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Perceived God support as a mediator of the relationship between religiosity and psychological distress

Christopher E. M. Lloyd [a] and Graham Reid [b]

[a]Human Sciences Research Centre, University of Derby, Derby, UK; [b]Department of Experimental Psychology, University of Oxford, Oxford, UK

ABSTRACT

This paper investigated whether perceived God support would mediate the negative relationship between religiosity and psychological distress. 253 Evangelical Christians completed the Patient Health Questionnaire for Anxiety and Depression, the Religiosity Inventory, and the Religious Support Scale. Mediation analyses revealed that perceived God support partially mediated the negative relationship between Evangelical religiosity and psychological distress. This meant that perceived God support could explain some of the negative religiosity-distress relationship. As such, Evangelical religiosity may be related to health benefits through adherents' sense of support from God, corroborating a divine attachment theory of religion. We argue that God support should be considered as one of the theoretical mechanisms through which religions may be associated with better psychological health.

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Divine attachment theory; god support; psychological distress; mediation analysis; religiosity

Psychological distress is defined as maladaptive mental and behavioural experiences, which deviate from the typical responses seen in healthy populations (Ridner, 2004). As an umbrella term that covers different types of mental trouble, including depression and anxiety, it is thought that nearly one in four people suffer from psychological distress (Bültmann et al., 2002). Epidemiological data have suggested that the lifetime risk for psychological distress is around 37%, with such experiences becoming seemingly more prevalent over time (Bonnewyn et al., 2007; Knapstad et al., 2021). Untreated distress has been associated with several undesirable outcomes, including occupational under-productivity (Holden et al., 2011), relationship infidelity (Hall & Fincham, 2009), and poor cardiovascular health (Winning et al., 2015). As such, a key focus of clinical research is to understand the factors that buffer psychological distress and mitigate such undesirable outcomes.

Given the potential inefficacy of psychopharmaceuticals and the difficulty experienced by different age groups in accessing therapy (Akil et al., 2018; Borson et al., 2019; Reardon et al., 2017), research has turned to lifestyle medicine to understand the factors that support good mental wellbeing (Sarris et al., 2014). Lifestyle medicine refers to the everyday

CONTACT Christopher E. M. Lloyd C.Lloyd@derby.ac.uk

behaviours that confer some protection on our wellbeing outside the traditional pathology-pharmacology understanding of health in the Western world (Lianov et al., 2019). Such behaviours that are studied within lifestyle medicine include exercise (Herbert et al., 2020), sleep (Becker et al., 2018), and nutrition (Rao et al., 2008): all of which have been shown to support psychological wellbeing. With notable traction over the past 70 years, is the finding that religiosity is another lifestyle variable, which is often correlated with less psychological distress (Koenig, 2012; cf. Lloyd, 2021a, 2021b). Religiosity refers to the extent to which individuals feel connected to the transcendent and are committed to associated practices, such as prayer, fellowship, and scripture reading (Hill & Pargament, 2003). It should be noted that whilst there is some overlap with spirituality in which individuals also feel connected to the transcendent, religiosity can be seen as being more structured within religious organisations (Zwingmann et al., 2011). Whilst there are some conflicting findings in the extant body of literature (e.g., Lawrence et al., 2016; Lewis et al., 1997), the general consensus is that increasing religiosity is negatively correlated with psychological distress (for meta-analysis, see Garssen et al., 2021). However, it should be noted that such findings are most often yielded from a subtype of Christianity, known as Evangelicalism (for discussion, see Lloyd & Hutchinson, 2022; Lloyd & Waller, 2020). Although difficult to define considering the theological, as well as political, nuances, Evangelicalism is roughly characterised as a Protestant trans-denominational tradition, which adheres to the following doctrines (Noll et al., 2019): the inerrancy of the Bible, a literal understanding of scriptures, an exclusive salvation from hell through faith in Jesus Christ, and the importance of converting nonbelievers to this theological position.

In order to explain the negative relationship between Evangelical religiosity and psychological distress that is frequently found in the literature, several theoretical mechanisms have been proposed (Page et al., 2020). From a cognitive perspective, it has been suggested that the religion-wellbeing link may be mediated by religions' fostering a sense of self-esteem, optimism, and existential certainty (Galek et al., 2015; Salsman et al., 2005; Schieman et al., 2017). From a behavioural perspective, there is some evidence that religion is associated with fewer incidences of psychological distress since religion is inherently social and social support has been found to be a protective buffer for wellbeing (Speed et al., 2020). Not only does social support provide a strong sense of social identity and belongingness (Greenfield & Marks, 2007), but participating in social groups has also been associated with the sharing of resources that may help alleviate psychological distress (Merino, 2014). For example, studies have found that participating in religious organisations permits people access to emotional support in times of trouble from fellow believers (Hovey et al., 2014). As for the physiological mechanisms, it has been suggested that the religion-health link may be mediated by the fact that religions tend to prohibit lifestyle choices that have adverse effects on one's biological systems, such as excessive alcohol consumption and illicit drug use (Edlund et al., 2010; Michalak et al., 2007). Taken together, it is understood that the social, cognitive and physiological aspects of religion can explain why Evangelicals who self-report higher religiosity also self-report fewer incidences of psychological distress.

That being said, given the familial language used to describe God the Father in Christianity, more recent research has also suggested that the religion-wellbeing link may be mediated by one's attachment style to one's representation of the divine (Bock et al., 2018; Pirutinsky et al., 2019; Rowatt & Kirkpatrick, 2002; Tung et al., 2018). Such a divine

attachment theory draws upon developmental psychology's understanding of the importance of children's relationships with their primary caregivers (Cherniak et al., 2020). According to this theory, individuals with different attachment styles seek proximity with their attachment figures during times of distress in different ways, experiencing different levels of support in terms of having their needs met (Ainsworth, 1979). This is because attachment figures are seen as a base, or an anchor point from which individuals can venture and explore the environment, whilst knowing they can ultimately trust this parental base to meet their needs. Of the attachment styles that have been identified, secure attachment is marked by feelings of intimacy, affection, validation and love towards and from one's attachment figures (Leman et al., 2018). Avoidant attachment, on the other hand, is the opposite of secure attachment in which attachment figures are seen as unwelcoming, reticent, and undependable (Li & Fung, 2014). And finally, somewhere in between secure and avoidant attachment is an anxious attachment style, which is marked by feelings of instability and uncertainty in which attachment figures are sometimes seen as affectionate, caring, and dependable, but are at other times seen as dismissive and unreliable (Campbell & Marshall, 2011). Accordingly, given that God the Father can be represented as a caregiver to which individuals can attach, it follows that research has suggested that divine attachment styles may also be implicated in explaining the religion-wellbeing link (Granqvist et al., 2012; Thauvoye et al., 2018).

Indeed, since John Bowlby and Mary Ainsworth's seminal work on attachment theory (Bretherton, 1992), it has been shown that a secure attachment style to one's primary caregiver is a good predictor of fewer incidences of psychological distress (Spruit et al., 2020). For example, research has found that the variability in attachment styles is associated with variability in depressive symptoms, likely owing to the quality of supportive interpersonal relationships established between individuals and their attachment figures (Pielage et al., 2005; Riggs et al., 2007). In a similar vein, accruing evidence has also suggested that secure attachment to God is a good predictor of better mental wellbeing (Bradshaw et al., 2010). This is because intimate relationships between individuals and God can resemble the key features of human attachments, including having a secure base from which to explore the world, whilst knowing that God is supportive in meeting one's needs (Kirkpatrick, 2005). Within Evangelical Christianity, believers live their lives in the faith that they can directly interact with God in times of trouble through divine supplication and prayer, which are obvious forms of seeking proximity and support (Winchester & Guhin, 2019). One of main ways in which secure attachment styles develop and may also help buffer the emergence of psychological distress is through feeling supported (Hiller et al., 2018). Support is defined as the extent to which attachment figures are responsive to their children's needs and display affectionate qualities, such as warmth, acceptance and involvement (Bean et al., 2006). Research has shown that parental support is associated with fewer incidences of anxiety and depression (Boudreault-Bouchard et al., 2013) and a greater willingness to use psychological services and more positive attitudes towards mental health help-seeking (Maiuolo et al., 2019). While perceptions of inadequate parental support may increase levels of psychological distress (e.g., Demaray et al., 2005), higher levels of perceived support may promote acceptance, self-esteem, trust and confidence, which are generally seen as buffers of negative affect (Colarossi & Eccles, 2003; Helsen et al., 2000). Taken together, the perceived support

received from one's parental figures or caregivers seems to be one of the mechanisms through which our attachment style is related to mental health outcomes.

However, it has not yet been investigated whether perceived support from God, as an indicator of secure attachment, mediates the relationship between Evangelical religiosity and psychological wellbeing. As such, the aim of the current study was to test whether perceived God support would significantly mediate the relationship between Evangelical religiosity and psychological distress. It was hypothesised that after controlling for perceived God support, the negative relationship between Evangelical religiosity and psychological distress would be reduced.

Methods

Ethics

Approval was obtained from the local Ethics Committee at the University of Derby (ETH2021-0070). Participants provided informed consent and could withdraw consent before, during and after the study. Anonymised data were kept on a GDPR-compliant storage system to which the researchers had exclusive access. Considering the potentially sensitive research question on mental health, information about mental health charities and helplines were included in the debrief. The study adhered to the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines throughout (Von Elm et al., 2007).

Participants

Participants were recruited from online faith groups across the United Kingdom. All identified as Evangelical, which is characterised by belief in a personal salvation, the inerrancy of the Bible, a literal interpretation of scriptures, and the importance of converting non-believers. Based on $\alpha = .05$, power = .95, and $f^2 = .15$, an a priori power analysis estimated a minimum sample size of at least 119 participants (G*Power 3.1; Faul et al., 2009). Included in our analyses was a total of 253 Evangelical participants (Male = 185; Female = 62; Other = 6) aged between 18 and 73 ($M = 46.11$ years, $SD = 13.72$). Participants did not receive any reimbursement for their participation.

Materials

Although there are several existing questionnaires to measure religiosity and psychological distress, we opted, where possible, to use measures that have been (i) assessed for psychometric validity and reliability and (ii) did not include too many items. The decision concerning the latter was made given that participants had to respond to a larger battery of questionnaires in which longer completion times can sometimes result in (i) scoring acquiescence or mindless responding and (ii) participant attrition due to boredom or fatigue.

Religiosity

To measure the variability in participants' religiosity, we used Worthington and colleagues' (2003), 10-item Religious Commitment Inventory. Responses were coded on a

five-point Likert scale, ranging from *not at all true of me* (1) to *totally true of me* (5). Example items included "my religious beliefs lie behind my whole approach to life" and "I often read books and magazines about my faith". The questionnaire has a scoring range of 10–50 in which higher scores indicate a greater level of religiosity. In the current sample, the items were internally consistent (α = .88) above the field standard of .70 (Taber, 2018). In previous research, it has been shown that the 10-item Religious Commitment Inventory has (i) good content validity and (ii) good test-retest reliability with temporal stability estimates of .84 and .87 at three weeks and five months, respectively (Worthington et al., 2003).

Psychological distress

We used the four-item Patient Health Questionnaire for Anxiety and Depression to assess participants' psychological distress over the past two weeks (Kroenke et al., 2009). Participants indicated the frequency of their distress on a four-point Likert scale, ranging from *not at all* (0) to *nearly every day* (3). Scores ranged from 0 to 12 in which higher scores represented more frequent psychological distress over the past two weeks. In the current sample, high reliability was observed (α = .88). The questionnaire, although brief, has also demonstrated good content validity in other validation research (e.g., Löwe et al., 2010).

God support

The God Support Subscale of Fiala and colleagues' (2002) Religious Support Scale was used to assess the extent to which participants felt supported by God. The subscale has seven-items, which are measured on a five-point Likert scale from *strongly disagree* (1) to *strongly agree* (5). Total scores ranged from 7 to 35 where higher scores indicated a greater sense of support from God. Example items include "God gives me the sense I belong" and "I feel appreciated by God". In the current sample, the items were closely related in their measurement of the underlying God support construct (α = .94). In previous research, this questionnaire has demonstrated good criterion validity in its ability to predict health outcomes before controlling for a general measure of social support (Willoughby et al., 2008).

Procedure

Microsoft Forms was used to host and disseminate the current study's questionnaires. Participants were first asked to provide informed consent and some demographic information, including their age, gender, and religious denomination. Afterwards, participants completed the measures of religiosity, psychological distress, and perceived God support amongst a larger battery of psychometrics (Lloyd & Kotera, 2022). To assess their commitment to Evangelical Christianity, participants were asked to endorse creedal statements with yes-no responses that aligned with Stanford and McAlister (2008)'s research definition of Evangelicalism.

Data analysis

Statistical analyses were conducted using the statistical language R (version 3.6.3). Data were screened for outliers by inspecting a Residuals-vs-Leverage plot and the statistical

assumptions for a mediation analysis were satisfied through visual inspection of the relevant plots (i.e., we assessed a QQ-plot for normality and a Residuals-vs-Fitted Plot for homoscedasticity). In the current study, we first assessed the direct pathway (c) by running a linear regression between religiosity and psychological distress. We then assessed the relationship between religiosity and the God support mediator with a linear regression (pathway a). Lastly, we assessed the mediated pathway (c') by re-running the linear regression between religiosity and psychological distress after controlling for the God support mediator.

Results

In order to test whether any negative relationship between Evangelical religiosity and psychological distress would be, at least in part, explained by participants' perceptions of support from God, we conducted a mediation analysis. It was found that perceived support from God did partially mediate the relationship between religiosity and psychological distress (for a descriptive summary of the variables, see Table 1). Looking at the average scores and distribution for each variable in Table 1, we found what is theoretically expected of Evangelical Christians. That is, that participants were typically high in self-reported religiosity, high in perceived God support, and low in psychological distress. As for the intercorrelations between religiosity, psychological distress, and perceived God support (Table 1), they align with existing research both in terms of direction and magnitude (e.g., Garssen et al., 2021; Pirutinsky et al., 2019). More specifically, we found evidence of small correlations in which more religious Evangelical Christians felt more supported by God and had lower levels of psychological distress, aligning with existing research.

Table 2 shows the impact of religiosity and perceived God support on psychological distress in Evangelical Christians. In step one, we found that religiosity explained 2.76% of the variance in psychological distress with $F(1, 249) = 8.09$, $p < .01$. In step two, we found that religiosity and perceived God support together explained 5.66% of the variance in psychological distress with $F(2, 248) = 8.50$, $p<.001$. The second model explained 2.9% more variance that the first model with $F(1, 248) = 8.65$, $p<.001$. The regression coefficients for religiosity, which reduced from model one to model two, whilst remaining statistically significant, confirmed the partial mediation.

Table 1. Descriptive statistics for the variables of interest, including religiosity (Religious Commitment Inventory), psychological distress (Patient Health Questionnaire for Anxiety and Depression) and Perceived God Support (God Support Subscale of the Religious Support Scale).

	M	*SD*	Range
Religiosity	39.76	7.42	19 – 50
Psychological Distress	4.00	3.30	0 – 12
God Support	30.79	4.12	8 – 35
	Religiosity	Psychological Distress	God Support
Religiosity	–		
Psychological Distress	–.18 **	–	
God Support	.15 *	–.21 ***	–

Note. The top section shows the means (*M*), standard deviations (*SD*), and ranges of the variables used in our mediation analysis. The bottom section shows the intervariable Pearson correlations.
*$p < .05$, **$p < .01$, ***$p < .001$.

Table 2. Regression analyses for the mediating effect of perceived god support on the relationship between religiosity and psychological distress.

Variable	*B*	95% CI	*P*
Step 1			
Intercept	6.32	[4.66, 7.96]	<.001
Religiosity	–.66	[– 1.11, –.20]	<.01
Step 2			
Intercept	10.46	[7.25, 13.66]	<.001
Religiosity	–.55	[– 1.00, –.10]	<.05
God Support	–.15	[–.24, –.05]	<.01

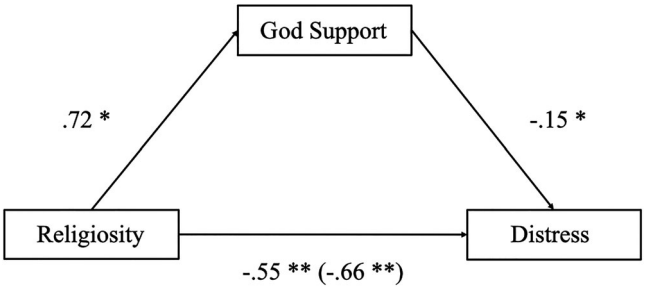

Figure 1. Regression coefficients for the relationship between religiosity and psychological distress as mediated by perceived god support. Note. A mediation model showing religiosity as a predictor of psychological distress, mediated by perceived support from God. Direct effect (total effect) from religiosity. Values attached to arrows are coefficients indicating impacts. *$p < .05$, **$p < .01$, ***$p < .001$.

Using 1000 bootstrapped samples, we then computed unstandardised indirect effects for the mediation model. Analyses revealed that the indirect effect was statistically significant, (.72) (– .15) = – .10, $p< .05$, CI [– .26, – .01]. For a visual representation of the mediation analyses, see Figure 1.

Discussion

The aim of the current study was to investigate if the negative relationship between Evangelical religiosity and psychological distress would be mediated by one's perception of the support they receive from God. We hypothesised that after controlling for perceived God support, the negative relationship between Evangelical religiosity and distress would be reduced. Mediation analyses revealed support for our hypothesis in that perceived support from God partially mediated the relationship between increasing Evangelical religiosity and decreasing experiences of psychological distress over the past two weeks.

Similar to existing research within the psychology of religion, our study found evidence that increasing religiosity was associated with fewer incidences of self-reported negative affect (for meta-analysis, see Garssen et al., 2021). Although there are some null findings reported within the wider literature (e.g., Lawrence et al., 2016; Lewis et al., 1997; Lloyd, 2021a), the general consensus is that increasing commitment to religion is a protective factor in the emergence and perpetuation of mental problems (e.g., Abdel–Khalek et al., 2019; Mosqueiro et al., 2015; You & Lim, 2019). Whilst our study used an index of psychological distress that encapsulated depression and anxiety (Kroenke et al., 2009),

other studies have also found religiosity to be associated with health benefits on other measures (Shattuck & Muehlenbein, 2020). For example, Hafizi and colleagues (2014) found that increasing religiosity was associated with fewer behaviours typical of borderline personality disorder. Similarly, Coin and colleagues (2010) found a negative relationship between religiosity and age-related cognitive decline. Thus, our results fit squarely within the extant body of literature, suggesting that self-reported religiosity and poor mental wellbeing are negatively correlated.

As for perceived support from God, who is depicted as a father-like figure within Christianity, we found that increasing perceptions of being supported were related to fewer incidences of self-reported distress. Such findings corroborate the growing body of evidence that parental support is a key factor in supporting healthy mental wellbeing in one's children (Hiller et al., 2018). By way of illustration, some studies have found that parental support is associated with less depression and anxiety in adolescents (Boudreault-Bouchard et al., 2013). Research has suggested that this is because feeling supported by one's caregivers is likely to foster good self-esteem, self-compassion, and acceptance: variables which are likely to confer protection against psychological distress (Bean et al., 2006; Colarossi & Eccles, 2003; Helsen et al., 2000). Indeed, parental warmth and acceptance are also associated with healthy adjustment in children during times of stress and transition (Swartz et al., 2011). This is because supportive parental figures are likely to represent a stable influence in children's lives during times of uncertainty and change and therefore provide a stabilising influence. Within the context of our study, an original contribution to the literature is that the benefits of feeling supported by a divine paternal figure, such as God, may have similar benefits to feeling supported by one's own parents. That is, Christians who represent the divine as a supportive father, in accordance with their teachings surrounding God's nature, also self-report similar benefits. Thus, the imagined or cognitively represented presence of a supportive parent like God may function in a similar way to the actual or perceived presence of a supportive physical parent.

Indeed, one of the key values of this study is the finding that one's perceived support from God partly explains some of the weakly negative relationship between Evangelical religiosity and psychological distress. That is, identifying as Evangelical seems not to fully explain participants' mental health outcomes, but may also be explained to a small extent by whether one feels supported by God. In recent years studies have explored the theoretical mechanisms through which the health benefits of religion can be explained (Page et al., 2020). Research has found that religious teachings surrounding suffering and existentialism can promote adaptive interpretations of difficult life events and thereby explain the mental wellbeing benefits of being religious (Wilt et al., 2019). Other research has shown that the religion-wellbeing link can be explained, at least in part, by access to social support from one's congregation. For example, a study by Salsman and colleagues (2005) found that indices of social support mediated the relationship between increasing religiosity and increasing life satisfaction. Interestingly, the majority of mediation studies looking at the variables which can explain the health benefits of religion have failed to find evidence of a complete mediation, leaving open the possibility of other explanatory mechanisms (Campos et al., 2020; Steffen & Masters, 2005; You & Lim, 2019). Thus, based on our finding that perceived God support partially mediates the Evangelical-wellbeing relationship, we suggest that parental support from God be incorporated into contemporary theorising within the psychology of religion.

Altogether, the results of our study somewhat inform a divine attachment theory of religion, which postulates that one conceptualisation of Christianity is as a source of potential attachment figures and attachment-relevant behaviours. That is, the discourse surrounding God the father and language of sonship that permeates the Christian tradition may encourage believers to develop attachment bonds similar to that with earthly caregivers. In our study, we found that feeling supported by God explained a small proportion of the association between the extent to which our participants were Evangelical and their experiences of mental distress over the past two weeks. Although difficult to operationalise and measure the extent to which believers seek and maintain actual proximity with an invisible God, central to Christianity is the teaching of God's omnipresence (for discussion on religious experiences, see Dein, 2017). As such, God is accessible at all times as a source of support and comfort for believers who can attach to Him unlike with physical attachments who are restrained by their physical presence, or lack thereof. Previous research has shown that religious individuals frequently turn to God when faced with difficult life events or threatening situations (Bjorck & Cohen, 1993) and this proximity seeking is heightened as a situation becomes more distressing (Sibley & Bulbulia, 2012). One of the ways in which Evangelical Christians may feel supported by seeking proximity with a fatherlike God is through prayer, which may serve a similar function to other supplicatory behaviours in human-to-human attachment (e.g., Bradshaw & Kent, 2018). Just like a safe haven for children who see their caregivers as 'older' and 'wiser', God in His characteristic and definitional knowledge and power may be perceived as the ultimate source of support for believers, which allows them to deal with distressing life events (for a theoretical discussion on the health benefits of prayer, see Breslin & Lewis, 2008). In sum, God support's mediating the negative relationship between religiosity and psychological distress fits squarely within a religion-as-attachment model, which may explain the mechanism through which Evangelicalism is associated with better mental health.

However, the findings of the current study should nonetheless be caveated by a few limitations. Firstly, the gender composition of our sample consisted of many more males than females, which could be problematic for two main reasons. The first reason is that studies have found that women are more likely to self-report higher levels of religiosity than men (Hackett et al., 2016). As such, the generalisability of our findings may be somewhat limited since religious populations are more likely to have a higher proportion of females. The second reason is that studies have found an interaction effect between the gender of one's caregiver and the gender of care recipients (Moilanen et al., 2015). Whilst there is evidence that maternal support is associated with lower levels of psychological distress (Vaughan et al., 2010), more recent studies have begun to focus on the role of paternal support in care recipients' development and resilience (Graziano et al., 2009). It has been found that involvement and support from a father figure may also be associated with lower risk for psychological distress and better management of stressful life events (Antonopoulou et al., 2012). However, the positive influence of paternal support coming from a father figure seems to be more evident in boys than in girls, with paternal support having a larger effect on boys' levels of psychological distress (Colarossi & Eccles, 2003). These results suggest that the effect of parental support may be particularly strong in same-sex dyads (e.g., father-son). Given that God is often depicted with masculine terminology, coupled with the greater number of males in our sample, the mediation effect of

God support between religiosity and psychological distress may have been enhanced by the gender composition of our sample. The second limitation in the current study is that we did not measure or control for the impact of pre-existing attachment styles that our participants have with their caregivers or romantic partners. As such, it is possible that the mediation effect of God support does not contribute to any unique variability in the relationship between religiosity and mental wellbeing. This is because perceived support from God may simply correspond to the feeling of support that participants have from their other human relationships. Research has shown that attachment styles generalise across relationships and that there is a pervasive similarity between attachment styles to God and attachment styles to corporeal figures (Beck & McDonald, 2004; Cassibba et al., 2008; Granqvist et al., 2007). And lastly, given the cross-sectional nature of our study, the temporal relationship between religiosity, perceived support from God, and psychological distress cannot be established. Thus, the directionality and causal relationships between our variables is unknown, making a longitudinal design, accounting for gender and pre-existing attachment styles, a clear next step in this area of research.

In conclusion, the aim of the current study was to investigate if the negative relationship between one's level of Evangelical religiosity and psychological distress would be mediated by the support participants perceive from God. Results revealed that God support partially mediated the negative relationship between increasing Evangelical religiosity and decreasing experiences of psychological distress over the past two weeks. Such findings suggest that another potential explanatory mechanism for the health benefits of being Evangelical is through the representation of a God who is available in times of difficulty to provide support. Such relationships with an all-powerful and all-loving celestial father are likely to lend themselves to feeling supported when facing life's difficulties, which would go some way in mitigating the impact and emergence of psychological distress. Further qualitative research, beyond the current quantitative study, is also recommended to illuminate contextual and personal meaning when conceptualising divine attachment and any possible relationships to psychological distress (Lloyd et al., 2022, 2021; Lloyd & Panagopoulos, 2022).

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Disclosure statement

No potential conflict of interest was reported by the author(s).

Declarations

Ethical approval

The questionnaires and methodology of the current study were approved by the Ethics Committee at the University of Derby. All authors confirm that the study was performed

in accordance with the ethical standards as laid out in the Declaration of Helsinki (1964) and its later amendments.

Informed consent from participants

Informed written consent to take part in this research was obtained from every participant prior to the commencement of the study. Participant data were then anonymised, but this has not distorted the scholarly meaning in any way.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ORCID

Christopher E. M. Lloyd http://orcid.org/0000-0001-9659-0890
Graham Reid http://orcid.org/0000-0002-6079-9323

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