ORIGINAL RESEARCH

Assessment of religious coping and psychological distress as screening tools in community mental health services

Isadora Rodrigues Rossignolo Jacob*, Marcos Hirata Soares, Katya Luciane de Oliveira

Universidade Estadual de Londrina, Londrina, PR, Brazil

Received: May 26, 2025 **Accepted:** August 7, 2025 **Online Published:** August 31, 2025
DOI: 10.63564/jnep.v15n9p39 **URL:** https://doi.org/10.63564/jnep.v15n9p39

ABSTRACT

Objective: To assess the use of SRQ-20 and RCOPE as complementary tools to the Nursing Process.
Methods: This is a descriptive and cross-sectional study carried out with 313 adults from two therapeutic communities (Therapeutic communities are usually residential facilities in which the community structure and function are agents of change. Community members progress through varying roles and responsibilities in their recovery and collectively ensure day-to-day functioning of the community.). and a community mental health treatment unit, located in two cities in northern Paraná (Brazil).
Results: The sample consisted of 313 individuals, aged between 18 and 68 years (M = 36.87, SD = 13.21). The majority of participants (57.9%) were female, of east-asian descent (35.7%), with a socioeconomic level equivalent to US$252.48 (65.8%) and incomplete secondary education (60%). Of the sample, 43.4% (n = 136) had a depressive disorder and 23.7% (n = 74) had an anxiety disorder. As for suicidal behavior, 52.1% of the participants mentioned having suicidal ideation at some point in their lives. Of those with ideation (n = 163), more than half (54.6%) reported not seeking help in times of crisis. Based on the frequencies obtained using the Self-Reporting Questionnaire (SRQ-20), 41.9% of the subjects obtained a score of 8 points, representing the cut-off point for risk of mental disorders. Regarding the hours of religious practices carried out by the participant (measured in weekly hours), the average obtained was 2.70 hours.
Conclusions: The application of the SRQ-20 helped identify that 48.58% of the individuals were classified as suffering from psychological distress. The early identification of signs of suffering and religious coping strategies have proven to be beneficial and necessary for the nurse's work process, as it adds better direction to the anamnesis and also to the alignment of the health team in promoting comprehensive care, including aspects of the spiritual dimension in nursing care.

Key Words: Suicide prevention, Coping strategies, Religion and psychology, Community mental health services, Psychiatric nursing

1. INTRODUCTION

Between 1990 and 2019, although the years of life lost to suicide worldwide decreased by 5.9%, mortality rates from suicide, alcohol use and mental/behavioral disorders in Brazil remain on a stationary trend.[1] Due to their prevalence, such disorders are considered public health problems and therefore, tools for early detection of common mental disorders are necessary.

Early detection of mental disorders has a direct impact on treatment and, consequently, on the quality of life of those

*Correspondence: Isadora Rodrigues Rossignolo Jacob; Email: isadora_rossignolo@hotmail.com; Address: Universidade Estadual de Londrina, Brazil.

affected. Thus, the early identification of depressive and anxiety disorders can mitigate their negative effects, contributing to a greater life satisfaction and overall mental health.[2] In this regard, it is important to highlight the relationship between suicide occurrence and psychological distress, which is recognized as a predictor of common mental disorders.

Among the protective factors against the risk of suicide, beyond those directly related to the care of mental disorders, is the search for religious belief as a means of alleviating suffering and stress arising from physical and emotional distress, an approach conceptualized as religious coping strategies. These strategies act positively in maintaining aspects such as resilience and promoting the subject's well-being.[3] Spirituality and religiosity exert a protective effect on individuals with depression. However, a study indicated that depressed individuals exhibited lower levels of spirituality and that religiosity, when expressed negatively (e.g., religious crisis), could serve as a risk factor for suicide.[4]

The most commonly used instruments for screening potential mental disorders in non-clinical populations are the General Health Questionnaire (GHQ)[5] and the Self-Reporting Questionnaire (SRQ-20). These tests are widely employed for their capacity to predict the likelihood of mental illness.[6]

One study demonstrated the significance of the SRQ-20 as a predictive tool for suicide risk, revealing that individuals with an anxious mood pattern were twice as likely to attempt suicide, while those experiencing depressive thoughts had up to four times the likelihood of a suicide attempt.[6]

The concept of "religious coping" was first described by Pargament[7] as an effort to manage major life stressors through actions centered on the sacred. This theory, at the time, emphasized various ways in which spirituality was linked to health outcomes, such as reducing anxiety, fostering emotional and relational connections, shaping life circumstances and contexts, and navigating the duality of perceiving oneself as either beneficial or harmful. Since then, the connection between health, well-being, and spirituality has been recognized, particularly in critical moments related to illness.[7]

A meta-analysis of 42 studies on religious and spiritual coping during the first wave of the COVID-19 pandemic concluded that religious/spiritual coping presented positive outcomes when combined with other strategies but was not effective when used in isolation.[8] Thus, religious coping can contribute to regulating cortisol levels and mitigating physiological responses to stress.[9]

Considering the positive association between spirituality and mental health—particularly in fostering resilience and reducing mental illnesses—mentally resilient individuals tend to navigate stressful and traumatic events more effectively. Spirituality thus functions as a protective factor against severe psychosomatic illnesses, enhancing an individual's capacity to recover from trauma and cope with psychological difficulties such as despair and sadness, thereby improving crisis management.[8]

In light of these considerations, this study aimed to evaluate the use of SRQ-20 and RCOPE as complementary tools in nursing anamnesis, with the objective of enhancing nursing care and improving mental health assistance.

2. METHOD

2.1 Participants

This study was conducted with a sample of 313 adults from two therapeutic communities (n = 214) and a community mental health treatment unit (n = 99) in two cities in northern Paraná, Brazil. The first city, with a population of 555,965 (2022), has a Human Development Index (HDI) of 0.824. The second city has 71,670 inhabitants and an HDI of 0.739. Both cities have comparable average salaries, with formal workers earning, on average, 2.7 and 2.3 times the monthly minimum wage in 2022, respectively.[10, 11]

The average age was 36.8 years (SD $\pm$ 13.2), with a minimum age of 18 and a maximum of 68. Females accounted for 57.9% of the sample (n = 181) and males for 42.1% (n = 132).

Inclusion criteria included: being an adult and having at least one diagnosed mental disorder, as well as not exhibiting signs of irritability, impulsivity, or any other indication of crisis at the time of the interview.

2.2 Instruments

Three instruments were employed for data collection. The first instrument used was a sociodemographic/clinical questionnaire elaborated by the authors to describe the participants' profile in terms of age, sex, marital status, suicidal ideation, leisure activities. education, family income, religion/religious practice and housing conditions.

The second instrument was the Religious and Spiritual Coping Scale by Panzini,[12] which was validated based on the original instrument developed by Pargament, the RCOPE Scale.[7] The RCOPE was designed to explore the religious dimension in terms of coping mechanisms, emphasizing the active role of individuals in interpreting and responding to life stressors, as well as addressing meaning-making, anxiety reduction, and the expressions shaped by how religiosity functions across various life contexts. The Brazilian version comprises 87 items rated on a five-point Likert scale: 1 =

not at all, 2 = a little, 3 = somewhat, 4 = a lot, and 5 = very much. Its structure is divided into two dimensions: a positive dimension, with 66 items and 8 factors, and a negative dimension, with 21 items and 4 factors. In terms of psychometric properties, the scale demonstrated excellent internal consistency (Cronbach's alpha = 0.97). This instrument was chosen because it evaluates how individuals cope with everyday adversities through faith and elements related to religiosity and spirituality.

The third instrument, the Self-Reporting Questionnaire (SRQ-20),[10] is a self-administered screening tool consisting of 20 yes/no items addressing somatic and psychological symptoms. While widely used in primary health care, the SRQ-20 is suitable for any population, as its purpose is to identify suspected (non-diagnostic) cases and symptoms associated with mood disorders, anxiety, and somatization. The maximum score is 20 points. Scores of 7 or 8 are commonly used as cutoff points for identifying probable cases of common mental disorders, with sensitivity and specificity varying according to the cultural context of the population.

An example of its simple and accessible language includes item 2, "Do you have a lack of appetite?" and item 18, "Do you feel tired all the time?". The SRQ-20 typically takes between 5 and 10 minutes to complete, with immediate scoring results. The SRQ-20 originated from a World Health Organization (WHO) initiative in the 1970s aimed at investigating mental health care demands and service availability.[13] In Brazil, it was initially validated in the 1980s using the semi-structured Clinical Interview Schedule (CIS). Subsequent revisions were made to reflect cultural and diagnostic advances, resulting in the current 20-item version that covers both somatic complaints and psychological symptoms.[13] Currently the instrument has gained global relevance due to its reliable psychometric performance in various contexts, such as its North American and Indonesian adaptations, and its utility in helping clinicians make timely and appropriate decisions.[14]

2.3 Procedures

2.3.1 *Data collection*

A sample size calculation was performed using IBM Sample Power v.3.0. Considering a 10% attrition rate and a margin of error of 0.1, the minimum required sample was estimated at 264 participants. Data were collected between 2022 and 2024 across two therapeutic communities and one community-based mental health treatment unit, which provides psychiatric care for individuals with mental disorders, located in the interior of Paraná, Brazil. The research was approved by the Human Research Ethics Committee of the State University of Londrina (CAAE: 4,276,621/2020).

2.3.2 *Data analysis*

Exploratory descriptive statistics for univariate analysis. For bivariate analysis, the Chi-square test was applied to dichotomous variables, and internal consistency was evaluated using Cronbach's Alpha and McDonald's Omega scores. Data were analyzed using JAMOVI™ software, version 2.3.28.

3. Results

The final sample included 313 participants, aged between 18 and 68 years (M = 36.87, SD = 13.21). The majority were female (57.9%), self-identified as east-asian (35.7%), with a socioeconomic level of US$ 252.48 (65.8%) per month, and incomplete secondary education (60%). Table 1 presents additional sociodemographic characteristics of the participants.

Table 1. Sociodemographic characteristics of adults with mental disorders (N = 313). Paraná (Brazil), 2024

Features		n	%
Sex	Male	132	42.1
	Female	181	57.9
Marital status	Married/Stable union	140	44.7
	Singles	124	39.6
	Divorced/Widowed/Others	34	15.7
Education	Elementary Education	188	60
	High School	84	26.9
	Higher education	41	13.1
Income*	< 252.48 (US$)	112	35.8
	252.49 (US$) to 504.96 (US$)	94	30
	504.97 (US$) 757.44 (US$)	80	25.5
	> 757.45 (US$)	27	8.7
Housing	Partner	140	44.7
	Partner and children	124	39.6
	Alone	34	15.7
Religion	Catholic	109	34.8
	Evangelical	125	40
	Spiritist	52	16.6
	Others	27	8.6
Occupation	Unemployed/Inactive	36	11.5
	Health professional	60	19.1
	Commerce/Industry/Agriculture	54	17.2
	Education	25	7.9
	Security	15	4.8
	Retired/Others	122	38.9
	Self-employed	1	0.31

*Value based on US dollars

Regarding housing conditions, a large proportion (44.7%) lived with their partner and/or partner and children. The average number of people per household was between 2 and 3. As for religious practices, evangelicals predominated (n = 40%), followed by Catholics (n = 34.8%) and Spiritists (16.6%). It is important to mention that of the religions highlighted here, all are general, that is, there was no specific denomination.

Spiritism can be understood as a belief in spirits and their communication with the living. Furthermore, its branches, including Kardecism (from Allan Kardec), followers of Umbanda, Candomblé, sects of African origin, and others that also advocate the use of supernatural knowledge and forces, are worth highlighting. Around 2% (n = 6) mentioned that they believed in spirituality, but did not attend any religious places, or even perform any religious rites/formalities. With regard to religious practices, measured in weekly hours, the average reported was 2.7 hours, with a range from 0 to 24 hours.

As for mental disorder diagnoses, Table 2 presents the frequency and distribution of the conditions identified in the participants. These were based on medical records of individuals receiving treatment at the community mental health treatment unit and compared with the results of the screening conducted using the SRQ-20.

Table 2. Classification of mental disorder diagnoses x screening using the SRQ-20 Scale, Paraná, 2024

Diagnostics of Mental Disorders	SRQ-20		Total (n)
	Suspected MD	No suspected MD	
Depressive disorder only	68 (50%)	68 (50%)	136
Anxiety disorder only	58 (78.3%)	16 (21.7%)	74
Bipolar disorder only	26 (89.6%)	3 (10.4%)	29
Schizophrenia only	15 (88.2%)	2 (11.8%)	17
Autism only	0	1 (100%)	1
More than one disorder	50 (89.2%)	6 (10.8%)	56
Total			313

Based on the frequencies obtained through the Self-Reporting Questionnaire (SRQ-20), 1.3% (n = 4) of the participants scored zero, while 29.5% of the sample reached a score of up to 7 points, and approximately 41.9% obtained a score of 8 points. Regarding the presence of mood, anxiety, and somatization disorders (indicating extreme probability), 27.5% (n = 86) of the sample had scores ≥ 9. The highest score recorded in the study was 18 points. Table 3 presents the associations between suicide attempts and the predicted likelihood of mental disorders, as identified by the SRQ-20.

Table 3. Association between suicide attempts and predicted mental disorders (MD) based on SRQ-20 scores. Paraná, Brazil, 2024

Suicide attempt	SRQ-20 Classification		
	No suspected MD	Suspected MD	Total
No	92	105	197
Yes	4	112	116
Total	96	217	313

Regarding suicidal behavior, 52.1% of participants reported experiencing suicidal ideation at some point in their lives. Among those who experienced suicidal ideation (n = 163), 54.6% (n=89) reported not seeking help during crises, while 45.4% (n = 74) reported having sought assistance. This association was found to be statistically significant using the Chi-square test ($\chi^2 = 41.986$; $p < .001$). Of the 95 individuals who sought help after a suicide attempt, 76.84% (n = 73) reported receiving assistance, whereas 23.16% (n = 22) stated that they did not. The Chi-square test indicated statistical significance for this association as well ($\chi^2 = 142.236$; $p < .001$). Regarding suicide attempts, 37% of respondents reported having attempted suicide. Chi-square test results indicated a statistically significant association among the variables presented in Table 3 ($\chi^2 = 64.232$; $p < .001$). Table 4 presents the scores related to the RCOPE scale.

Table 4. Internal consistency scores of the positive and negative coping subscales of the RCOPE scale, Paraná, Brazil, 2024

	Average	SD	Cronbach's alpha	McDonald's Omega
Positive Coping	3.31	0.61	0.93	0.94
Negative Coping	2.32	0.61	0.76	0.78

4. Discussion

4.1 Psychic distress and sociodemographic variables

Poverty has a profound and multifaceted impact on mental health, creating a direct interaction with mental illness, which makes it clear that there is an urgent need to implement effective and targeted actions for this population group. An interdisciplinary approach must be adopted to support and integrate these actions, considering a range of perspectives from individual care programs to the formulation of public policies at the national level. This will enable a broader and more effective response to the complex needs of society.[15]

It is therefore understood that poverty can lead to psychological suffering in adults, or rather, it can exacerbate the effects generated by the psychological discomfort felt by this condition In this context, it is important to highlight that religiosity/spirituality has significant protective effects against mental health problems associated with unemployment, for example, becoming a good mechanism for coping with stress.[16]

Regarding the scores obtained by applying the SRQ-20, approximately 71.4% (n = 224) of the subjects presented risks of mental suffering, with scores between 7 and 8. These data reflect concerns about suicidal behavior since mental disorders are significant risk factors for suicide.[17] Although no subject scored twenty points, it is important to say that the risk of suicide is increased when there is a suspicion of any type of mental disorder.

In this way, the applicability of the SRQ-20 translates as an important element for predicting the increased risk of suicidal behavior, regardless of the cutoff point, which can vary from one study to another. Therefore, another important point that integrates the use of the SRQ-20 to the chosen public (coming from therapeutic communities).

Thus, in an ideal community model, the subject is expected to meet the expectations of the whole, based on self-knowledge, motivating attitudes for change, and commitment to the whole process of self-care. However, the intense presence of suffering and the lack of stimuli for maintaining resilience/self-care can make it difficult for the subject to manage their emotional/participatory behavior.[18]

Consequently, the usefulness of the SRQ-20 should attract the attention of professionals working in these communities, mainly because they require greater support approaches for social strengthening and maintenance of symptoms that lead to suffering.[19]

In terms of the overall burden of mental illness, depressive disorder was the second leading cause of disability disorders during an individual's lifetime. Anxiety ranked sixth, accounting for almost 42.5 million people with this type of disorder.[1] It is important to emphasize that depressive disorders were more common in young women, as was also the case here, with a predominance of females.

As in the present study, depression was present in 43.4% of the sample, while anxiety accounted for 23.7% of the diagnoses reported by the subjects.

In this sense, this research also revealed that 17.9% of the sample had more than one diagnosis of mental disorder. Thus, it is worth highlighting that other types of disorders were also included as being responsible for disabilities during life, such as schizophrenia, use of psychoactive substances, and autism.[20]

In a recent Colombian study, individuals with depressive disorders who attempted suicide had already reported/sought help from professionals and/or family members. It is worth noting that in this study, most of the subjects who mentioned suicidal ideation (n = 163), 54.6% (n = 88) did not seek help. Therefore, protective measures for the act must be highlighted, since, in this same study, having a mental illness and/or having attempted suicide (at some point) proved to be a predictive factor for the act.[17]

In terms of occupation, 38.9% (n = 122) of the individuals reported working independently, 11.5% stated that they were unemployed/on leave and the rest were in other occupations, such as the industrial/commercial sector, education, and health. This configuration contributes to an unstable financial situation that generates additional stress, as in the studies that evaluated the main symptoms that triggered the psychosocial determinants as being responsible for the strong association with mental suffering.[21]

Thus, as in the current study, the authors also showed that being female, having a low income (<252.48 -US$), and having incomplete secondary education act as conditioning factors that were most associated with mental disorders.[21] Low income/education also contributes to the lack of early identification of mental disorders, mainly because access to health services becomes more limited/distant. This condition has an impact on the individual's health, as it leaves the subject more vulnerable, also reducing their quality of life.[22] Therefore, there is a bidirectional link suggesting that poverty and mental health interact in such a way that low financial conditions can favor the emergence of mental disorders, and the disorders themselves can aggravate poverty. Thus, both can influence and be influenced by such negative factors and events, as well as impact social/religious support and precarious survival conditions.[15]

Housing conditions, especially family and social configurations, also reflect on factors that promote mental health. In this research, 44.7% (n = 140) of participants reported living with their partners and/or partners and children. It is therefore understood that the social configuration as well as the family history with bad psychosocial antecedents, can act as predictive factors for suicide attempts, especially when there is a late diagnosis of associated mental disorders, or even when the individual is exposed to situations of violence in parental contexts.[23]

4.2 Religious/spiritual coping related to psychological suffering

To ascertain construct validity, the internal consistency of the positive and negative coping subscales of the RCOPE Scale was estimated. The scores obtained were similar to the scores of the original scale, since the positive dimension and its factors presented had a better Cronbach's alpha (α) performance compared to the negative dimension. In the original scale, the positive dimension presented an Alpha (α) of 0.98, while in the current research this score was Alpha (α) = 0.93, which reflects the expected values. Regarding the negative dimension, the current scale presented a good level of internal consistency (α = 0.76), while the original scale had a score of α = 0.86.[12]

As for religion, there was a predominance of evangelicals (40%; n = 125) and Catholics (34.8%; n = 125), followed by Spiritists (16.6%; n = 52). The data found in the present research are similar to a recent study on religious affiliations and how they influence general and health-related decision-making, in which a large proportion of the subjects were also predominantly Catholic (43.9%; n = 1,133) and Evangelical (18.7%).[24]

In this way, the influence exerted by religiosity/spirituality and adopted beliefs also directly reflects on the subject's actions. Evangelical Christians represent a quarter of the US population, so it is known that they may face challenges in mental health treatment, such as the belief that some psychiatric problems are a consequence of personal sin.[25]

In Brazil, according to the latest IBGE census, around 22.2% declared themselves as evangelicals (of these, 60% were of Pentecostal origin, 18.5% missionary and 21.8% undetermined).[26] Thus, understanding the beliefs and attitudes arising from the evangelical faith, as well as adopting resilient strategies and overcoming fear, are measures that can influence psychiatric practice by these professionals, so that practices and knowledge can be identified that can have both a positive and negative impact on mental health care by nurses.[25]

Studies on religiosity suggest the benefits of belief in relation to coping measures. The subject begins to believe in himself, in his own strength and is (often) guided by social support. An example of this is the current study on the religious dimension in a North American sample of African-American adults, in which such associations (beliefs/faith) with health behaviors and depressive symptoms were examined. The authors evaluated five indexes on religiosity (including positive and negative aspects on coping) and showed that subjects belonging to positive religious groups engaged in healthier habits, while the negative group demonstrated greater negative health behavior, such as high alcohol/cigarette consumption, more depressive symptoms and, consequently, greater risks of suicidal behaviors.[16–27]

When investigating weekly dedication to religious practices (measured in hours/week), the average obtained was 2.70 hours. In an Indian study (n = 381), it was highlighted that the presence of depressive symptoms was more associated with less time spent on religious practice, while individuals without depressive symptoms had higher levels of religious engagement.[27] It is worth noting that the way in which the subject experiences the experience (religious/spiritual dimension) and uses these resources (focused on faith) can influence the way in which they cope, in addition to favoring positive and negative effects (which are not always so explored).

Furthermore, evaluating religious affiliation based on decision-making can contribute to a greater understanding of this relationship (religion/health). Therefore, it is understood that having a religious affiliation can positively contribute to reducing the use of tobacco/other drugs.[28] When compared to those who have multiple religions, subjects who reported having more than one belief demonstrated better levels of happiness and optimism, when compared to just one religion. However, in another study, it was found that anxiety levels were lower in groups without religion, however, in this group (with low/no religiosity) depression levels were higher.[27]

Corroborating the findings on mental health and the benefits of religiosity/spirituality, it is essential to mention that the report of faith suggests significant and impactful results on depression and, consequently, on suicidal tendencies, since religious engagement generates and experience of grounded inner peace, by positively associating engaged actions with happiness, attribution of "reason in things" and promotion of life.[24]

Therefore, when using faith in a positive way (reading sacred books, visiting churches or other temples, praying, among other actions particular to religions), the subject connects themself to divine appreciation and tends to have stronger feelings of gratitude. This feeling is strongly linked to the most recent studies on the benefits of religiosity, which suggest a high moral impact, mainly because it is a highly valued human characteristic.[29]

The benefits of religiosity and spirituality also had a direct impact on individuals with autism, as in the case of a study carried out with adolescents. However, it is important to emphasize that, although the current study does not address the same sample, the positive impact on these subjects revealed greater communication when weaving elements of

religiosity and faith, when compared to people who did not attend any religion.[30] In a study on the impact of religion on mentally healthy people and with mental disorders, it was observed that patients with mental disorders showed greater belief in God and often used more prayers compared to the other group, as well as people with high spirituality, intrinsic religiosity and religious affiliation had a lower prevalence of depressive symptoms.[31,32]

Personalized attention, as well as interventions based on religion and spirituality, can have a profound impact on mental health treatment, as it helps to reduce stress and, consequently, psychological suffering.[33] One example is based on the practice reported in studies published by Christian community nurses in countries such as the United States, who provide comprehensive care based on religious values, reclaiming a significant role in public health interventions, as well as illustrating a greater diversity related to care practices, including Christian principles in nursing care.[34]

However, the literature still lacks studies on the perception of the population that receives care based on the holistic principles and incorporated by spiritual aspects. However, it is worth mentioning that in some cases, there is a negative tendency towards high religiosity, which ends up worsening the symptoms of depressive/anxiety disorders, presenting feelings of guilt, for example, and generating sadness/remorse and, with that, further exacerbating the suffering, mainly because they confront aspects of the religious teaching they had.[35] The use of negative elements related to faith can impact suicidal behavior, since, for each increase of 1 unit in the negative religious coping score, the chances of attempted suicide increased by 1.83 times (95% CI 1.11; 3.00).[36] These data are also responsible for collaborating with nursing practice as a promoter of comprehensive care.

5. Conclusion

The application of the SRQ-20 contributed to the understanding that most individuals are likely to be experiencing psychological distress, although screening data were compared with diagnoses of depressive disorders. However, early identification of signs of suffering proves beneficial for the nurse's work process, as it provides better guidance for the anamnesis and the Nursing process.

Regarding the inclusion of religiosity and spirituality in nursing practice, it is understood that there are several benefits to this dyad. Brazilian nurses' knowledge about religiosity/spirituality should be incorporated into training and nursing education itself to improve their understanding and competence in holistic and person-centered care.

In this way, it is important to mention that religiosity acts positively when there is an attribution of meaning reflected by the individual, that is, when his belief is strengthened and he is able to exercise his role in a consolidated and balanced way. It is therefore expected that more studies can focus on the benefits of religiosity and spirituality in daily applications in the health field, mainly for therapeutic communities, as well as health professionals such as nurses, who can acquire skills to deal with their own and others' faith, since the dimension of spirituality in health care should not be limited to the area of mental health, but have repercussions in other Nursing specialties.

Acknowledgements

We appreciate the health services involved, as well as your representatives.

Authors contributions

The nurse and doctoral student at IRRJ was responsible for all stages, including data collection, theoretical development, analysis, and data processing. Professor MHS was responsible for reviewing the work, as well as data processing and contributing to discussions. Professor KLO was responsible for data review and critical input on the text. All authors read and approved the final manuscript.

Funding

This work was supported by CAPES (Coordination and Improvement of Higher Education Personnel) and with translation support from the UEL Writing Center.

Conflicts of Interest Disclosure

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Informed consent

Obtained.

Ethics approval

The Publication Ethics Committee of the Association for Health Sciences and Education. The journal's policies adhere to the Core Practices established by the Committee on Publication Ethics (COPE).

Provenance and peer review

Not commissioned; externally double-blind peer reviewed.

Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

DATA SHARING STATEMENT

No additional data are available.

OPEN ACCESS

COPYRIGHTS

REFERENCES

[1] Zheng Y, Tyrovolas AMS, Yip PSF. Epidemiological changes, demographic drivers and global Years of life lost from suicide over the period 1990-2019. Suicide Life-threat behav. 2022 [cited 2024 dec 08]; 52(3): 439-51. PMid:35137457 https://doi.org/10.1111/sltb.12836

[2] de Carvalho MLSND, Costa MR, Simões NS, et al. Child mental health: early detection and interventions in anxiety disorders and depression. LEV [Internet]. 2024. Set. 2; 15(39): 3106-15. https://doi.org/10.56238/levv15n39-116

[3] Morais WBS, Nascimento FF, Penha JC, et al. Trend in mortality from mental and behavioral disorders due to alcohol use in Brazil, 2010-2021. Epidemiol Serv Saude [Internet]. 2024 [cited 2024 Jul 24]; 33: 1-12. PMid:39016404 https://doi.org/10.1590/s2237-96222024v33e20231483.en

[4] Kucharska K, Gajewski R. Czynniki ryzyka a czynniki ochronne zachowań samobójczych u osób z diagnozą depresji. 2023. https://doi.org/10.34766/fetr.v56i4.1227

[5] Oliveira TAA, Gouveia VV, Ribeiro MGC, et al. General Health Questionnaire (GHQ12): new evidence of construct validity. 2023. p. 803-810. PMid:36888864 https://doi.org/10.1590/1413-81232023283.09452022

[6] Silveira LB, Kroeff CR, Teixeira MAP, et al. The use of self-reportng questionnaire (SRQ-20) for clinical group identificaton and suicide risk predicton. Revista Psicologia e Saúde. Porto Alegre (Brasil); 2021. p. 49-61. https://doi.org/10.20435/pssa.v13i4.1219

[7] Cheng C, Ying W. A meta-analytic review of the associations between dimensions of religious coping and psychological symptoms during the first wave of the COVID-19 pandemic. Front Psychiatr. [Internet]. 2023; 14: 1097598. PMid:36741121 https://doi.org/10.3389/fpsyt.2023.1097598

[8] Haney A, Lane S. Religious Coping Is Differentially Associated with Physiological and Subjective Distress Indicators: Comparing Cortisol and Self-Report Patterns. Medicina Comportamental. 2023; 1-9. PMid:37964623 https://doi.org/10.1080/08964289.2023.2277926

[9] IBGE [Internet]. Rolândia. Atualizada em 2024 [cited Set 10]. Available from: https://cidades.ibge.gov.br/brasil/pr/rolandia/panorama

[10] IBGE [Internet]. Londrina. Atualizada em 2024 [cited Set 10]. Available from: https://cidades.ibge.gov.br/brasil/pr/londrina/panorama

[11] Panzini RG, Bandeira DR. Spiritual/religious coping. Arch. Clin. Psychiatry. 2007; 34(1 Suppl): 126-135. https://doi.org/10.1590/S0101-60832007000700016

[12] Harding TW, de Arango MV, Baltazar J, et al. Mental disorders in primary health care: a study of their frequency and diagnosis in four developing countries. Psychol Med. 1980. May; 10(2): 231-41. PMid:7384326 https://doi.org/10.1017/S0033291700043993

[13] Prasetio CE, Triwahyuni A, Prathama AG. Psychometric Properties of Self-Report Questionnaire-20 (SRQ-20) Indonesian Version. 2022; 49(1): 69. https://doi.org/10.22146/jpsi.69782

[14] Marbin D, Gutwinski S, Schreiter S, et al. Perspectives in poverty and mental health. Frontiers in Public Health. 2022. PMid:35991010 https://doi.org/10.3389/fpubh.2022.975482

[15] Amissah C, Nyarko K. Facing the Ills of Unemployment: The Role of Religiosity and Social Support. Journal of Religion and Health. 2020; 59: 2577–2594. PMid:31912351 https://doi.org/10.1007/s10943-019-00977-6

[16] Buitrago SCC, Agudelo JMP, Marín MN, et al. Predictive model of suicide risk in Colombian university students: quantitative analysis of associated factors. Front. Psychiatry. 2024; 15: 1291299. PMid:38855643 https://doi.org/10.3389/fpsyt.2024.1291299

[17] De Leon G, Unterrainer HF. The Therapeutic Community: A Unique Social Psychological Approach to the Treatment of Addictions and Related Disorders. Front. Psychiatry. 2020; 11: 786. PMid:32848950 https://doi.org/10.3389/fpsyt.2020.00786

[18] Lemes AG, Nascimento VF do, Rocha EM da, et al. Community therapy as complementary care for drug users and its contributions to anxiety and depression. Esc Anna Nery [Internet]. 2020; 24(3): e20190321. https://doi.org/10.1590/2177-9465-ean-2019-0321

[19] Global Burden of Disease 2021: mental health messages. Lancet Psychiatry. 2024; 11: 573. PMid:39025623 https://doi.org/10.1016/S2215-0366(24)00222-0

[20] Torres Neto F, Lovisi GM, Unger RJG, et al. Common mental disorders among populations assisted by Primary Health Care in Brazil: an integrative review [Internet]. 2023; 31(3): e31030119. https://doi.org/10.1590/1414-462x202331030119

[21] Katugume P, Namukowa JB, Nankunda O, et al. Coping Strategies, Challenges and Potential Interventions among Adult Patients with HIV and Mental Illness Comorbidity in Southwestern Uganda. Global Public Health. 2024; 19(1). PMid:38989538 https://doi.org/10.1080/17441692.2024.2372802

[22] Christoffersen MN, Kahn L. Can life events predict first-time suicide attempts? A nationwide longitudinal study. 2024; 15(3): 371-393. PMid:38954423 https://doi.org/10.1332/17579597Y2024D000000020

[23] Borges M, Lucchetti G, Leão FC, et al. Religious Affiliations Influence Health-Related and General Decision Making: A Brazilian Nationwide Survey. J. Environ. Res. Public Health. 2021; 18(6): 2873. PMid:33799740 https://doi.org/10.3390/ijerph18062873

[24] Hussey I. Sexual misconduct amongst evangelical leaders: a practical theological reflection. Practical Theology. 2023; 16: 655-668. https://doi.org/10.1080/1756073X.2023.2168228

[25] Rajan V, Saya GK, Menon V, et al. Prevalence of Depressive Symptoms and Its Association with Religiosity and Spiritual Intelligence Among Adults in Rural Puducherry, India: A Community-Based Study. J Relig Health. 2024. PMid:38848026 https://doi.org/10.1007/s10943-024-02063-y

[26] IBGE [Internet]. Census: Number of Catholics falls and number of Evangelicals, Spiritualists and those with no religion increases. Updated in 2024 [cited Jan 25]. 2010. Available from: https://agenciadenoticias.ibge.gov.br/agencia-sala-de-imprensa/2013-agencia-de-noticias/releases/14244-asi-censo-2010-numero-de-catolicos-cai-e-aumenta-o-de-evangelicos-espiritas-e-sem-religiao

[27] Peres MFP, Swerts D, De Oliveira AB, et al. Mental Health and Quality of Life Among Adults With Single, Multiple, and No Religious Affiliations. Journal of Nervous and Mental Disease. 2020; 208(4): 288-293. PMid:32221182 https://doi.org/10.1097/NMD.0000000000001115

[28] Huynh VS, Tran-Thien GP, Nguyen TB, et al. What Do We Know About the Influence of Believers' Religiosity on Happiness and Gratitude? A Perspective for Clinical Practice. Psychol Res Behav Manag. 2024; 19(17): 2433-2447. PMid:38912159 https://doi.org/10.2147/PRBM.S465729

[29] Schnitker S, Medenwaldt J, Williams E. Religiosity in adolescence. Current Opinion in Psychology. 2020; 40: 155-159. PMid:33176270 https://doi.org/10.1016/j.copsyc.2020.09.012

[30] Van Nieuw Amerongen-Meeuse J, Schaap-Jonker H, Anbeek C, et al. Religious/spiritual care needs and treatment alliance among clinical mental health patients. Journal of Psychiatric and Mental Health Nursing. 2020. PMid:32890450 https://doi.org/10.1111/jpm.12685

[31] Coelho-Júnior HJ, Calvani R, Panza F, et al. Religiosity/Spirituality and Mental Health in Older Adults: A Systematic Review and Meta-Analysis of Observational Studies. Front. Med. 2022; 9: 877213. PMid:35646998 https://doi.org/10.3389/fmed.2022.877213

[32] Bobyk OA. Assessment of the influence of religiosity on mental health. Medicine. 2024; 12(1): 118-125. https://doi.org/10.29234/2308-9113-2024-12-1-118-125

[33] Kayser J, Tenke CE, Svob C, et al. Family Risk for Depression and Prioritization of Religion or Spirituality: Early Neurophysiological Modulations of Motivated Attention. Frente. Hum. Neurosci. 2019; 13: 436. PMid:31920595 https://doi.org/10.3389/fnhum.2019.00436

[34] Burt S, Lewis R, Braithwaite Y. Faith Community Nursing. Journal of Christian Nursing. 2024; 41: 160-165. PMid:38853314 https://doi.org/10.1097/CNJ.0000000000001178

[35] Papaleontiou-Louca E. Religiosity: Is It Mainly Linked to Mental Health or to Psychopathology? Religions. 2024; 15(7): 811. https://doi.org/10.3390/rel15070811

[36] Jacob IRR, Soares MH, Oliveira KL. Religious coping and suicidal ideation as a predictive model for suicide attempts. Journal of Nursing Education and Practice. 2024; 14(5): 1-8. https://doi.org/10.5430/jnep.v14n5p31