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## ARTIGOS

## Coping religioso/espiritual, eventos estressores precoce e sintomas psiquiátricos: um estudo de mediação entre protestantes

*Religious/spiritual coping, early stressful events, and psychiatric symptoms: a study of mediation among protestants*

*Afrontamiento religioso/espiritual, acontecimientos estresantes tempranos y síntomas psiquiátricos: un estudio de mediación entre protestantes*

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**Resumo:** A religiosidade e/ou espiritualidade (R/E) está associada a melhores índices de saúde física e mental, pelo uso de estratégias de enfrentamento como o coping religioso/espiritual (CRE). O estudo explorou a relação do CRE com a saúde mental e eventos estressores em protestantes. De forma mais específica, hipotetizou-se que o CRE total mediaria o efeito da negligência emocional (um dos tipos mais frequentes de evento estressor) sobre sintomas de depressão, ansiedade e estresse nos participantes. A amostra foi composta de 254 participantes protestantes que responderam um questionário sociodemográfico, o questionário de traumas na infância (QUESI), a escala de religiosidade da Duke (DUREL), a escala de depressão, ansiedade e estresse (DASS-21) e a escala breve de enfrentamento religioso/espiritual (SCOPE-14). A R/E mostrou-se um

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preditor significativo do CRE Total (CRET). O efeito da mediação foi significativo para os desfechos da depressão, ansiedade e estresse. O CRET mediou a relação entre negligência emocional e estresse. Os resultados apontam para a importância de trabalhar a dimensão espiritual do sujeito na psicoterapia.

**Palavras-chave:** Religião; Enfrentamento; Trauma psíquico.

**Abstract:** Religiosity and/or spirituality (R/S) is associated with better levels of physical and mental health, through the use of coping strategies such as religious/spiritual coping (RSC). The study explored the relationship between RSC and mental health and stressful events among Protestants. Specifically, it was hypothesized that total RSC would serve as a mediator in the association between emotional neglect (one of the most frequent types of stress exposure) and symptoms of depression, anxiety, and stress among the participants. The sample was composed of 254 Protestant participants who answered a sociodemographic questionnaire, the Childhood Trauma Questionnaire (QUESI), the Duke Religiosity Scale (DUREL), the Depression, Anxiety and Stress Scale (DASS21) and the Brief religious/spiritual coping (SCOPE-14). R/E proved to be a significant predictor of Total RSC (TRSC). The mediation effect was significant for the outcomes of depression, anxiety and stress. TRSC mediated the relationship between emotional neglect and stress. The results point to the importance of working on the spiritual dimension of the subject in psychotherapy.

**Keywords:** Religion; Coping; Psychic trauma.

**Resumen:** La religiosidad y/o espiritualidad (R/S) se asocia con mejores niveles de salud física y mental, mediante el uso de estrategias de afrontamiento como el afrontamiento religioso/espiritual (RSC). Esta investigación examinó la relación entre el CRE y los resultados de salud mental y las experiencias estresantes entre protestantes. Se planteó la hipótesis específica de que el CRE total actuaría como un mediador en la asociación entre la negligencia emocional (uno de los tipos de exposición al estrés más frecuentes) y los síntomas de depresión, ansiedad y estrés en protestantes. La muestra estuvo compuesta por 254 participantes protestantes que respondieron un cuestionario socio-demográfico, el Cuestionario de Trauma Infantil (QUESI), la Escala de Religiosidad de Duke (DUREL), la Escala de Depresión, Ansiedad y Estrés (DASS21) y el Breve afrontamiento religioso/espiritual (SCOPE- 14). R/E demostró ser un predictor significativo de RSC total (TRSC). El efecto de mediación fue significativo para los resultados de depresión, ansiedad y estrés. TRSC medió en la relación entre negligencia emocional y estrés. Los resultados apuntan a la importancia de trabajar la dimensión espiritual del sujeto en psicoterapia.

**Palabras clave:** Religião; Afrontamiento; Trauma psíquico.

## Introduction

Early Stressful Events (ESEs) are adverse, stressful situations experienced during childhood or adolescence, with the potential to trigger various psychopathologies and have lasting ef-

fects throughout life (Costa et al., 2019; Giotakos, 2020). The types of ESEs most discussed in the literature include physical, sexual, and emotional abuse, as well as physical and emotional neglect (Giotakos, 2020).

Literature findings indicate various disruptive health effects associated with early stress exposures (ESEs). According to Juruena et al. (2020), evidence suggests that early-life stress can cause persistent changes in the Hypothalamic-Pituitary-Adrenal (HPA) axis's response to stress in adulthood, leading to psychiatric disorders such as panic attacks, generalized anxiety disorder, phobias, and depression. Other negative impacts include altered emotional processing and deficits in reward sensitivity (Herzberg & Gunnar, 2020).

Giotakos (2020) notes that ESEs may disrupt a child's neurobiological development, thereby reducing stress resilience and leading to future issues in emotional regulation. Given the detrimental effects of ESEs on individuals' lives, psychological science seeks to investigate which coping mechanisms might serve as functional interventions to promote health. In this regard, and/or spirituality (R/S) is understood to potentially influence ESEs. These constructs are associated with effects on illness (when religious teachings or practices are used in a punitive and oppressive way) and wellness (when the individual's relationship with religion is linked to a sense of meaning, purpose, and social connection). R/S is a structuring factor of subjectivity and serves as a meaningful coping resource in times of suffering (Murakami & Campos, 2012).

## Religion and mental health

Research on R/S has increased considerably in recent years. Considering that 92% of the Brazilian population reported belonging to a religion according to an IBGE survey (Brazilian Institute of Geography and Statistics [IBGE], 2010), studies on aspects of this phenomenon are necessary (Waldron et al., 2018), especially given the diverse religious groups in Brazil with highly distinct practices.

Defining religion encounters various challen-

ges, as it is impossible to precisely encompass the religious universe in a single expression (Figueiredo, 2019). Each religion has unique characteristics that completely distinguish it from others. In this context, the present work aims to provide an operational definition for investigative purposes, as proposed by Koenig et al. (2001) define religion as an organized set of beliefs, prescribed behaviors, rituals, and symbols shared within a community to seek the sacred. For a better understanding, it is important to differentiate between "spirituality" and "religiosity," acknowledging that, although often associated, they have distinct meanings.

Spirituality is characterized by the subjective pursuit of understanding essential questions about the meaning of existence and one's relationship with something larger than oneself (Koenig et al., 2001); it is a personal feeling and may or not express itself through religion (Murakami & Campos, 2012). Consistent with this, Ribeiro and Minavo (2014) distinguish religion based on its institutional perspective and spirituality based on personal interiority that leads to a connection with the transcendent.

Studies on religion and spirituality have demonstrated positive effects on the health of religious and/or spiritual people. Findings show that religious beliefs provide support to individuals recovering from traumatic events (Leo et al., 2021). Those who have suffered trauma may turn to God, religion and/or other spiritual entities in search of help. A review by Andrade et al. (2020) on R/S and suicide found that most studies demonstrated the protective effects of these constructs against suicidal behavior. In a study by Carothers et al. (2005), adolescent mothers with high religiosity and/or spirituality showed significantly higher self-esteem than the non-religious group and had lower depression scores.

Similarly, studies investigating ESEs and mental health emphasize the benefits of R/S for individuals who have experienced trauma. For instance, Reiland and Lauterbach (2008) examined the self-esteem of individuals who suffered childhood trauma and found that those with higher levels of religiosity had significantly higher average self-

-esteem compared to those with lower religiosity. Likewise, a study involving 10.283 Seventh-Day Adventists in the United States revealed that ESE victims experienced fewer negative effects of trauma in adulthood due to aspects related to religiosity and/or spirituality (Reinert et al., 2016).

Conversely, some studies found no effects of R/S on the mental health of people subjected to childhood trauma. These studies suggest that negative religious coping is significant in individuals who have experienced trauma. A literature review by Walker et al. (2009) showed that most studies indicate a decline in R/S or a combination of growth and decline. Among the 34 studies reviewed, seven suggested that R/S might moderate the development of symptoms related to Axis 1 disorders from the Diagnostic and Statistical Manual of Mental Disorders - DSM 5 (American Psychiatric Association, 2013).

Waldron et al. (2018) demonstrated that all ESE subtypes were associated with negative views of God within religiosity. In this perspective, the perception of God as a punitive figure mediated the relationship between early emotional abuse and low self-esteem in adulthood, as well as interpersonal problems. Kosarkova et al. (2020), studying adults in the Czech population, highlight that childhood maltreatment and insecure adult attachment styles lead to greater use of negative religious and/or spiritual coping strategies, causing individuals to perceive God as distant and unloving. In a US same, individuals who experienced emotional, physical, and sexual abuse in childhood by a male figure are more likely to view God as distant (Bierman, 2005).

Kennedy and Drebing's (2002) research present ambivalent findings regarding the religiosity of individuals who experienced childhood abuse. This population tends to diverge into two groups: those who become closer to or distant from God and those who distance themselves from Him. Following the trauma, Protestant individuals may experience either growth or decline in their religious beliefs and practices. A critical factor in increased religiosity was the utilization of established beliefs as a coping mechanism

for managing trauma, often referred to as coping strategies.

Ways of dealing with stressful situations are generally referred to as coping strategies, which encompass both cognitive and behavioral resources (Oman & Syme, 2018; Panzini & Bandeira, 2007; Tix & Frazier, 1998). When these practices focus on aspects of R/S, aiming to minimize, tolerate, or help develop better ways of overcoming situations that generate distress, they are defined as Religious/Spiritual Coping (RSC) (Bamford & Lagattuta, 2010; Panzini et al., 2007; Wong-McDonald & Gorsuch, 2004).

RSC is a set of coping strategies arising from religion and/or spirituality to manage stressful events through beliefs, cognitive evaluation, and religious behaviors. Depending on the outcome of the strategy, it can be classified as Positive Religious/Spiritual Coping (PRSC) or Negative Religious/Spiritual Coping (NRSC) (Panzini & Bandeira, 2007). RSC measurements can relate PRSC and NRSC values to obtain a Total Religious/Spiritual Coping value (TRSC) (Macedo & Esperandio, 2021). The literature links PRSC to health and quality of life, whereas NRSC is associated with lower scores on these indices (Fatima et al., 2022).

Pargament et al. (1998) differentiate RSC into positive and negative dimensions. PRSC involves a secure relationship with the sacred that yields benefits, such as reevaluating the stressor to find beneficial meaning and seeking comfort in religious literature, God, or the divine (Counted et al., 2022). Conversely, NRSC is related to strategies that generate negative consequences for the individual or dissatisfaction related to God, the sacred, or one's religion, such as reinterpreting the stressful situation as abandonment by God or lack of forgiveness (Cowden et al., 2022).

RSC is considered an effective predictor of health (García et al., 2017; Koenig, 2001), as it can facilitate more positive appraisals and reinterpretive cognitions, making situations appear less threatening. Furthermore, it provides a model for emotion management based on religious principles (e.g., seeking joy, love, and gratitude).

In contrast, NRSC can lead to increased guilt and negative thoughts, resulting in detrimental consequences for the individual's mental health (Koenig, 2009; Sharp, 2010).

Given the various findings on the relationship between ESEs and R/S, this study aimed to analyze TRSC as a potential mediator between emotional neglect—a common form of early stress exposure—and lower levels of depression, anxiety, and stress in Protestants. Additionally, the study examined the relationships among early stressful events, coping, mental health, and depression to explore subsequent analytical models. The hypothesis proposed that higher levels of TRC would mediate the relationship between emotional neglect and reduced symptoms of depression, anxiety, and stress. This investigation was conducted with a Protestant sample, representing one of the fastest-growing religious groups in Brazil, whose specific faith practices may influence how individuals use religious and/or spiritual coping strategies when facing adversity. The results of this research contribute to a better understanding of the role of the religious and/or spiritual dimension in psychological care within this sample and encourage further studies on coping mechanisms in different religious contexts.

## Method

### Participants

The sample was collected by convenience. A total sample of 254 Protestant participants from various denominations met the eligibility criteria, which included being 18 years or older and providing consent by signing the Informed Consent Form. This final number (n=254) represents the total number of participants after data cleaning and filtering, ensuring that only complete and eligible responses were included in the analysis. Among the participants, 44.9% reported having changed religions, with ages ranging from 18 to 70 years. The majority (76.4%) were female, while 49.2% identified as mixed race and 35% as white. Regarding marital status, 49.6% were married, and 44.1% were single. In terms of education, 24.8%

had incomplete higher education. Additionally, most participants (74.4%) reported being raised by both parents. Information about socioeconomic status, gender identity or sexual orientation was not collected in this study.

When asked about childhood trauma, 42.1% of participants responded affirmatively. Regarding child abuse specifically, 17.3% reported experiencing it. Among this group, 16.1% indicated abuse

by a male figure, and 8% of these cases were reported to have occurred multiple times. Concerning psychotherapy, 15.4% of participants stated they were currently undergoing treatment. These data were collected online. More detailed general information, including participants' perceptions of childhood trauma and responses about R/S collected through the sociodemographic questionnaire, are presented in Table 1.

**Table 1** - Sociodemographic characteristics

Variables	n	%
Gender		
Female	194	76.4%
Male	60	23.6%
Marital Status		
Single	112	44.1%
Married	126	49.6%
Stabel union	5	2%
Divorced	8	3.1%
Widow	3	1.2%
Level of education		
Incomplete elementary school	6	2.4%
Complete elementary school	4	1.6%
Incomplete High school	8	3.1%
Complete High school	49	24.8%
Incomplete higher education	73	28.7%
Complete higher education	49	19.3%
Incomplete postgraduate education	13	5.1%
Complete postgraduate education	38	15%
Denomination		
Congregational	150	59.1%
Not Specified	36	14.2%
Baptist	27	10.6%
Assembly	13	5.1%
Presbyterian	9	3.5
Bethel	4	1.6
Reformed Church Mission 58	3	1.2%
Evangelical Action	2	0.8%
Others	10	3.9%
Childhood traumatic events		
Separation from loved ones	82	32.3%
Bullying and aggression	97	38.2%
Surgery or serious illness	30	11.8%
Suffered an accident	22	8.7%
Family isolation	33	13%
Caregivers abused substances	23	9.1%
Witnessed various forms of violence	70	27%
Relocation	83	32.7%

Variables	n	%
Death of close relatives	91	35.8%
Diagnosis of psychological disorders		
Anxiety	17	6.7%
Depression	1	0.4%
Mixed anxiety and depression disorder	2	0.8%

## Measures

**Sociodemographic Questionnaire** to collect information about gender, age, marital status, family income, education, psychotherapy, medication use, diagnosis of diseases, childhood caregivers, traumatic situations, religion adhered to, etc.

**The Childhood Trauma Questionnaire (QUESI) (Bernstein et al., 1994)** aims to investigate whether the individual experienced early adverse events (EAPs). The instrument is divided into three validity questions and 25 items that assess the subtypes of EAPs: sexual abuse, physical abuse, emotional abuse, physical neglect, and emotional neglect. The instrument uses a Likert scale ranging from 1 to 5, where 1 means "never" and 5 means "frequently." Each of these subtypes has a subscale with 5 items, with scores ranging from 5 to 25. The Cronbach's alpha for the subscales ranges from  $\alpha = 0.79$  to  $\alpha = 0.94$  (Bernstein et al., 1994).

**Duke Religious Index (DUREL) (Koenig et al., 1997)** was translated and adapted for Brazil by Moreira-Almeida et al. (2008). It is a brief 5-item scale that assesses three dimensions of religiosity related to health: Organizational Religiosity (RO, item 1), Non-organizational Religiosity (RNO, item 2), and Intrinsic Religiosity (RI, items 3-5). The items of RO and RNO are evaluated based on frequency (1 to 6), and the items of RI are assessed based on intensity (1 to 5). Its scoring ranges from 0 to 6 for RO and RNO, and from 3 to 15 for RI. The RI subscale obtained Cronbach's alpha of  $\alpha = 0.758$ , and the overall score was  $\alpha = 0.733$ , indicating good discriminant validity.

**Depression, Anxiety and Stress Scale (DASS-21) (Lovibond & Lovibond, 1995)**, was adapted and validated for Portuguese by Vignola (2013), is a 21-item instrument designed to assess de-

pression, anxiety, and stress. It uses a four-point Likert scale ranging from 0 to 3. The scale is divided into three subscales, each comprising seven items, which assess specific symptom clusters for depression, anxiety, and stress. The internal consistency was  $\alpha = 0.92$  for depression,  $\alpha = 0.90$  for stress, and  $\alpha = 0.86$  for anxiety.

**Brief Religious/Spiritual Coping Scale (SCOPE-14) (Pargament et al., 2011)** was adapted and validated for use in Brazil by Esperandio et al. (2022). It is a 14-item measure, divided into two subscales, each comprising seven items, assessing Positive Religious/Spiritual Coping (PRSC) and Negative Religious/Spiritual Coping (NRSC). PRSC is exemplified by the search for spiritual support and resignification, while NRSC expresses an insecure relationship with God and indicates the presence of spiritual conflicts. The scale uses a five-point Likert measure (1 = not at all/does not apply; 5 = very much/very applicable). Individual subscale scores range from 7 to 35 points. Internal consistency for the Brazilian version was  $\alpha = 0.884$  for PRSC and  $\alpha = 0.845$  for NRSC. The score of Total Religious/Spiritual Coping - TRSC can also be calculated as a methodological alternative (Silva et al., 2019). It is obtained by combining the average PRSC scores and the inverted NRSC scores. This design method has shown adequate results in other studies that use the concept of religious/spiritual coping (Panzini & Bandeira, 2005; Silva et al., 2019).

## Procedure

The instruments were placed on a single page on the Google Forms platform, and the survey was shared via a link on social media. Specifically, the dissemination was conducted through Christian groups and pages on WhatsApp and

Instagram, targeting the religious community. Respondents accessed the form voluntarily. The data collection took place between July and October 2023. Initially, upon clicking the link, they were presented with the Informed Consent Form (ICF), which provided information about the nature of the study. After reading the information, participants were asked to consent to participate in the research and to future publication of the results. The average time required for completion of the survey was 20 minutes. All 254 participants provided their consent.

### Ethical issues

This study followed the ethical guidelines of Resolution 466/12 of the National Health Council, and was approved by the research ethics committee (opinion number 5.376.026). All participants provided informed consent, ensuring confidentiality and informing them that they could withdraw from the study at any time.

### Data Analysis

The data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 18.0.3 and the Macro Process version 4.2\_beta. Descriptive statistics were computed for the QUE-SI, DUREL, DASS-21, and SCOPE-14 instruments, including measures of central tendency and dispersion for the total sample and for subgroups defined by sociodemographic characteristics (e.g., sex, marital status, income, and education).

According to Frazier et al. (2004), testing a mediation model requires examining the effect of the predictor variable on other variables included in the model. Initially, simple linear regression analyses were conducted to investigate the predictive relationships among the variables (e.g., religiosity over TRSC; TRSC over mental health outcomes; and emotional neglect over TRSC and mental health outcomes). To test the main study hypothesis, multiple mediation analyses were performed using Hayes' PROCESS Macro (Model 4). This method assesses the indirect effect of the independent variable (Emotional Neglect) on the outcome variables (Depression,

Anxiety, and Stress) through the mediator (TRSC). This approach allowed for the examination of a parallel multiple mediator model, where TRSC mediates the relationship between Emotional Neglect and all three outcomes. The mediation analysis followed the criteria established by Preacher and Hayes, focusing on the indirect effect. The analysis tests for partial or full mediation by comparing the total effect ( $c$ ) and the direct effect ( $c'$ ), which is crucial for determining the exact role of the mediator.

To correct for potential bias, bootstrapping was performed with 1.000 resamples to account for asymmetric distributions (Field, 2021). Thus, each coefficient was found to be significantly different from zero at  $p < 0.05$ , with the 95% confidence interval for the effect not including zero.

### Results

Table 2 presents the correlations between the study variables, along with the internal consistency coefficients (Cronbach's  $\alpha$ ) for each measure.

R/S exhibited significant positive correlations with PRSC ( $r = .392, p < .01$ ) and TRSC ( $r = .461, p < .01$ ). Conversely, it showed negative correlations with NRSC ( $r = -.192, p < .01$ ), depression ( $r = -.298, p < .01$ ), anxiety ( $r = -.234, p < .01$ ), and stress ( $r = -.312, p < .01$ ). A positive correlation was also observed between religiosity and/or spirituality and emotional neglect ( $r = .237, p < .01$ ).

PRSC was negatively correlated with NRSC ( $r = -.682, p < .01$ ) and positively correlated with TRSC ( $r = .673, p < .01$ ). Notably, PRSC showed a positive correlation with emotional neglect ( $r = .199, p < .01$ ), suggesting that individuals with higher levels of emotional neglect tend to rely more on PRSC. No significant correlations were observed between PRSC and the different types of abuse (physical, emotional, or sexual). This finding suggests that the use of PRSC is not directly related to prior abuse experiences.

NRSC correlated negatively with TRSC ( $r = -.682, p < .01$ ) and positively with the symptoms of depression ( $r = .448, p < .01$ ), anxiety ( $r = .352, p < .01$ ), and stress ( $r = .395, p < .01$ ). Furthermore, NRSC showed positive correlations with physi-

cal abuse ( $r = .164$ ,  $p < .01$ ), emotional abuse ( $r = .204$ ,  $p < .01$ ), and sexual abuse ( $r = .142$ ,  $p < .05$ ). Interestingly, it displayed a negative correlation with emotional neglect ( $r = -.207$ ,  $p < .01$ ).

TRSC correlated negatively with physical abuse ( $r = -.130$ ,  $p < .05$ ) and emotional abuse ( $r = -.171$ ,  $p < .01$ ). It correlated positively with physical neglect ( $r = .128$ ,  $p < .05$ ) and emotional neglect ( $r = .270$ ,  $p < .01$ ). Additionally, TRSC exhibited negative correlations with depression ( $r = -.339$ ,  $p < .01$ ), anxiety ( $r = -.212$ ,  $p < .01$ ), and stress ( $r = -.303$ ,  $p < .01$ ).

Positive correlations were observed among

the abuse and neglect variables, specifically between physical abuse and emotional abuse ( $r = .520$ ,  $p < .01$ ) and sexual abuse ( $r = .310$ ,  $p < .01$ ), as well as between physical neglect and emotional neglect ( $r = .205$ ,  $p < .01$ ). Different forms of abuse presented positive correlations with psychological symptoms, ranging from  $r = .144$  to  $r = .424$  ( $p < .05$  or  $p < .01$ ). Finally, the dimensions of depression, anxiety, and stress showed strong and positive correlations with each other ( $r = .777$  to  $r = .807$ ;  $p < .01$ ), indicating high comorbidity among the assessed symptoms.

**Table 2** - Correlations and reliability coefficient of the variables

Variables	$\alpha$	1	2	3	4	5	6	7	8	9	10	11	12
1. Religiosity	0.72	1	.392**	-.192**	.461**	-.062	-.151*	-.018	.055	.237**	-.298**	-.234**	-.312**
2. PRSC	0.89		1	-.024	.673**	-.035	-.056	.034	.071	.199**	-.043	.080	-.017
3. NRSC	0.84			1	-.682**	.164*	.204**	.142*	-.098	-.207**	.448**	.352**	.395**
4. TRSC	0.78				1	-.130*	-.171**	-.085	.128*	.270**	-.339**	-.212**	-.303**
5. Physical Abuse	0.75					1	.520**	.310**	-.023	-.442**	.212**	.144*	.163**
6. Emotional Abuse	0.84						1	.433**	-.153*	-.651**	.424**	.412**	.418**
7. Sexual Abuse	0.94							1	-.024	-.319**	.229**	.234**	.258**
8. Physical neglect	0.09								1	.205**	-.160*	-.173**	-.133*
9. Emotional neglect	0.90									1	-.324**	-.307**	-.286**
10. DASS depression	0.89										1	.777**	.804**
11. DASS anxiety	0.89											1	.807**
12. DASS stress	0.91												1

Note. \*\* The correlation is significant at the 0.01 level. \* The correlation is significant at the 0.05 level.

Simple linear regression analyses were performed to investigate the extent to which the variables of mental health, TRSC, and R/S were mutually explained. Table 3 presents the regression coefficients ( $\beta$ ),  $p$  values, 95% confidence intervals (CI), and significance levels for the models tested.

R/S accounted for 32.4% of the variance in TRSC ( $F(1, 252) = 122.006$ ,  $p < .005$ ,  $R^2$  adjusted = .324), with  $\beta = .571$  (95%CI [2.186 – 3.135]), indicating that higher levels of R/S predict a greater use of TRSC strategies.

Regarding the mental health variables, TRSC explained 11.8% of the variance in depression ( $F(1, 252) = 33.808$ ,  $p < .005$ ,  $R^2$  adjusted = .118), with  $\beta = -.344$  (95% CI [-8.102 – -4.002]); 5.3% of the variance in anxiety ( $F(1, 252) = 15.205$ ,  $p < .005$ ,  $R^2$

adjusted = .053), with  $\beta = -.239$  (95% CI [-6.160 – -2.026]); and 8.7% of the variance in stress ( $F(1, 252) = 24.109$ ,  $p < .005$ ,  $R^2$  adjusted = .087), with  $\beta = -.295$  (95%CI [-7.598 – -3.248]). These negative coefficients indicate that higher levels of TRSC are associated with lower scores for depression, anxiety, and stress symptoms, reinforcing the protective function of this variable on psychological well-being.

Emotional neglect explained 8.9% of the variance in TRSC ( $F(1, 252) = 24.631$ ,  $p < .005$ ,  $R^2$  adjusted = .089), with  $\beta = .298$  (95% CI [.023 – .053]), suggesting that participants with higher levels of emotional neglect tend to employ more TRSC strategies. Conversely, emotional neglect had significant negative effects on psychological outcomes, explaining 8.6% of the variance in depression

( $F(1, 252) = 24.888, p < .005, R^2 \text{ adjusted} = .086; \beta = -.300, 95\% \text{ CI } [-.952 - -.420]$ ), 7.8% of the variance in anxiety ( $F(1, 252) = 22.360, p < .005, R^2 \text{ adjusted} =$

$.078; \beta = -.285, 95\% \text{ CI } [-.881 - -.363]$ ), and 5.5% of the variance in stress ( $F(1, 252) = 15.647, p < .005, R^2 \text{ adjusted} = .055; \beta = -.242, (95\% \text{ CI } [-.844 - -.283])$ ).

**Table 3** - Regression coefficients

Predictor	Outcome	$\beta$	T	IC 95%*	p
Religiosity/spirituality	TRSC	.571	11.046	2.186 - 3.135	$p < .01$
TRSC	Depression	-.344	-5.814	-8.102 - -4.002	$p < .01$
TRSC	Anxiety	-.239	-3.899	-6.160 - -2.026	$p < .01$
TRSC	Stress	-.295	-4.91	-7.598 - -3.248	$p < .01$
Emotional neglect	TRSC	.298	4.963	.023 - .053	$p < .01$
Emotional neglect	Depression	-.300	-4.989	-.952 - -.420	$p < .01$
Emotional neglect	Anxiety	-.285	-4.729	-.881 - -.363	$p < .01$
Emotional neglect	Stress	-.242	-3.956	-.844 - -.283	$p < 0.01$

Note. \*Results based on 1.000 bootstrap samples

A multiple mediation analysis was conducted to explore the role of the TRSC variable (M) in the relationship between Emotional Neglect (X) and different indicators of psychological distress (Depression, Anxiety, and Stress - Y). The results are presented in Figure 1.

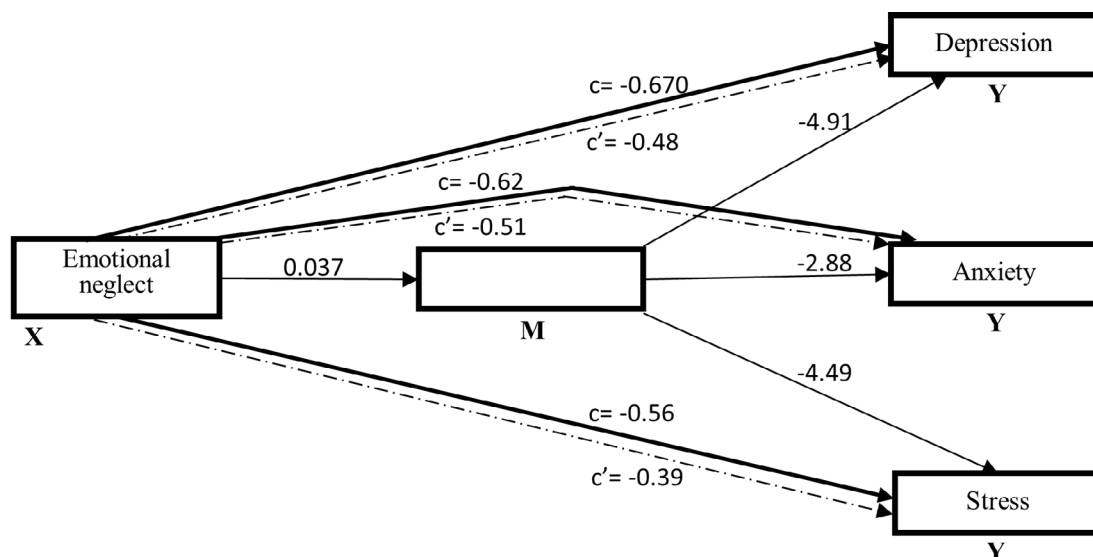
Emotional neglect showed a significant negative total effect (c) on all outcomes (Depression:  $c = -.670$ ; Anxiety:  $c = -.6$ ; Stress:  $c = -.56$ ). The indirect effect of Emotional neglect on Depression, mediated by TRSC (a x b), was significant ( $\beta = -.1863, 95\% \text{ BCA CI } [-.3190, -.0766]$ ). The direct effect of Emotional neglect on Depression ( $c' =$

$-.48$ ) remained significant. TRSC explained 27.81% of the total effect, indicating partial mediation.

Regarding Anxiety, a significant indirect effect was found ( $\beta = -.1095, 95\% \text{ BCA CI } [-.2323, -.0190]$ ). The direct effect ( $c' = -.51$ ) also remained significant, characterizing partial mediation. The indirect effect explained 17.66% of the total relationship between emotional neglect and anxiety.

For Stress, the indirect effect was also significant ( $\beta = -.1705, 95\% \text{ BCA CI } [-.3068, -.0283]$ ). The direct effect ( $c' = -.39$ ) remained significant, and the indirect effect accounted for 30.45% of the total effect, resulting in partial mediation.

**Figure 1** - Mediation model between emotional neglect, TRSC and mental health



## Discussion

The results of this study partially confirmed the proposed hypotheses, demonstrating the relevant role of R/S and TRSC in the relationship between experiences of emotional neglect and psychological symptoms of Depression, Anxiety, and Stress. Taken together, the correlation, regression, and mediation analyses indicated that R/S acts as a protective factor and that TRSC plays a partial mediating role between early adversities and psychological distress in Protestant individuals (Macedo & Esperandio, 2021; Murakami & Campos, 2012).

The correlations indicated patterns consistent with the literature. R/S was positively associated with PRSC and TRSC, and negatively associated with NRSC and symptoms of Depression, Anxiety, and Stress. This suggests that higher levels of R/S are related to better indicators of mental health, while individuals with lower scores tend to exhibit higher levels of Depression, Anxiety, and Stress (Macedo & Esperandio, 2021). Religious and spiritual beliefs provide a frame of reference that gives meaning to life and suffering, making negative experiences more tolerable or amenable to transformation (Cohen et al., 2025; Wnuk, 2024).

The correlations found between emotional neglect and R/S ( $r = .237$ ) and PRSC ( $r = .199$ ) suggest that individuals who experienced Emotional neglect—characterized by a lack of affective support and emotional validation—may more frequently turn to R/S as a compensatory source of comfort, security, and meaning. Macedo and Esperandio (2021) described this pattern as faith functioning as a compensatory attachment mechanism in the face of emotional deprivation.

PRSC was not significantly associated with the different types of abuse (physical, emotional, or sexual), reinforcing that its use appears to be more related to a lack of emotional support than to direct exposure to violence. Conversely, NRSC was positively associated with psychological distress symptoms and abuse experiences, as shown by the research of Fátima et al. (2022), who concluded that NRSC is associated with impaired mental health. Other findings in the literature de-

monstrate that the use of NRSC, such as feelings of divine punishment or spiritual abandonment, are related to poorer emotional outcomes (Ano & Vasconcelles, 2005; Pargament et al., 2011).

In this study, physical neglect did not demonstrate significant correlations with psychological symptomatology. This result diverges from consolidated findings in the literature that point to a negative association between neglect and mental health indicators (e.g., Grummitt et al., 2022; Schreier et al., 2020). The sample composition offers a plausible explanation for this divergence. Given that the large majority of participants (74.4%) reported having been raised by both parents, it is possible that the presence of a more stable and complete parental structure functioned as a resilience factor, decreasing the expected impacts of physical neglect and, consequently, neutralizing the correlation with psychological distress (Bazon et al., 2010; Dantas et al., 2019).

Based on the regression analyses, R/S demonstrated a strong predictive power for coping, accounting for 32.4% of the variance in Total Religious Coping. This finding suggests that R/S is a prominent personal resource, leading more religious individuals to utilize faith-based coping strategies more frequently. Additionally, TRSC proved to be a significant negative predictor of mental health, explaining between 5% and 12% of the variance in symptoms of Depression, Anxiety, and Stress. These results reinforce the protective function of religious coping in maintaining psychological well-being and confirm the patterns established by the literature on R/S and health (Koenig, 2018; Lee et al., 2020).

The multiple mediation analysis confirmed that TRCS partially mediates the relationship between emotional neglect and psychological symptoms. The indirect effect of emotional neglect on Depression ( $\beta = -0.1863$ ), Anxiety ( $\beta = -0.1095$ ), and Stress ( $\beta = -0.1705$ ) was significant, with TRCS explaining 27.8%, 22.5%, and 30.2% of the total effect, respectively. These findings indicate that a portion of the impact of emotional neglect on psychological symptoms occurs through R/S, which attenuates, but does not completely eliminate,

the direct effect of emotional trauma. It likely acts on the relationship between the individual and the stressful environmental situation, helping to minimize or tolerate it (Folkman & Lazarus, 1980).

Emotional neglect proved to be a central finding, presenting significant correlations, regressions, and mediations with the other variables investigated. This relevance is justified by its high prevalence in the sample, affecting 95% of participants. This rate is consistent with the literature, which recognizes emotional neglect as the most frequent form of child maltreatment (Jurueña et al., 2020). Due to its high frequency and statistically robust effects, emotional neglect was the early stressor selected for the analysis of the mediating role of TRSC in relation to psychological disorders.

The mediation produced negative scores for the three maladaptive outcomes. This result demonstrates that higher levels of TRSC are associated with better mental health outcomes, while individuals with lower scores tend to exhibit higher levels of Depression, Anxiety, and Stress (Macedo & Esperandio, 2021).

In other words, Protestant individuals who experienced emotional neglect may find, in R/S and PRSC a symbolic source of comfort, belonging, and meaning, which partially reduces the psychological vulnerability associated with these experiences. In the study by Ano and Vasconcelles (2005), partial mediation suggests that, although religiosity has a protective role, it does not fully substitute the impact of absent affective support on emotional development (Pargament, 1997).

From a theoretical perspective, these results reinforce models that conceptualize and consider R/S as a variable within case formulation, as a sociocultural aspect that can involve the individual. For the sample in this study, R/S may have functioned as a protective resource, a form of psychological resilience, capable of assisting in the cognitive and emotional reinterpretation of adverse events (Pargament et al., 2000; Schwalm, et al., 2021). However, they also indicate that its effect may be conditioned on the quality of the religious experience: when based on feelings of

guilt, punishment, or divine abandonment (negative religious and/or spiritual coping), it can intensify psychological distress, as evidenced by the positive correlations between this type of coping and symptoms of Depression and Anxiety (Pargament et al., 1990).

Finally, it is important to note that the absence of correlations between PRCS and experiences of physical, emotional, or sexual abuse may reflect the differentiated impact of these types of trauma on the spiritual dimension. Direct violence experiences tend to generate greater religious ambivalence, spiritual distancing, or questioning of beliefs, whereas emotional neglect experiences may favor the search for a compensatory spiritual relationship (Exline, 2013).

Future research can adopt longitudinal designs and mixed methods to investigate how religiosity and religious coping evolve over time in individuals exposed to different forms of childhood adversity, while also considering relevant sociocultural variables (e.g., gender identity, sexual orientation, socioeconomic position, race, ethnicity, and vulnerability). It is also interesting that different samples be studied and compared.

## Final Considerations

High levels of R/E are associated with higher TRSC scores in Protestants, which in turn correlate with lower symptoms of depression, anxiety, and stress in individuals with childhood trauma. This highlights the importance of religious and/or spiritual coping strategies in managing trauma and stress in this population. These findings are valuable for psychology, health, positive psychology, and clinical practice, suggesting potential for intervention development. Future research should include diverse religious groups and explore other childhood trauma subtypes, as well as adopt a longitudinal approach to better understand the causal dynamics between trauma and coping. Further studies could also investigate: (a) differences between religiosity and spirituality in individuals with formal or informal religious practices (How is spirituality developed in individuals who do not belong to a religious

group? How can spirituality be a protective or negative factor in these individuals? What is the conception of spirituality for these populations?), (b) the social connection with the religious group (Do people feel better because of the connection with something transcendent and/or because of the connection with the social group, which provides potential reparative experiences?) and (c) different religious and their interrelationships.

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