1934). Third, the more agreement in society on those role expectations, the clearer the role will be, and the less role strain the individual will experience (White, 2015). People might experience uncertainty or stress over the enactment of ambiguous roles where they receive many messages about the expectations. Fourth, SIT suggests that the more variance in the individual's many roles, the greater the role strain will be, because there will be greater role conflict where the expectations for one role violate the expectations for another. Finally, SIT suggests that the strain a certain role causes, the harder it is for the individual to shift into that role, and the easier it is for the individual to shift out of that role.

E.**Critical Application**

The past research on the relationship between religion and childhood anxiety provides mixed results further confounding the relationship. Both RCT and SI provide frameworks for guiding future research. RCT looks at how the relationships in the religious community, in family, and with god create relational images that may be either positive or negative, and thus, how and when religion influences the development of childhood anxiety. Similarly, SIT looks at how social interactions and religious beliefs influence the meaning that the child assigns to objects in their world. These meanings may provide protection or risk for childhood anxiety.

E. Applying RCT

RCT assumes children naturally seek connection and that these connections are how the child learns about themselves and the world (Rausch, 2014 citing Miller, 1997 & Miller & Stiver, 1997). Religion provides opportunities for connection to family, to religious community members, and to a god; these connections provide new paths for learning and understanding the world and themselves. If relationships with the religious community and/or god provide safety, understanding, and acceptance, then the child will develop positive relational images which will promote resiliency and reduce anxiety. This may even reduce anxiety in a child with a very

difficult even abusive home life since RCT proposes that if children are provided with a safe and authentic relationship they will begin to develop new, healthy relational images.

However, religion often provides strict belief systems that may cause repeated disconnection with the god and religious community if the child does not hold the same beliefs or the child feels they cannot meet the religious expectations (Rausch, 2014 citing Miller, 1997 & Miller & Stiver, 1997). Similarly, some religions have a god who is responsive and connected, but some have a god who is distant and critical. These religious relational experiences will create disconnection and negative relational images such as the CRP. Negative relational images and the CRP will lead the child to experience anxiety. Thus, if their religion community is not growth fostering, authentic, and accepting in their interactions with the child they may develop anxiety. If the child feels abandoned by God or punished by him, then the child may develop anxiety.

RCT proposes that it is difficult to maintain connection in America because the cultural framework promotes power and oppression dynamics (Rausch, 2014 citing Miller, 1997 & Miller & Stiver, 1997). Many religions, especially more conservative branches, promote patriarchy and child obedience. According to this RCT proposition, structure oppresses women and children in a way that makes it difficult for them to experience authentic connection. Similarly, religious promotes god as all powerful and judging people's choices, which creates a power dynamic making it difficult to experience connection with god.

RCT explains the mixed data on the relationship between childhood anxiety and religion by suggesting that it isn't the branch of religion that matters, as the research supports, but it is the way families, religious communities, and the child applies religion to relationships that defines how it will impact childhood anxiety.

G. Applying SIT

There are several major assumptions in SIT that play a role in analyzing the relationship between childhood anxiety and religious beliefs including: behavior must be understood by the meanings of the actors, which are developed within the context of society and depend on the context of the situation the actor is currently in; and the ideas that humans can look at themselves as objects and assign meaning to their own behaviors (Blumer, 1969).

This aligns with a role for religion in the development and the treatment of childhood anxiety, because children are typically born into a family with established religious beliefs (Mead, 1964). These beliefs influence parenting and the child's learned symbols. It influences the interactions of everyday life for a child. It is a filter by which meaning is given to objects and symbols in the child's life. These meanings may result in anxiety for the child. It may also influence how they interpret the meaning of mental illness, of symptoms, and of treatment, which as we saw above all interact with childhood anxiety outcomes.

SIT proposes that a person experiences less stress when they can perform a role well, and they can perform a role well when 1) the expectations are clear; 2) the expectations do not conflict with other roles; 3) and there is societal agreement on the expectations of the role (White, 2015). Similarly, the more roles a person experience the less often these requirements will be met, thus role strain will increase. Religion provides information about expectations and roles.

Many religions provide clear expectations about how men, women, children, adults, etc. should act. This clarity plays a role in determining role strain (White, 2015). Similarly, if these expectations are not agreed upon or conflict with another role the child holds, then they may experience role strain. For example, children who are homosexual may be in violation of religious role expectations. Similarly, religion provides for defining objects as sacred, and once we regard them as sacred, they take on special significance and give meaning to our lives.

SIT would suggest that by providing clarity and conflict for role expectations and by giving meaning to symptoms, mental health, and treatment, religious beliefs influence childhood anxiety development and treatment. The flexibility of individual meanings and balances of clarity versus conflict may explain the conflicting evidence about this relationship.

H. Comparisons

Both theories explain the mixed evidence about childhood anxiety and religious beliefs as due to the flexibility in individual cognitions. However, RCT explains that one individual who is Christian and homosexual may experience anxiety due to the way their relationships in religious communities have provided disconnection, while another may not experience this anxiety if their relationships around religion have involved connection. SIT does not seem to explain this

element as well. It suggests that religion would provide meaning to being homosexual, but if two people in the same religious community have different meanings there is no explanation as to why this difference occurred since it focuses on objects which are the same for both Christians. However, SIT may better explain fluctuations in anxiety by relying on situationally dependent meanings and the presence or lack of presence of certain symbols.

I. Conclusions

RCT and SIT are very similar approaches to understanding how religion affects childhood anxiety. While both theories look at the social relationships influenced by religion, they have a slightly different focus. RCT looks at the beliefs the child develops about themselves, the world, and relationships as a standalone entity called the relational image. SIT looks at the meaning the child attributes to people, to objects, and to identity roles. SIT seems to be more situationally dependent for the child by looking at the meaning attributed to the objects in front of the child at any given moment, which might make sense given that most children with anxiety are only anxious in certain situations. However, anxious children tend to respond anxiously consistently, and thus, it may also make sense that RCT looks at general beliefs the child holds in a relational image and applies to all situations. Future research might look further at differentiating between how consistent the cognitions underlying anxious are in childhood.

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