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# Mental Health and Religiosity: The Role of Experiential Avoidance in the Symptoms of Depression, Anxiety, and Stress

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## Abstract

Several studies have considered religiosity to be a protective factor against several mental health difficulties. However, other studies suggest the opposite, that is, that religiosity is a risk factor associated with psychological symptoms. In this context, there are no studies that evaluate this relationship considering the role of experiential avoidance, which is a predictive transdiagnostic variable of various mental health disorders. This study evaluated the relationship between experiential avoidance, attitudes toward religion, and symptoms of depression, anxiety, and stress in a sample of believers using a non-experimental cross-sectional design in the city of Valdivia, Chile. Results indicate that experiential avoidance is positively related to symptoms of depression, anxiety, and stress, being the only predictor variable of the three symptomatic dimensions. Engaging in regular religious practice was not associated with religious literalness or experiential avoidance, while religious literalism was negatively associated with stress. Finally, Evangelicals showed a more regular religious practice than Catholics, while Catholics showed a higher index of religious literality; however, these differences were not associated with mental health. The clinical implications of these results are discussed.
*Key words*: experiential avoidance, religiosity, attitudes towards religion, religious literality.

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### *Novelty and Significance*

*What is already known about the topic?*

- The relationships underlying the association between religiosity and mental health remain unclear.
- Religious literality and religious practice are relevant factors in the well-being of believers.
- Experiential avoidance has been associated with a number of mental health problems.

*What this paper adds?*

- The positive association between experiential avoidance and symptoms of depression, anxiety, and stress is confirmed.
- No association was found between religious literality and mental health symptomatology, only a mild and negative one with stress. Neither religious practice nor religious confession were found to be associated with symptoms of depression, anxiety, or stress.
- Work on experiential avoidance can contribute to the well-being of Christian believers irrespective of their religious literality, practice, or confession.

Mental health disorders are currently a global public health concern. According to the World Health Organization, between 2005 and 2015, the number of people living with anxiety and depression disorders increased exponentially, partly as a consequence

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of population ageing, demographic growth, and the proportional increase of age groups in which depression is more prevalent (OPS, 2017). Mental health is also associated with cultural factors and social determinants, such as religion, which is defined as the belief system, spiritual practices, or both, organized around the worship of an all-powerful deity or deities and that includes behaviours such as prayers, meditation, and participation in public rituals (American Psychological Association, 2010). One of the approaches to the formal study of religions is through the concept of religiosity, which encapsulates several aspects of the religious activities, beliefs, and principles. In its wide range of cultural forms and modes of spiritual experience, religiosity has been postulated as a protective factor of mental health (Salgado, 2014). However, there are also authors who have found that some aspects of religiosity are negatively associated to mental health, suggesting that religiosity is a risk factor associated with anxiety and depressive symptoms (Simkin & Etchevers, 2014). Therefore, the relationship between religiosity and mental health seems to be far from clear. One potential reason for this is that the operational definition of religiosity may be affected by conceptual models that focus on different aspects of the religious dimension (e.g. religious participation, individual religiosity, spirituality, characteristics of religious spaces, and religious fundamentalism) (Koenig, 2008).

Considering that even the results of the relationship between mental health and religiosity are inconclusive, it is necessary to study other variables that can help clarify said relationship.

A key component of religiosity concerns attitudes towards religion (Fontaine, Duriez , Luyten, & Hutsebaut, 2003). This perspective observes the attitudes that underlie religious content, making it possible to explore the attitudes towards religion of believers and non-believers. Thus, regardless of the rejection or openness that one has towards transcendence, divinity, or God, everyone has an interpretive attitude that can oscillate between a literal or symbolic interpretation, with this axis indicating the level of literal attachment to religious content such as sacred texts, beliefs, liturgies, and religious symbols. A second factor explains the strength of a person's belief through the axis of inclusion or exclusion of transcendence, which takes into account the closeness or distance with respect to transcendence, understood as contact with the ultimate reality to which religious expressions are directed (Hutsebaut, 1996).

Some studies have evaluated the relationship between attitudes towards religion and social phenomena. For example, Grove, Hall, Rubenstein, and Terrell (2019) demonstrated that attitudes towards religion with a tendency toward greater literality and greater religious strength are a general predictor of prejudice towards specific groups such as atheists, homosexuals, Christians, and highly religious people. In addition, it has been shown that a higher index of literalism of Christian parents is related to a parenting style that provides less support for the religious autonomy of their children (Nguyen & McPhetres, 2018). However, few studies have evaluated the connections between attitudes towards religion and mental health. Among these, some exploratory studies have evaluated the relationship between anxiety and attitudes towards religion, showing that attitudes with a literal tendency are associated with guilt and that, in people with less literal beliefs, they are associated with greater suspiciousness (Śliwak & Zarzycka, 2012).

Experiential avoidance (EA) is a mental health variable that can potentially be linked to attitudes toward religion. EA encompasses all deliberate efforts to avoid and/or escape the content of a particular experience, such as thoughts, emotions, and physical

sensations that are experienced as aversive, even when this leads to actions that are inconsistent with one's values and goals (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). EA is an important clinical variable and a transdiagnostic category that underlies several physical and mental illnesses (Gloster, Meyer, & Lieb, 2017). EA is also the counterpart of the psychological flexibility dimension, which is defined as the ability to be in contact with the present moment and which therefore allows an adaptive response to various situational demands, so that the person moves towards the values that he/she deems important to live a meaningful life (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). In addition, it has been observed that EA acts as a transdiagnostic mechanism that underlies multiple mental disorders such as depression and anxiety (Mellick, Mills, Kroska, Calarge, Sharp, & Dindo, 2019) and mediates between a range of difficulties such as emotional dysregulation, mood, or post-traumatic stress (Henschel, Williams, & Hardt, 2021).

EA, a variable born within the context of third-generation therapies (Hayes, 2004), is a key construct in therapeutic intervention models such as Acceptance and Commitment Therapy (ACT; Hayes, 2016), which works directly on decreasing levels of EA while also seeking to disarticulate a series of cognitive micro processes such as literalness and cognitive fusion (Luciano & Valdivia, 2006). The theoretical explanation of these phenomena is grounded in Relational Framework Theory (RFT; Hayes, Barnes-Holmes, & Roche 2001), a new paradigm for the experimental analysis of a variety of social behaviours mediated by language. Basically, RFT indicates that behaviour governed by verbal rules can be understood through three functional classes: pliancy, tracking, and augmenting, which vary with respect to the relationships between behaviour, environmental contingencies, and consequences (Roche, Barnes-Holmes, Barnes-Holmes, Stewart, & O'Hora, 2002). Pliancy is a rule-governed behaviour that is predominantly controlled by the consequences mediated by the speaker, representing the correspondence between the behaviour and the rule; tracking is a rule-governed behaviour that is predominantly controlled by the correspondence between environmental contingencies and the rule; finally, augmenting is a rule-governed behaviour that can occur together with pliancy or tracking to alter the extent to which the consequences specified by rules have reinforcing or punishing properties (Zettle & Hayes, 1982).

In the context of Christian religiosity, both ACT and RFT have been useful constructs for behaviour analysis and therapeutic applications. Barnes-Holmes, Hayes, and Gregg (2001) point out that RFT analyses can shed light on the role played in behaviour by verbal contingencies such as "God", "eternal damnation", or religious rules themselves. For example, the expression "repent of your sins, accept Jesus as your only saviour, and you will have eternal happiness" implies a verbal rule that indicates a remote and delayed consequence, since it can only be corroborated after death; however, it can also generate a psychological effect of happiness or give meaning to life in the present, which may be the result of a tracking or augmenting function. In other words, the verbal rules behind some religious beliefs can have a psychological impact depending on the level of literality with which certain religious contents are appreciated, which could contribute to or harm some aspects of mental health. For its part, ACT has been described as a model that can be harmoniously adapted to the Christian perspective (Rosales & Tan, 2016), being applicable to religious leaders working in spiritual care (Nieuwsma, Walker, & Hayes, 2016) or to the guidance of Christian consultants, respectfully integrating ACT and the Christian tradition (Knabb, 2016). Despite these applications, the literature does not describe how EA behaves in different Christian

religious confessions such as Evangelicals or Catholics, or in different frequencies of religious practice. EA, attitudes towards religion, and mental health are likely to be intertwined. One reason for this is that EA and attitudes towards religion share focus on the process of interpretation of experiences, beyond the content of the experiences themselves (Hayes *et alia*, 1996; Fontaine *et alia*, 2003). A second reason is that, to a certain degree, both variables evaluate literality, which is one of the defining components for the clinical evaluation of EA (Faustino, Vasco, Farinha Fernandes, & Delgado, 2021; Morin, Grégoire, & Lachance, 2020). At the same time, in attitudes towards religion, the literal versus symbolic factor reflects whether an individual tends to process content religious literally or symbolically, being used to measure his/her cognitive processing style (Hutsebaut, 1996; Duriez, Fontaine, & Hutsebaut, 2000).

Therefore, our general objective is to evaluate the relationship between EA, religious literality, religious practice, and religious confession and their impact on the mental health symptomatology of depression, anxiety, and stress in groups of believers. In this context, our specific objective is to observe whether religious practice or religious confession have an effect on mental health symptomatology, since recent evidence shows that being a practising believer (exhibiting characteristics such as attending religious meetings) has a different impact on mental health compared to being a non-practising believer (Upenieks, 2022). Furthermore, it has also been observed that mental health symptoms can vary according to religious confession and religious practice in Catholic or Evangelical Christians (Schwadel & Falci, 2012).

Thus, our first hypothesis is that, in the population of Christian believers, religious literalism will be associated with EA and therefore both will be associated with mental health symptoms. Secondly, we hypothesise that religious practice can have an effect on the mental health of believers. Finally, we expect to find that regular religious practice is associated with greater religious literality and therefore with a higher level of EA.

## Method

### *Participants*

A sample of 230 volunteers (146 women and 84 men) of legal age (mean or M= 39.14; SD= 15.75, range: 18-89) from the city of Valdivia (Chile), were selected using convenience sampling. Of these 230 volunteers, 68.3% self-identified as Evangelical and the remaining 31.7% as Catholic. All of them had no previous psychiatric diagnosis, were not receiving pharmacological treatment, and were not visually impaired. All subjects gave written informed consent, and the research protocol was approved by the Ethics Committee of Universidad Austral de Chile.

### *Instruments*

*Depression, Anxiety and Stress Scale* (DASS-21; Lovibond & Lovibond, 1995). The mental health component was evaluated using the Chilean validation (Antúnez & Vinet, 2012) of the DASS-21, which has a Cronbach's $\alpha$ reliability of .91. This questionnaire has 21 items, with responses recorded on a Likert scale ranging from 0 ("it didn't happen to me") to 3 ("it happened to me a lot, or most of the time"). In the present sample, the reliability of the DASS-21 scale scores was considered satisfactory ($\alpha$= 0.92). By dimension, internal consistencies were $\alpha$= .83 for stress scores, $\alpha$= .80 for anxiety scores, and $\alpha$= .84 for depression scores.

*Acceptance and Action Questionnaire* (AAQ-II, Bond, Hayes, Baer, Carpenter, Guenole, Orcutt, & Zettle, 2011). To evaluate EA, we used the Spanish validation (Ruiz, Langer, Luciano, Cangas, & Beltrán, 2013) of the AAQ-II, which has a Cronbach's $\alpha$ reliability of .82. This instrument has 7 items evaluated on a 7-point Likert scale ranging from

"never" to "always". This instrument has been found to have good consistency and reliability in both clinical and general populations (Dinis, Pinto Gouveia, Xavier, & Gregório, 2012).

*Post-Critical Belief Scale* (PCBS; Duriez *et alia*, 2000). To assess religious attitudes, that is, the level of symbolism and literality, we used the Argentinian validation (Rabbia, Brussino, & Vaggione, 2012) of the PCBS. Only the Orthodoxy and Second Ingenuity subscales were used, composed of 8 items respectively with responses on a 6-point Likert scale, ranging from "totally disagree" to "totally agree." In this sample, the per-scale scores had acceptable reliability (Orthodoxy $\alpha$= .82; Second Ingenuity $\alpha$= .84). Some of the literality items are: "I consider that the stories of the Bible should be understood literally, as they were written" and "God has been defined once and for all, that's why he never changes."

To evaluate *Religious Practice* (regular/non-regular religious practice), participants were asked "Do you practice your faith/religiosity?," referring to active participation such as attending liturgical services and engaging in religious activities like prayer and Bible reading at least once a week. Responses were dichotomized between those who engaged in these practices weekly (regular religious practice) and those who reported doing it "sometimes", "almost never", or "never" (non-regular religious practice).

### *Procedure*

The questionnaires were administered in person in the Universidad Austral de Chile and in local Evangelical churches of Valdivia. Prior to the delivery of the questionnaires, and with the intention of instructing the participants, a five-minute explanatory talk was given by one of the members of the research group. In this brief talk, the participants were informed of the objectives of the study and received the informed consent document, which clarified ethical aspects such as confidentiality and the voluntary nature of participation. Once the informed consent was signed, the questionnaires were administered, considering approximately fifteen minutes per person.

### *Data Analysis*

First, we obtained descriptive statistics and calculated bivariate correlations among the variables. Second, we used generalized linear models (GLM) with Poisson distribution to evaluate the effect of EA, religious practice, religious literality, and religious confession on the three mental health variables evaluated (i.e. depression, anxiety, stress). In addition, age, gender, and years of formal education were included as fixed factors in all analyses. As we detected overdispersion in the analyses, we corrected the standard errors using a quasi-GLM model where the variance is given by the product of the mean and the dispersion parameter (Zuur, Ieno, Walker NJ Saveliev, & Smith, 2009). A backward model selection procedure were used to evaluate the change in deviance of a full model versus a nested one that does not include the predictor being evaluated. This analysis of deviance follows an *F*-distribution with degrees of freedom equal to p1 – p2 and n – p1 (p1 and p2 are the number of parameters in the full and nested models respectively, while n is the number of observations) (Zuur *et alia*, 2009). We started with a full model that included all predictors (including the interaction between religious confession and religious practice) and removed one predictor at a time, until we obtained a minimum adequate model. Third, we used one-way ANOVAs to evaluate the effect of religious confession (i.e. Catholic and Evangelical) and religious practice on literality and EA. Finally, we used a Chi-squared test to evaluate whether there is an association between religious practice and religious confession.

All analyses and graphs were produced in R version 4.2.1 (R Core Team, 2022).

## Results

The correlations between EA and depression, anxiety, and stress were positive, moderate-strong, and statistically significant. Religious literality only had a weak relationship with EA but not with depression, anxiety, or stress (see Table 1).

*Table 1*. Pearson correlations between mental health variables, experiential avoidance (EA), and religious literality (i.e. Literality).

| | Depression | Anxiety | Stress | EA | Literality |
|---|---|---|---|---|---|
| Depression | - | 0.622* | 0.637* | 0.559* | 0.048 |
| Anxiety | | - | 0.718* | 0.434* | 0.047 |
| Stress | | | - | 0.517* | 0.001 |
| EA | | | | - | 0.215* |

*Note*: *= $p$ <.001.

Given that the three variables of mental health are positively correlated with one another (see Table 1), it is not surprising for all of them to show a similar pattern in terms of the explanatory variables affecting them. In particular, depression, anxiety, and stress were positively affected by EA (see Figure 1 and Table 2). However, religious confession, religious practice, gender, years of education, and age were not important explanatory variables for any of them. Although literality did not affect depression or anxiety, stress showed a negative association with religious literality (slope= -0.012, *SE*= 0.004) (Table 2).

*Table 2*. Results of a backward model selection for each evaluated mental health variable. The order of the predictors indicates the order in which they were removed from the final model.

| | Predictor | *F* | *df* | *p* |
|---|---|---|---|---|
| | Gender | 0.233 | (1, 217) | .63 |
| | Age | 0.733 | (1, 218) | .39 |
| | Years of education | 0.975 | (1, 219) | .32 |
| | Religious literality | 1.265 | (1, 221) | .26 |
| Depression | Time as a believer | 1.702 | (1, 222) | .17 |
| | Practice (Confession) | 2.631 | (1, 225) | .11 |
| | Religious Confession | 0.049 | (1, 226) | .82 |
| | Practice | 0.528 | (1, 227) | .47 |
| | Experiential Avoidance | 104.14 | (1, 228) | <.001 |
| | Years of education | 0.060 | (1, 217) | .81 |
| | Gender | 0.198 | (1, 219) | .66 |
| | Time as a believer | 1.013 | (1, 220) | .39 |
| | Practice (Confession) | 1.632 | (1, 223) | .20 |
| Stress | Religious Confession | 0.041 | (1, 224) | .84 |
| | Practice | 0.050 | (1, 225) | .82 |
| | Age | 2.984 | (1, 226) | .09 |
| | Experiential Avoidance | 70.968 | (1, 227) | <.001 |
| | Religious literality | 7.011 | (1, 227) | <.01 |
| | Gender | 0.730 | (1, 217) | .39 |
| | Age | 1.112 | (1, 218) | .29 |
| | Religious literality | 1.232 | (1, 219) | .27 |
| | Time as a believer | 1.417 | (1, 220) | .24 |
| Anxiety | Years of education | 1.704 | (1, 223) | .19 |
| | Practice (Confession) | 3.362 | (1, 225) | .07 |
| | Practice | 0.184 | (1, 226) | .67 |
| | Religious Confession | 0.192 | (1, 227) | .66 |
| | Experiential Avoidance | 56.844 | (1, 228) | <.001 |

*Notes*: Practice= regular and non-regular practitioners; Religious Confession= Catholic or Evangelical; Practice= interaction between religious practice and creed; *df*= indicate numerator and denominator degrees of freedom respectively.

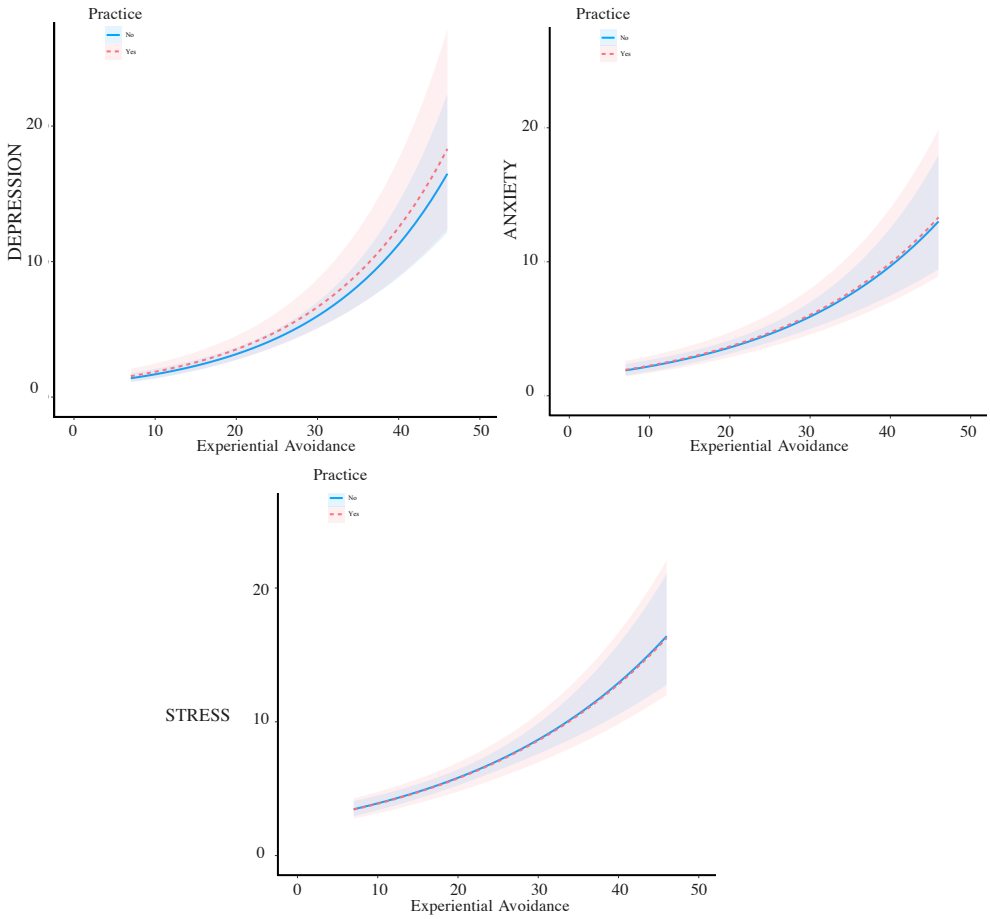


*Figure 1*. Experiential avoidance and symptomatology in groups of practicing and no-practicing believers. Lines represent predicted values and 95% confidence bands of a generalized linear model with Poisson distribution that includes experiential avoidance and practice as main effects on mental health variables.

Catholics and Evangelicals did not differ in EA ($F_{1,228}$= 1.57, $p$= .212), although they did differ in literality ($F_{1,228}$= 26.35, $p$ <.001), with Evangelicals being less literal than Catholics ($M$±1 $SD$: Catholics= 52.04±12.6; Evangelicals= 44.32±9.56). Regular and non-regular practitioners did not differ in EA ($F_{1,228}$= 0.112, $p$= .739) or literality ($F_{1,228}$= 3.32, $p$= .070). Finally, religious confession and religious practice were not found to be independent ($\chi^2[1]$= 58.38, $p$ <.001) (see Table 3).

*Table 3*. Frequencies of religious confession (Catholic or Evangelical) and religious practice (regular or non-regular).

| | Catholic *n* (%) | Evangelical *n* (%) | Total |
|---|---|---|---|
| Non-regular Practice | 40 (54.8%) | 14 (8.9%) | 54 |
| Regular practice | 33 (45.2%) | 143 (91.1%) | 176 |
| Total | 73 | 157 | 230 |

## Discussion

Overall, the results indicate that religious literality was not associated with mental health, was only mildly and negatively associated with stress, and was stronger in Catholics. In addition, engaging in regular or non-regular religious practice was not associated with religious literalness or EA, though more regular practice was observed in Evangelicals compared to Catholics. In summary, overall, EA is the variable with the greatest impact on mental health symptoms in believers, regardless of their religious literality, religious practice, and even confession. Thus, our first hypothesis was partially fulfilled, since although religious literality is weakly associated with EA, only EA is associated with all mental health symptoms. Our second hypothesis was not fulfilled, since religious practice does not alter any mental health symptoms. Finally, our third hypothesis was not fulfilled either, as religious practice was not associated with either religious literalness or EA.

These results are not consistent with studies indicating that religious practice is related to better mental and physical health (AbdAleati, Zaharim, & Mydin, 2016) or that the frequency of religious practices such as meditation and personal prayer is positively associated with psychological well-being (González Rivera *et alia*, 2017).

Furthermore, our results show that having a literal interpretation of religious content does not significantly alter the symptomatic aspects of mental health in believers but is weakly associated with EA. Religious literality seems to be a factor that shows contradictory relationships with mental health. On the one hand, there are reasons to suspect that it is a risk factor because literal believers may be prone to attribute their discomfort to evil spirits (Krause & Pargament, 2018) or suffer feelings of threat or fear for literally believing in divine judgment or punishment (Musick, 2000). On the other hand, there are also contents of the sacred texts that, if read literally, construct meaning in the midst of situations of suffering (Park, 2005), suggesting that a literal reading could have a positive impact on mental health (Upenieks, 2021).

We also found a negative association between religious literalism and stress, suggesting that higher religious literality could indicate a lower degree of stress in believers. In this context, a believer with a literal attitude might claim that "there is only one correct answer to every religious question". This categorical statement could become a stress saver, because the religious and literal person is unwilling to consider other alternative religious explanations (Webb, 2004). Thus, literally religious people, by having only one type of religious interpretation, can also simplify the explanation of their own psychological experience through the same approach, since religious people often use their own religious language to express and give meaning to their anguish or despair regarding traumatic or stressful events (Webb, 2004). These results are not in line with previous studies that report that believers with a higher literality in their views of religious content show much more intense symptoms of anxiety and feelings of guilt (Śliwak & Zarzycka, 2012). The negative relationship with stress could be explained by the hypothesis proposed by these authors, who describe a double function of literality: though more literal believers experience security thanks to their beliefs, which could be protective against stress, literal religious interpretations can also generate feelings of guilt and therefore anxiety when behaviours do not conform to religious demands and norms. For example, it has been reported that literal religious people experience more anxiety when they approach death (Dezutter, Soenens, Luyckx, Bruyneel, Vansteenkiste, Duriez, & Hutsebaut, 2008). This appears to be consistent with the RFT approach in

that some aspects of religious literalism, depending on whether its verbal rule has a tracking or augmenting function, can have a positive or negative psychological impact (Barnes-Holmes *et alia*, 2001). In this context, it would be necessary to make a functional analysis of the specific verbal rules of some religious concepts to observe when these can bring psychological discomfort, relationally extrapolating our findings to other verbal rules of a non-religious nature.

The dimension of depression evaluated here does not seem to be related to religious literalism. However, researchers have reported some positive relationships with religiosity in general. For example, studies conducted in Chile suggest that religiosity is a protective factor in depressed women with suicidal risks (Taha, Florenzano, Sieverson, Aspillaga, & Alliende, 2011) and in depressed elderly women (Gallardo & Sánchez, 2014).

We also found that EA was positively associated with symptoms of depression, anxiety, and stress, something that has been previously documented (Tull, Gratz, Salters, & Roemer, 2004). In this sample of believers, EA was the most stable and significant predictor of psychopathology. The literality variable also played a predictive role, but only for stress, and its contribution to prediction was less than that of avoidance.

Although there is no explicit research on EA and attitudes towards religion, some authors have evaluated the relationships between EA and some specific religious phenomena, but without identifying a clear pattern of effects. For example, the relationship between the experience of spiritual struggles and poorer mental health is stronger in people with higher levels of EA (Dworsky, Pargament, Wong, & Exline, 2016); also, researchers have reported a moderating role of religiosity that reduces avoidance in Israeli university students after exposure to traumatic situations such as terrorist events (Korn & Zukerman, 2011).

It is important to note that our study has three important limitations. (i) First, because of our cross-sectional design, we cannot establish causal relationships among variables. (ii) The self-reported modality of the questionnaires might cause some of the answers to be biased. (iii) Furthermore, we did not consider some relevant variables related to the religious phenomenon such as spirituality and instruments that specifically evaluate religious practices of believers in dimensions such as reading religious texts, participation in religious services, and prayer or meditation. (iv) It is necessary to take these results with caution, as religious practice in this study has been evaluated mainly in the Christian religion (the Catholic and Evangelical confessions). Therefore, these results could vary if the differences between practising and non-practising groups in other religious traditions are observed. (v) The use of the AAQ-II has been questioned, since it is a scale that measures neuroticism/distress and not EA of aversive private events (Wolgast, 2014); in consequence, we suggest considering at least one additional experiential avoidance scale, such as The Brief Experiential Avoidance Questionnaire (Gámez, Chmielewski, Kotov, Ruggero, Suzuki, & Watson, 2014), to determine the association between the psychological strategies used by believers to face private events and their style of religiosity, as our study has outlined.

Overall, these results have three main implications. First, at the intervention level, it can be posited that there is a functional difference between religious literality and the literality present in EA. In this regard, it is important to point out that EA refers to a cognitive and interpretative process of coping with psychological events of consciousness (thoughts, emotions, and sensations) –a cognitive process that operates in the background, independent of the contents of these events, including those related to religiosity–, while attitudes towards religion contribute with specificity to how

people interpret and approach religious practice. Thus, in psychotherapeutic work with religious people, this difference is an important factor to consider, but it can also guide psychotherapists to focus on the EA dimension without being trapped in religious content. In fact, a contextual-functional approach such as Acceptance and Commitment Therapy (ACT) could serve as a clinical model for symptom management without disrupting religious content, at least in depressive and anxious symptoms. From the perspective of ACT, this functional change could offer support for taking actions aligned with the client's values, regardless of their supposed truth in a specific socio-verbal context (Luciano, Rodríguez, & Gutiérrez, 2004; Mairal, 2007), such as those derived from literal religious interpretations.

A second implication is that EA can be considered a cross-cultural variable (Monestès *et alia*, 2016) that can predict symptoms across multiple groups of believers, even if only partially. Consequently, it has been suggested that therapeutic interventions that reduce EA, such as ACT, can be a plausible way of contributing to people's psychological well-being regardless of their attitudes towards religion, religious literality, and engagement in religious practice.

Third, given that religious values and meanings are relevant for the stability of treatment in believers (Borisova, Kopeyko, Gusev, Gedevani, & Vladimirova, 2021), working on the reduction of EA coexists with a psychotherapeutic perspective that respects the religious contents of believers and does not regard them as a therapeutic obstacle. Thus, believers with mental health difficulties may feel more secure in seeking psychological help; at the same time, this approach can make it easier for believers receiving psychological treatment not to feel their beliefs threatened by therapeutic interventions.

These results may open an exploratory path to continue studying the relationships between EA and attitudes towards religion, religious literalism, religious practices, and religious confessions. Therefore, for future studies, it would be important to explore the relationship between religiosity and mental health utilizing an instrument of emotional awareness or internal affective states such as the Five Facet Mindfulness Questionnaire (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). This would make it possible to determine whether people with more literal religiosity styles are less aware of their own symptomatic experiences in relation to depression, anxiety, and stress, because a high degree of religious literality may alter one's perception of internal psychological content.

In conclusion, according to our results, EA is the only variable with a significant impact on the symptoms of depression, anxiety, and stress across all Christian believers, irrespective of religious literality, religious practice, and religious confession.

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