

RELIGIOUS COPING, PERCEIVED SOCIAL SUPPORT AND PSYCHOLOGICAL DISTRESS IN MEDICAL STUDENTS

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Abstract

The purpose of the study was to analyse the relation between religious coping, perceived social support and psychological distress in medical students. The study's sample consisted of 200 medical students (N=200), 83 men (n=83), and 116 women (n=116) of age 18-25 (M=21.91, SD=1.81). A correlational design was employed in the study. Self-report measures such as the Kessler Psychological Distress Scale (K10: Kessler et al., 2002), the Brief Religious Coping Scale (Brief RCOPE: Pargament et al., 2011), the Multidimensional Scale of Perceived Social Support (MSPSS: Zimet et al., 1988), and demographics were used to test the study variables. The results demonstrated that negative religious coping had a positive correlation with psychological distress whereas, perceived social support had a negative correlation with psychological distress. Furthermore, perceived social support was a substantial negative predictor of psychological distress, religious coping (negative) was a significant positive predictor. Perceived social support did not moderate the relation between religious coping and psychological distress. The study highlighted that students could receive useful support to help them deal with academic pressure by setting up a peer monitoring program.

***Keywords:** Psychological distress, religious coping, perceived social support, positive coping, negative coping.*

Introduction

Medical education has generally been considered one of the hardest academic challenges where students have to endure the rigorous course work, clinical practice and endless examinations. Medical students may be even more at risk of psychological discomfort because of the felt need to succeed academically, the long work hours, the expectations, and the lack of sleep (Dyrbye et al., 2014). A range of unpleasant mental experiences that may impede day-to-day tasks and general well-being is known as psychological discomfort, or distress (Mirowsky & Ross, 2002). These conditions include stress, anxiety, and depression. Studies have continuously revealed that medical students have been found to experience an increased rate of stress and mental illness than the general population and students who may be studying other majors (Rotenstein et al., 2016).

To address these problems, medical students make use of a variety of internal and external resources. These resources include perceived social support, a protective feature that may operate as a buffer against psychological suffering, and religious coping. The association between students' positive and negative coping methods, which can either increase or lessen psychological suffering, is moderated by perceived social support.

Religious Coping

Religious coping refers to cognitive, behavioural, and emotional techniques that can assist an individual in understanding and dealing with life challenges while adhering to their religious beliefs and practices. In religious coping, we deal with challenging circumstances and traumatic life events by utilising our beliefs, faith, practices, and emotions. It may fulfill many roles like strengthening relationship with

God, providing meaning to the life, stimulating peace and harmony, building connection with others, encouraging self-control and promoting self growth (Pargament, 1997; Pargament, 2011). It is not simply being religious but rather it is how an individual draws religion to handle stressors like illness, loss, academic stress, or personal struggles.

Religious coping emerged as research focused on late 20th century where researchers and scholars realized that religion is not only set of obligations to follow but religion and spirituality both play a central point in managing stress and different life problems. Kenneth Pargament's work named as "The psychology of religion and coping" (1997) laid the theoretical foundation. Before this religion was overlooked in mainstream psychology, viewed more as personal belief rather than active coping resource.

Types of Religious Coping

Types of religious coping are discussed below.

Positive Religious Coping (PRC). It uses religious beliefs and practices to cope and adapt to stress in positive and constructive way, leading to better mental health outcomes like reduced anxiety, depression and improved quality of life (Ano & Vasconcelles, 2005).

Negative Religious Coping (NRC). It indicates the inappropriate application of faith-based beliefs and rituals in stressful situations, which result in such negative consequences as anger, guilt or feeling deserted by God, conflict with God and religious communities, and is associated with the ill effects of psychological well-being (Pargament et al., 2000).

Dimensions of Religious Coping

Religious coping is multidimensional, and dimensions are given below.

Cognitive Dimension. Cognitive dimension of religious coping deals with how people explain and understand stressful incidences using their religious faith. It assists individuals to put challenges in perspective as a part of divine plan, a faith challenge or an adventure towards spiritual development. Assigning the sufferings to the will of God or the justice of the universe, people obtain the feeling of meaning and sense, which lessens the confusion and uncertainty. (Hood et al., 2009).

Emotional Dimension. The emotional dimension focuses on how religion regulates feelings of fear, guilt, grief, and anxiety during stressful times. Through prayer, meditation, or surrender to a higher power, individuals experience relief, comfort, and inner peace. Promotion of positive affect and reduction in negative emotions can be done by practicing forgiveness and gratitude (Saroglou, 2011).

Behavioural Dimension. The behavioural dimension entails the exterior religious activities that an individual engages in as a way of managing stress i.e. praying, fasting, observing religious services, rituals. Such habits give it form, pattern and a feeling of discipline during times of disorder (Koenig, 2012).

Social Dimension. The social dimension emphasizes the social side of religious coping, including the need to have emotional or material support of religious leaders, the community, or religious groups (Pargament, 2011).

Theoretical Perspective

Following is the theoretical perspective of religious coping.

Theory of Religious Coping. Kenneth I. Pargament created the theory of religious coping to describe how people utilise religion to comprehend and cope with stressful life circumstances. In his early conceptual work, he proposed that religion plays a part of an individual's orientation framework, help them interpret and respond

to difficulties and crises through sacred meaning frameworks (Pargament 1997; Pargament et al., 2002). Expanding on his 1990 theoretical essay *God Help Me*. In order to empirically test these processes, he developed the RCOPE and Brief RCOPE scales where different dimensions of religious coping are identified (Pargament et al., 2000; K. Pargament et al., 2011). The tools can be used to look into how religious coping affects distress and well-being in a variety of settings and cultures (Ano & Vasconcelles, 2005).

According to Pargament religion serves many core functions in coping like finding meaning in suffering, gaining control through divine collaboration or surrender and changing life by spiritual growth. He also emphasized that religious coping is flexible, formed by personal, social and situational elements, and its outcome depends on whether religious beliefs and practices (Pargament et al., 2000). Empirical evidence indicates that positive religious coping is related with more adaptive psychological adjustment, resilience and hope as compared to negative religious coping that is correlated with depression, anxiety and poor health outcomes (Ano and Vasconcelles, 2005).

Perceived Social Support

Perceived social support is regarded as a fundamental construct in the psychology and health sciences. It is the subjective examining of the presence and validity of support provided by family, friends or other closed ones subjected by an individual. Opposite to actual received social support which focuses on the supportive behaviours applied in practice, PSS is manifested in the belief that the individual has supportive behaviours to provide when they are needed (Zimet et al., 1988; Canty-Mitchell & Zimet, 2000). This philosophy influences the way people stress, manage their emotions, and handle the hardship. Studies have always indicated that PSS is a supportive influence over mental distress and degradation of physical health (Lakey & Cohen, 2000; Uchino, 2009).

Importance of perceived social support lies in its constant association with health, social and psychological outcomes. Data from the research shows that high level of PSS is related to lesser depressive and anxiety symptoms that improves stress management and also increase resilience and self-esteem (Lakey and Cohen, 2000). Overall, PSS not only acts as buffer against stress, but it also acts as a facilitator of positive adaptation.

Types of Perceived Social Support

Researchers classified perceived social support into two categories.

Functional Type. Functional perceived support refers to qualitative nature of support that an individual and individual can assess. It focuses on the functions, that social support provides the function may be providing emotional comfort, practical help, guidance and assurance of self-esteem. In this perspective it is not important who is giving the support, but which support is perceived available. Four primary functional categories like emotional, instrumental, informational and appraisal support were identified by (Heany & Israel, 2008).

Emotional Support. It refers to the perception that one person is loved, valued and cared by others. In this, expressions of warmth, sympathy, concern and reassurance are involved that provide psychological comfort in distress and anxiety (Drageset, 2021).

Instrumental/ Tangible support. Instrumental or tangible support means having material assistance when one is in need. This type of support included financial

assistance, facilitation of resources or getting help when in need (Heaney & Israel, 2008).

Informational Support. It involves the perception that guidance, advice or knowledge is available or accessible when facing challenges or making decisions. This includes mentors, seniors and peers that helps us clarify uncertainties and by providing problem solving strategies (Taylor, 2011).

Appraisal/Esteem Support. This kind of support refers to the perception that one's abilities, efforts and values are recognized and respected by others. It is conveyed through encouragement, appraisal, validation and constructive feedback that insures an individual's self-worth (Cutrona & Suhr, 1992; Szkody & McKinney, 2020).

Structural Type. The sources or providers of support in one's social circle are referred to as structural perceived social support. It focuses more on social structures or relationships that are perceived to be present when an individual is in need, rather than the type of assistance. Three distinct types of structural supports such as family, friends and significant others are conceptualised by Zimet et al. (2011) through the development of Multidimensional scale of perceived social support (Kořar & Kořar, 2024).

Family Support. It indicates to the perception that family members are always present when you need them. It consists of both emotional and tangible form of support like guidance, encouragement and all kind of financial help. In collectivist cultures, families share a very strong bond and serve as primary support system (Acoba, 2024).

Friends Support. It is the perceived presence of peers who offer companionship, understanding and assistance in times of need. Unlike family support, that is necessary in times of crisis, friendships are often voluntary making them a crucial source of emotional and social reinforcement (Yang et al., 2021).

Significant Others Support. Significant other support means that you have some special person like spouse, romantic partner or a very close confident, who is always available to provide love, care, support and assistance in hard times. This kind of support is most often characterized by trust, comfort, intimacy, exclusivity, and offering a person reliable source of security (Kořar & Kořar, 2024).

Theoretical Perspective

Theories related to perceived social support are given below.

Main Effect/ Direct Effect Model. Main effect model is a theory in social psychology and health psychology; it explains how social assistance has a direct influence on health and well-being. The main idea of this theory is that how supportive social relationships promotes better mental and physical health outcomes. This happens because supportive relations or ties enhance self-esteem, sense of belonging, emotional stability and positive behaviours (Cohen & Wills, 1985; Lakey & Cohen 2000). PSS in this model is understood as a stable ongoing resource that gives an individual, sense of belongingness, self-worth and security (Lakey & Cohen, 2000).

Additionally, main effect model highlights the role of social integration (the degree to which an individual perceives themselves as part of meaningful relationships. Supportive relationships create an opportunity for emotional exchange, companionship, and shared identity which increase positive affect and reduces feeling of isolations (Cohen, 2004).

Psychological Distress

Psychological distress is a multidimensional construct that demonstrates the emotional suffering a person is experiencing when confronted with stressors that overwhelm coping resources. It is most often characterized by the symptoms such as

anxiety, depression, irritability, and somatic complaints that disturb normal functioning of life and well-being (Mirowsky and Ross, 2003). Psychological distress not always meet diagnostic criteria just like most of the clinically diagnosed disorders, but psychological distress reflects significant discomfort and impaired psychological adjustment. It is considered a transdiagnostic indication of mental health in both clinical practices and research (Kessler et al., 2002). This concept is highly relevant in psychology because it connects environmental stressors, personality traits, and mental health outcomes.

The definition of psychological distress is a condition of emotional pain that is usually accompanied by signs of anxiety and sadness (Drapeau et al., 2012). These indicators include sadness, restlessness, hopelessness, and loss of sense of control over life circumstances. It may also overlap with psychiatric disorders, psychological distress is usually conceptualized as continuum rather than a categorical condition, ranging from mild to severe experiences (Ridner, 2004).

Dimensions of Psychological Distress

Psychological distress is not a unitary construct, rather it has several dimensions that are discussed below.

Emotional Dimension. The subjective sense of unease and suffering that a person feels when confronted with challenges or pressure is what defines the emotional dimension of psychological distress. These emotions mostly include sadness, anxiety, fear, irritability, and feelings of hopelessness. These emotional states diminish an individual's ability to regulate mood and may create a sense of being overwhelmed by circumstances (Mirowsky and Ross, 2003).

Cognitive Dimension. This dimension includes maladaptive thought patterns, impaired concentration, and persistent negative thinking about self or future. People suffering from psychological distress often experience cognitive distortions like excessive worry, indecisiveness, rumination and self blame (Brailovskaia et al., 2020). These distorted cognitions may elevate emotional distress and interfere with problem-solving and decision-making abilities (Hill et al., 2022). Addressing cognitive aspects through different interventions such as cognitive behavioural therapy (CBT) can significantly reduce distress and improve resilience (Brailovskaia et al., 2020).

Behavioural Dimension. This dimension reflects the ways psychological distress manifests in actions and observable conduct. Distressed individuals may withdraw socially, avoid responsibilities, show irritability or demonstrate aggression. People may adopt maladaptive copings like substance use, overeating, or procrastination (Ridner, 2010). These activities worsen the negative impacts of distress by interfering with interpersonal relationships, academic or professional performance, and general quality of life.

Somatic Dimension. This dimension highlights the physical expressions of psychological distress, which are often linked to body's stress response. Its common symptoms include headaches, fatigue, muscle tension, gastrointestinal problems and disturbance in eating and sleep schedule (Ben-Zur, 2019). These psychosomatic complaints demonstrate the mind and body connection, where psychological strain translates into psychological discomfort.

Theoretical Perspective

There are different theories that work on the perspective of psychological distress two of them are given below.

Stress and Coping Theory. Lazarus and Folkman (1984) created stress and coping hypothesis, which describes how individuals evaluate and handle stressful

circumstances. According to this model, stress results from an individual's perception that environmental demands are exceeding their personal and social resources. This process involves primary appraisal, where individuals evaluate whether an event or situation is threatening or not, and secondary appraisal in which they evaluate their resources and coping mechanisms to deal with those circumstances. So, stress is not only determined by external events but by the person-environment interaction and their subjective interpretation of those events (Biggs et al., 2017).

According to this perspective, coping refers to behavioural and cognitive strategies for handling demands whether internal or external that are thought to be burdensome or beyond one's capacity. Coping is divided into two categories; emotion-focused coping, which attempts to control emotional suffering, and problem focused coping which focuses on source of stress (Lazarus & Folkman 1984). Contemporary research expands this framework by acknowledging the role meaning-focused and avoidance coping strategies (Compas et al., 2017). The context, individual resources, and social support network all affect how well a coping strategy works. According to recent research, adaptive coping techniques including asking for help and rephrasing difficulties can lessen psychological distress and enhance well-being (Guo et al., 2022).

Perceived Social Support, Religious Coping and Psychological Distress in Medical Students

Due to workload, academic pressure, and emotional tiredness medical students frequently suffer significant levels of psychological discomfort which can have detrimental impact on their mental health (Quek et al., 2019). Perceived social support has a protective effect, that it offers emotional reassurance, minimizes feelings of loneliness and increases coping ability during stressful experiences (Rathakrishnan et al., 2022). Additionally, in religious coping faith-based strategies like prayer, it has been discovered that among medical students suffering hardships, faith in God and spiritual contemplation can reduce stress and foster resilience (Mahfoud et al., 2023). Literature has shown that students who have a high level of social and religious support exhibit less anxiety, depression, and burnout, and that the holistic nature of the support system in medical training is significant (Quek et al., 2019). Peer networks can thus be strengthened, and spiritual well-being programs should be integrated to improve psychological health and academic achievement of medical students.

Literature Review

Below is the literature review of religious coping, perceived social support and psychological distress

Religious Coping and Perceived Social Support

Mesidor and Sly (2019) investigated the effects of religious coping, general coping techniques, perceived social support, PTSD symptoms, resilience, and posttraumatic growth on the 2010 Haitian earthquake survivors. A total of 256 Haitian college students were participant of the study residing in temporary tents, with 58.1% male having age ranging from 18 to 60. The study's goal was to investigate the relationship between survivors' posttraumatic growth and coping mechanisms, resilience, perceived social support, and PTSD symptoms. The study's findings demonstrated that resilience, perceived social support, active coping, and positive religious coping all strongly predicted posttraumatic growth, with positive religious coping being the most powerful predictor. Future implications suggest that research should explore cultural and spiritual factors influencing posttraumatic growth using mixed methods and validated assessment tools for Haitian population

Dalmida et al. (2013) investigated the psychological health of HIV/AIDS patients and the significance of social support and religious coping. The study's goal was to find out how social support and religious coping connect to symptoms of depression and health outcomes in persons living with AIDS/HIV (PLWHA). The sample include 292 people living with AIDS/HIV recruited from clinics and AIDS-service organizations in Southeastern United states. The study discovered that depressed symptoms were prevalent among PLWHA and were associated with worse health outcomes, with little social support and bad religious coping raising the likelihood of depression. Future efforts should focus on integrated care where health care providers address PLWHA's mental, social and spiritual needs to improve overall HIV outcomes.

Perceived Social Support and Psychological Distress

Zhang et al. (2018) studied the influence of resilience and perceived social support, as well as the moderating function of gender in the prevalence of psychological distress among Chinese college students. The study used a cross-sectional design including 1400 college students from 13 universities across six provinces in China. The study's findings demonstrated a correlation between college student's perceived social support and resilience and their level of psychological distress, while resilience being more influential for males and social support more significant for females. Future interventions must focus on enhancing resilience in male students and strengthening social support networks for female students to effectively reduce psychological distress.

Ye et al. (2008) investigated how social support affected patients receiving peritoneal dialysis's anxiety and depressed symptoms brought on by psychological stress. The study's objective was to investigate the relationship between anxiety and depression in patients with end-stage renal disease (ESRD) and psychological stress and social support. ESRD patients receiving peritoneal dialysis for a minimum of a year were included in the study, which used structured questionnaires to gather information on demographics, medical history, psychological stress, social support, and emotional symptoms. The study discovered that higher psychological distress enhanced anxiety and depression symptoms in peritoneal dialysis patients, while stronger social support helped to alleviate these symptoms.

Religious Coping and Psychological Distress

Fatima et al. (2021) investigated the mediated connections between self-control, psychological distress, and religious coping among Muslim men and women in Lahore. This study looked at whether self-regulation mediates the relationship between psychological distress and both positive and negative religious coping, as well as if these mediated associations vary by gender among young Muslim adults. The study included 247 young Muslim adults aged 19-28, with balanced gender representation and stringent exclusion criteria to assure a healthy, educated south Asian population. The study's findings demonstrated that the association between religious coping and psychological discomfort is mediated by self-regulation, with positive coping lowering stress and anxiety and negative coping raising stress. These effects were more pronounced in males than in women. This suggests that future research should cover a range of age and socioeconomic groups to investigate if the links between religious coping, self-regulation, and psychological distress alter across developmental and cultural contexts.

Rationale

Medical students tend to be under a lot of academic stress, emotional pressure and heavy workloads, which makes them highly susceptible to psychological distress

(Dahlin et al., 2010). Psychological distress, which is defined by anxiety, depression, and emotional exhaustion, may negatively impact academic performance, relationships with other people, and overall well-being (Dyrbye et al., 2014). Coping mechanisms and social resources are important in the environment where students are exposed to stress to define the way students cope and adjust to stress. Some of these strategies that have been proven to be significant are religious coping and perceived social support, which are protective strategies that lessen the detrimental effects of stress and improve psychological resilience.

Religious coping is the use of religious rituals and beliefs to deal with challenges in life (Pargament, 1997). Positive religious coping strategies, such as praying, seeking spiritual assistance, or finding religious meaning, were associated with higher standards of emotional stability and lower levels of psychological distress (Ano & Vasconcelles, 2005). However, negative religious coping, such as feeling punished by God or not believing in God, can exacerbate suffering and hinder emotional adjustment (Pargament et al., 1998). Religion may provide a model of meaning-making and emotional resilience to medical students whose occupation usually subjects them to suffering and moral dilemma (Lee et al., 2020).

Perceived social support, or the notion that one gets stable emotional and practical assistance from family, friends, and significant people, has been uniformly associated to better mental health outcomes (Zimet et al., 1988). The perceived social support could work against the stressful impact due to high perceived levels that prevent a sense of belonging, self-worth, and security (Cohen and Wills, 1985). Social support can be an important moderator between psychological distress and medical students who tend to experience loneliness and academic rivalry (Tempski et al., 2012).

The relationship between religious coping, perceived social support, and psychological distress is one of the most important spheres that should be considered more thoroughly, especially in collectivist cultures, such as the one in Pakistan, which place a significant cultural emphasis on religion and social relations. Although faith and community play a key role in coping behaviours, very few studies have focused on the interaction of these variables among the Pakistani medical students. This relationship can be of great value in the understanding of mental health intervention, which is culturally sensitive and has been designed to provide better coping mechanisms and psychological well-being among the upcoming healthcare providers.

Thus, the study's goal is to examine the relationship between medical students' psychological distress, perceived social support, and religious coping, hence it is expected to contribute to the ever-increasing body of literature concerning mental health and coping behavior in academic and clinical settings. The study aims to inform the practices in counselling, student support and policy frameworks of medical education by identifying the protective factors that help reduce distress.

Objectives of the Study

Following are the objectives of the study:

1. To investigate the relationship between religious coping, perceived social support and psychological distress in medical students.
2. To investigate the moderating role of perceived social support in the relationship between religious coping and psychological distress in medical students.

Hypotheses

Below are the hypotheses of the study:

1. There is likely to be correlation between religious coping, perceived social support and psychological distress in medical students.

2. Religious coping (positive and negative) is likely to predict psychological distress in medical students.
3. Perceived social support is likely to predict psychological distress in medical students.
4. Perceived social support will moderate the relationship between positive and negative religious coping and psychological distress in medical students.

Method

In this chapter research design, sample and sampling technique, assessment metrics, process, and ethical considerations are included.

Research Design

The current study used a correlational research approach to examine the association between medical student’s perceived social support, religious coping, and psychological distress.

Sample

Sample consisted of 200 medical students (N=200), having a mean age of 18–25 years (M=21.91, SD=1.81). There were 116 female pupils and 83 male students. Data from public and private colleges was collected through purposive sampling based on following criteria:

Table 1 provides descriptive data for the demographic variables.

Table 1

Descriptives of demographics (N=200).

Variables	N (%)	M (SD)
Age		21.91 (1.81)
Gender		
Male	83 (41.5)	
Female	116 (58)	
Family System		
Nuclear	163 (81.5)	
Joint	37 (18.5)	
Birth order		
Eldest	57 (28.5)	
Middel Child	91 (45.5)	
Younger Child	52 (26)	
Residing in		
Hostel	118 (59)	
With family	82 (41)	

Institution Status	
Public	58 (29)
Private	142 (71)
Degree Program	
MBBS	155 (77.5)
BDS	45 (71)
Study Year	
First	56 (28)
Second	24 (12)
Third	75 (37.5)
Fourth	31 (15.5)
Fifth	14 (7)

Operational Definitions of Variables

Operational definitions of study variables are given below.

Perceived Social Support. In difficult or stressful situations, it reflects a person's subjective viewpoint on evaluation of the quantity, accessibility, and sufficiency of assistance they receive from friends, family, and important people. It depicts one's impression rather than the actual help received and serves as an essential protective barrier against psychological suffering. Perceived social aid/support is a conceptualisation of how much people believe they are loved, cared for, and appreciated by others (Zimet et al., 1988). The Multidimensional Scale of Perceived Social Support (MSPSS), which gauges the assistance of three important sources, friends, family, and significant others is based on this operational concept of perceived social support.

Religious Coping. The use of religious practices, resources, and beliefs to comprehend and deal with challenging life circumstances and emotional problems is known as religious coping. It is determined by one's capacity to turn to religion for solace, direction, and purpose during difficult times. According to current research, religious coping refers to the extent to which individuals use positive religious coping (seeking spiritual support, forgiveness, or religious reassessment) and negative religious coping (spiritual discontent or being punished by God) to deal with stress (Pargament et al., 2000). The Brief Religious Coping Scale (Brief RCOPE), created by Pargament et al. (1998), which assesses both positive and negative religious coping, serves as the foundation for this operational definition.

Positive Religious Coping. It explains the application of positive, faith-based approaches that demonstrate a consistent relationship with God, a spiritual association, positive religious evaluations, and adaptive attempts to find spiritual sustenance in difficult situations. It is measured in this study using the Brief RCOPE items 1 through 7; high scores indicate high adaptive and faith-enhancing coping (Pargament et al., 2011).

Negative Religious Coping. It is characterized by dysfunctional religious coping mechanisms, spiritual tension, animosity against God, feelings of spiritual punishment and discontent, and ambiguity about religion. Negative religious coping is

measured by the final seven questions of the Brief RCOPE; higher scores imply greater conflict and suffering (Pargament et al., 2011).

Psychological Distress. A. It is the degree to which people suffer emotionally because of encountering stressful situations in their life and is typified by symptoms of stress, anxiety, and sadness. It is a subjective condition of mental discomfort that usually interferes with our daily functioning and involves feelings of tiredness, stress, and despair (Mirowsky & Ross 2002), The operational definition of psychological discomfort is based on the total items of the Kessler psychological distress scale (K10) (Kessler et al., 2002).

Assessment Measures

Assessment instruments for the present study are given below.

Demographic Sheet. It included age (in years), no. Of siblings, area of residence, birth order, family income, family system, employment status, name of college, status of institute (public or private), degree program name (MBBS or BDS), year of study and previous year percentage.

Multidimensional Scale of Perceived Social Support (MSPSS). It is developed by Gregory D. Zimet and colleagues in 1988. This scale is used to gauge perceived social support. A 7-point Likert scale, with 1 denoting "strongly disagree" and 7 denoting "strongly agree," is used for this assessment. The scale's twelve components are split into three subscales that assess support from friends, family, and significant others. With a reliability of 0.88, this scale is extremely dependable. Completing this scale takes three to five minutes (Zimet et al., 1988).

Brief Religious Coping Scale (Brief RCOPE). It is a scale that is formulated by Kenneth I. Pargament and his friends in 1998 but its brief version was given in 2000 again by Pargament et al. It consists of 14 items, which again are separated into two subscales, one scale that is used to measure the positive religious coping, and the other one that measures negative religious coping. It is a 3-point Likert scale in the course of which zero implies the not at all and 3 showed great deal. In both positive and negative religious coping, there is a high rate of reliability (0.92 and 0.81 between the subscales, respectively) in the measure (Pargament et al., 2011).

Kessler Psychological Distress Scale (K10). In 2002, Ronald C. Kessler developed the K10 as part of the U.S. National Health Interview Survey (NHIS) and the World Health Organization World Mental Health (WMH) Surveys. This scale is used to gauge psychological distress symptoms like depression and anxiety, consists of ten items. For this, 5-point Likert scale is employed, with 1 representing never and 5 always. This scale's reliability, which falls between 0.93 and 0.94, is regarded as good. The scale takes three to four minutes to complete (Kessler et al., 2002).

Procedure

Before starting data collection all the preliminary measured were considered. First of all, permission letter from COMSATS University's Head of Humanities department was shown to targeted medical colleges for the purpose of data collection. In order to obtain approval, the college administration was informed of the study's objectives. The questionnaires were filled from 2 private medical colleges and 2 public sector colleges. 200 medical students were chosen using purposive sampling, and the researcher gave a brief introduction, explained the goal of the study, and the participants were reassured that their data is safe and will be kept confidential and anonymous. It was insured to them that their participation is entirely voluntary and they can withdraw anytime.

Firstly, the researcher went to college A that was a private institution and took permission from the principle of the college and was only given access to college cafeteria, common room and then data was collected randomly. After that, the researcher went to college B that was also private institution, the permission was granted from the registrar, he then restricted the researcher to enter classes and labs, then data was collected randomly. Data from public sector institution was also gathered the same way and the questionnaires were distributed randomly among students roaming around in college premises.

The whole data collection was done in 3 weeks, with the total number of 200 questionnaires were filled from all the colleges. And the response rate was low because of the tough and busy schedules of medical students. The college administrations and students were recognized for their support and cooperation for the purpose of data collection, and researcher also thanked every participant for their participation. Ultimately, the gathered data was examined and analysed, the findings are discussed.

Ethical Considerations

Following were the ethical concerns, that were kept in mind for the study.

- Autonomy of the participant was prioritized, informed consent from each participant was obtained and all the necessary information was provided to them, and all the queries were addressed.
- The researcher adhered to the guidelines, and confidentiality and anonymity was ensured of the participant's information.
- The study did not cause harm to anyone associated to it.
- The study maintains the anonymity and no participant were compelled to disclose their personal information.
- The study strictly used the gather data for research purposes only.

Results

The data was examined using SPSS version 27. Research factors and demographics were statistically analysed using descriptive statistics. Cronbach Alpha was used to evaluate the scales' internal consistency. First, Pearson correlation was used to evaluate the relationship between psychological discomfort, perceived social support, and religious coping. Perceived social support was then assessed as a moderator in the relationship between psychological suffering (distress) and both positive and negative religious coping using hierarchical regression.

The descriptives and Cronbach's alpha are shown in Table 2.

Table 2

Descriptives and Reliability of Study Variables (N=200)

Study Variables	k	a	M	SD	Range
Religious Coping	14	.79	23.83	6.50	0-42
Positive Religious Coping	7	.91	16.26	4.4	0-21
Negative Religious Coping	7	.85	7.57	5.11	0-21
Perceived Social Support	12	.92	56.15	16.0	12-84
Psychological Distress	10	.92	28.19	9.39	10-50

Note. k=Number of items, a=Reliability, M= Mean, SD= Standard Deviation.

According to Ursachi et al., (2015), reliability is considered acceptable if it is between 0.6-0.7, but if the reliability is 0.8 or above then its is considered very good. Present study variables psychological distress, religious coping and perceived social support show above 0.6 indicating strong reliability for overall scale, also all the subscales also indicated good reliability above 0.8.

It was hypothesised that in medical students, psychological distress, perceived social support, and religious coping would be correlated.

Table 3 displays the correlation between research variables and demographics.

Table 3

Correlation of Demographics with Study Variables (N=200)

Study Variables	1	2	3	4	5	6	7
1.Age	–						
2.Gender	-.44**	–					
3.Year of Study	.75**	-.19**	–				
4.Positive Religious Coping	-.12	.27**	-.04	–			
5.Negative Religious Coping	.20**	-.16*	-.04	-.07	–		
6.Perceived Social Support	.01	-.06	-.01	.08	-.09	–	
7.Psychological Distress	.05	.05	.08	.06	.32**	-.17*	–

Note. *p<0.05, **p<0.01

The above table revealed that age showed negative correlation with age and positive correlation with negative coping. Meanwhile gender had positive favourable correlation with positive religious coping, but gender showed negative relation with negative coping indicating that men show more negative religious coping. On the other hand, negative religious coping was positively correlated with psychological suffering (distress), similarly perceived social support showed positive relation with distress. This led to partial acceptance of hypotheses.

It was hypothesized that relationship between psychological distress, positive and negative coping will be moderated by perceived social support. Table 4 uses hierarchical regression to show moderation.

Table 4

Hierarchical regression analysis for psychological distress, positive and negative religious coping and perceived social support. (N=200)

Variables	B	95% CL for B		SE B	β	R ²	ΔR ²
		LL	UL				
Step 1							.11***
Constant	28.19						
Positive Religious Coping	.81	-.43	2.06	.63	.08		
Negative Religious Coping	3.04***	1.7	4.29	.63	.32		
Step 2							.02*

Constant		28.19						
Positive Religious Coping		.92	-.31	2.16	.63	.09		
Negative Religious Coping		2.92***	1.68	4.16	.63	.31		
Perceived Social Support		-1.4*	-2.65	-.165	.63	-.15		
Step 3							.13***	.00
Constant		28.24						
Positive Religious Coping		.89	-.38	2.1	.64	.09		
Negative Religious Coping		2.91***	1.66	4.1	.63	.31		
Perceived Social Support		-1.38*	-2.63	-.12	.64	-.15		
Positive coping× Social Support		-.24	-1.29	.81	.53	-.03		
Negative coping× Social Support		.35	-.87	1.58	.62	.04		

Note. B= Unstandardized Regression Coefficient, SE= Standard Error, β = Standardized Regression Coefficient, CI= Confidence Interval; UL= Upper Limit; LL= Lower Limit.

The moderation table showed that how relation of psychological distress, positive and negative coping is moderated by perceived social support. Entire model explains 13.3% variance in psychological distress $F(5, 194) = 5.95, P < .001$. Upon adding negative and positive religious coping, Model 1 revealed an 11% variation in psychological distress $F_{change}(2,197) = 12.02, p < .001$. It demonstrated that psychological discomfort (distress) was positively predicted by negative religious coping. In Model 2, perceived social support was added and showed 2% variance in psychological distress, the increase in variance was significant $F_{change}(1,196) = 4.99, p = .027$. Perceived social support negatively predicted psychological distress. In Model 3, when the interaction terms were added the model further improved to 0% to the model $F_{change}(2,194) = 0.24, p = .79$. This showed that interaction terms of negative coping and social support, positive coping and perceived social support were not significant. The moderation hypothesis was therefore rejected.

Summery of Results

- The correlation analysis reported that perceived social support showed negative correlation with distress meanwhile, negative religious coping showed significant positive relation with psychological distress.
- Psychological distress was significantly positively predicted by negative religious coping. Because it suggested a lower level of psychological discomfort, psychological distress was found to be predicted by perceived social support.
- The moderation analysis showed that moderation was not established because neither of the interaction terms showed significance.

Discussion

The central aim of this study was to examine the relation in medical students' psychological distress, perceived social support, and religious coping. Perceived social support has been shown to moderate the relation between psychological suffering and religious coping. Descriptive analysis, addition t-test, moderation utilising hierarchical regression, and Pearson correlational analysis were thus carried out. The findings and hypothesis of the present study are discussed in the context of previous literature.

The main hypothesis of the study was that psychological distress, perceived social support, and religious coping both positive and negative would be strongly correlated. This concept was assessed using Pearson correlation analysis. The findings showed that good religious coping had no relation with any of the variables, negative religious coping had a significant positive correlation with psychological distress, and perceived social support had a negative relationship with psychological distress. As the hypothesis was partially approved which means that men had higher negative religious coping. The findings are also validated by earlier studies, such as those by Pirutinsky (2024), showed that negative coping was generally stable but increased during stressful situations. Additionally, people having more negative religious coping reported more depressive symptoms regardless of their circumstances. Furthermore, a different study found that social support lowers stress and enhances mental health in adults, demonstrating that lower levels of stress, anxiety, and depression are linked to higher levels of social support (Acoba, 2024). Positive religious coping might not mitigate psychological symptoms in all populations, according to another result that found no relation in positive religious coping and psychological distress (Dolan et al., 2021). Another research revealed that, even after adjusting for family structure, income, and education, women were considerably more likely than males to adopt constructive (positive) religious coping. This implies that women use religion and spirituality more frequently as a coping strategy when faced with stressful circumstances (Ahmad & Jafree, 2023).

The second hypothesis of this study is that psychological distress in medical students will be predicted by negative and positive religious coping. Negative coping is associated with higher levels of worry, anxiety, depression and is also a substantial predictor of psychological distress, according to earlier studies (O'Brien et al., 2018; Liu et al., 2021). The previous literature demonstrated that psychological suffering (distress) was strongly positively predicted by bad religious coping. According to another study, negative religious coping leads to spiritual conflict, guilt, and fear, all of which greatly increase stress, anxiety, and depression. Across a variety of demographics, these maladaptive religious interpretations regularly show up as predictors of increased psychological suffering (Abu-Raiya et al., 2011; Exline et al., 2014; Pargament et al., 2001).

The study's third hypothesis was that psychological distress would be predicted by perceived social support. The results demonstrated that a lower level of psychological discomfort is highly predicted by social support, which is a negative determinant (predictor) of psychological distress. The notion is greatly supported by existing literature, as Dour et al. (2013) studied that higher perceived social support resulted in greater reduction in depression and a lesser degree of anxiety by the time following treatment, indicating that social support helps reduce psychological distress. Another study suggests that psychological discomfort (distress) is negatively related with perceived social support and that students with greater levels of stress, anxiety, and depression can benefit from perceived social support (Bukhari & Afzal, 2017).

The last hypothesis of the study was that the relationship between psychological distress and both positive and negative religious coping will be attenuated (moderated) by medical students' views of social support. Hierarchical regression study revealed no moderation between psychological discomfort and religious coping (positive or negative) based on perceived social support. Upon reviewing the literature, no study found out to have social support as a moderator in relation of religious coping (positive and negative) and psychological discomfort (distress). However, a model explains that social support mitigates the detrimental consequences of challenging life circumstances on psychological suffering (distress). Simply said, while under stress, those with better support networks feel less negative emotional impacts (Cohen & Wills, 1985). Positive religious coping may be strong enough to mitigate the negative effects of psychological distress regardless of perceived social support.

For a number of reasons, the current study's findings refute the hypotheses. One of them is that they frequently deal with increased academic pressure, long study sessions, emotional tiredness, and competition, all of which might overshadow the efficacy of coping mechanisms. When people are under prolonged or severe stress, even adaptive strategies like perceived social support and religious coping (positive and negative) may not be able to provide meaningful protective effects. Numerous studies have shown that compared to the general population, medical students frequently display significantly higher levels of anxiety, despair, and burnout (Dyrbye et al., 2006).

As the students are more likely to interpret stress as failure, punishment, or personal inadequacy, coping mechanisms may become less effective under these circumstances, and negative coping may become more prevalent. Therefore, negative religious coping was a significant predictor of psychological discomfort (distress) in the current study, but positive religious coping was not. The enormous emotional and academic burden is more likely to limit the ability to use constructive coping mechanisms to lessen suffering.

Second reason is that the nature of the support medical students typically receives. Most of the students received “perceived” support rather than strong functional or instrumental support, it means that they feel emotionally supported but do not receive that practical assistance to manage academic or psychological stress. According to relational regulation theory, only strong functional and frequent social interactions create meaningful changes in psychological outcomes (Lahey & Orehek, 2011). Because perceived social support in this sample way may have been more emotional than practical, it might not have been powerful enough to mitigate the relationship between distress and both good and negative religious coping. Moreover, academic culture of medical colleges often restricts students from engaging consistently with support systems further weakening the moderating effect.

Third reason is that the coping strategies included may exhibit temporal variability means that their effectiveness may change over time depending on situational demands. Like, positive religious coping may provide short term relief during acute stress but may not significantly reduce chronic distress caused by academic pressures. In the same way, social support can be more effective in crisis cases compared to an unchanging moderating factor. Research indicates that context and timing of coping and support use determine their outcomes on psychological outcomes critically (Folkman & Moskowitz, 2004).

Conclusion

This study sought to determine the relationship between medical student's perceived social support, psychological discomfort (distress), and religious coping, a population that is known to face increased academic pressure, emotional strain, and burnout. The results of the study showed that there was no moderating effect of perceived social support on the relationship between psychological distress and religious coping (both positive and negative), but there was a strong positive correlation between psychological suffering (distress) and negative religious coping. While negative correlation between psychological discomfort (distress) and perceived social support. This study will medical students improve their psychological health and resilience by strengthening supportive networks and addressing maladaptive coping mechanisms.

Limitations

The limitations for the present study are.

1. The sample size of 200, which is insufficient to detect interaction effects, reducing the statistical power for moderation analysis.
2. The research's conclusion are self-report data which indicates that there is likely to be a social desirability bias.

Suggestions

Suggestions for the present study are mentioned below

1. As this research is limited to medical students only, future research can also be done on paramedical or allied health sciences students.
2. As this research is limited to correlational study, future researchers can also use experimental designs.
3. Adapting or developing religious coping scales according to local culture and spiritual context will enhance construct validity.
4. Future researches should assure a larger and more diversified sample size because the sample of 200 limits the generalizability of findings.

Implications

Following are the implications of the study

1. This research will help to implement structured stress management workshops that integrates coping strategies in accordance with students' cultural and religious context.
2. It will help establishing peer monitoring, that can provide functional support, helping students navigate academic pressure. Mentors can offer both emotional and practical guidance, increasing the effectiveness of social support in buffering stress.
3. It will help counselling centres design culturally and religiously sensitive interventions recognizing the local practices of religious coping.
4. Colleges can provide different platforms or mobile apps to provide continuous support and instant access to resources. The traditional social support networks can be supplemented using virtual communities, particularly during high stressors such as exams or clinical rotations.

References

- Abu-Raiya et al., (2011). *Religion and spirituality in coping with stress among Muslims*. *Mental Health, Religion & Culture*, 14(1), 49–62.
- Acoba, E. F., et al. (2024). Social support and mental health: the mediating role of perceived stress. *Frontiers in Psychology*, 15. <https://doi.org/10.3389/fpsyg.2024.1330720>

- Ahmad, S et al., (2023). Influence of gender identity on the adoption of religious spiritual, preventive and emotion-focused coping strategies during the COVID-19 pandemic in Pakistan. *Annals of Medicine*, 55(2), 2291464. <https://doi.org/10.1080/07853890.2023.2291464>
- Ano, G. G et al., (2005). Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of Clinical Psychology*, 61(4), 461–480. <https://doi.org/10.1002/jclp.20049>
- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. International Universities Press.
- Beehr, T. A., Bowling, N. A., & Bennett, M. M. (2010). Occupational stress and failures of social support: When helping hurts. *Journal of Occupational Health Psychology*, 15(1), 45–59. <https://doi.org/10.1037/a0018234>
- Ben-Zur, H. (2019). Coping styles and affect. *International Journal of Stress Management*, 16(2), 87–101. <https://doi.org/10.1037/1072-5245.16.2.87>
- Bewick, B et al., (2010). Changes in undergraduate students' psychological well being as they progress through university. *Studies in Higher Education*, 35(6), 633–645. <https://doi.org/10.1080/03075070903216643>
- Biggs, A et., (2017). Lazarus and Folkman's psychological stress and coping theory. *The Handbook of Stress and Health*, 351–364. <https://doi.org/10.1002/9781118993811.ch21>
- Bonanno, G. A, et al., (2010). Weighing the costs of disaster. *Psychological Science in the Public Interest*, 11(1), 1–49. <https://doi.org/10.1177/1529100610387086>
- Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books.
- Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, 98(2), 310–357. <https://doi.org/10.1037/0033-2909.98.2.310>
- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. Basic Books.
- Brailovskaia, J. Et al., (2020). Psychological distress, coping strategies, and social support among university students: A cross-cultural comparison. *Frontiers in Psychology*, 11, 511. <https://doi.org/10.3389/fpsyg.2020.00511>
- Brancu, M. Et al., (2014). The impact of social support on psychological distress for U.S. Afghanistan/Iraq era veterans with PTSD and other psychiatric diagnoses. *Psychiatry Research*, 217(1–2), 86–92. <https://doi.org/10.1016/j.psychres.2014.02.025>
- Bukhari, N. D. S. R. et al., (2017). Perceived Social Support predicts Psychological Problems among University Students. *International Journal of Indian Psychology*, 4(2). <https://doi.org/10.25215/0402.082>
- Canty-Mitchell, J. Et al., (2000). Psychometric properties of the multidimensional scale of perceived social support in urban adolescents. *American Journal of Community Psychology*, 28(3), 391–400. <https://doi.org/10.1023/a:1005109522457>
- Cardella, L. A. et al., (2004). The Relationship Between Religious Coping and Psychological Distress in Parents of Children with Cancer. *Journal of Psychosocial Oncology*, 22(1), 19–37. https://doi.org/10.1300/j077v22n01_02
- Cassidy, J. et al., (2013). Contributions of attachment theory and research: A framework for future research, translation, and policy. *Development and Psychopathology*, 25(4pt2), 1415–1434. <https://doi.org/10.1017/S0954579413000692>
- Chan, D. W. (2002). Stress, Self-Efficacy, social support, and psychological distress among prospective Chinese teachers in Hong Kong. *Educational Psychology*, 22(5), 557–569. <https://doi.org/10.1080/0144341022000023635>
- Chu, P. S et al., (2010). Meta-analysis of the relationships between social support and wellbeing in children and adolescents. *Journal of Social and Clinical Psychology*, 29(6), 624–645. <https://doi.org/10.1521/jscp.2010.29.6.624>

- Coan, J. A. (2018). Towards a neuroscience of attachment. *Handbook of Attachment: Theory, Research, and Clinical Applications* (3rd ed., pp. 241–262). Guilford Press.
- Cohen, S et al., (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, 98(2), 310–357. <https://doi.org/10.1037/0033-2909.98.2.310>
- Cohen, S et al., (2007). Psychological stress and disease. *JAMA*, 298(14), 1685–1687. <https://doi.org/10.1001/jama.298.14.1685>
- Collins, N. L et al., (2000). A safe haven: An attachment theory perspective on support seeking and caregiving in intimate relationships. *Journal of Personality and Social Psychology*, 78(6), 1053–1073. <https://doi.org/10.1037/0022-3514.78.6.1053>
- Compas, B. E et al., (2017). Coping and emotion regulation from childhood to early adulthood: Points of convergence and divergence. *European Journal of Developmental Psychology*, 14(6), 728–748. <https://doi.org/10.1080/17405629.2016.1182015>
- Dagan, O et al., (2018). Adult attachment representations and depressive symptoms: A meta-analysis. *Journal of Affective Disorders*, 236, 274–290. <https://doi.org/10.1016/j.jad.2018.04.091>
- Dalmida, S. G et al., (2013). The Psychological Well-Being of People Living with HIV/AIDS and the Role of Religious Coping and Social Support. *The International Journal of Psychiatry in Medicine*, 46(1), 57–83. <https://doi.org/10.2190/pm.46.1.e>
- Dolan, J. G et al., (2021). Association of psychological distress and religious coping tendencies in parents of children recently diagnosed with cancer: A cross sectional study. *Pediatric Blood & Cancer*, 68(7), e28991. <https://doi.org/10.1002/pbc.28991>
- Dour, H. J et al., (2013). Perceived social support mediates anxiety and depressive symptom changes following primary care intervention. *Depression and Anxiety*, 31(5), 436–442. <https://doi.org/10.1002/da.22216>
- Drapeau, A et al., (2012). Epidemiology of psychological distress. In L. L'Abate (Ed.), *Mental illnesses – Understanding, prediction and control* (pp. 105–134). IntechOpen. <https://doi.org/10.5772/30872>
- Dyrbye, L. N. et al., (2006). Systematic review of depression, anxiety, and other indicators of psychological distress among U.S. and Canadian medical students. *Academic Medicine*, 81(4), 354–373. <https://doi.org/10.1097/00001888-200604000-00009>
- Dyrbye, L. N et al., (2014). Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Academic Medicine*, 89(3), 443–451. <https://doi.org/10.1097/ACM.000000000000134>
- Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196(4286), 129–136. <https://doi.org/10.1126/science.847460>
- Exline, J. J et al., (2014). *Anger toward God: Measurement and implications for adjustment*. *Journal of Personality and Social Psychology*, 106(1), 30–46.
- Fadilpasic, S et al., (2017). Relationship of religiousness and religious coping with quality of life among war trauma survivors. *Psychiatria Danubina*, 29(3), 291–301. <https://doi.org/10.24869/psyd.2017.291>
- Fatima, S et al., (2021). Mediated associations between religious coping, Self-Regulation, and psychological distress vary for young Muslim men and women in Lahore, Pakistan. *Journal of Religion and Health*, 61(1), 109–124. <https://doi.org/10.1007/s10943-021-01413-4>
- Feeney, J. A. (2019). Adult romantic attachment: Developments in the study of couple relationships. *Annual Review of Psychology*, 70, 387–410. <https://doi.org/10.1146/annurev-psych-010418-103503>

- Fierloos, I. N et al., (2022). Socio-demographic characteristics associated with perceived social support among parents of children aged 0–7 years: The CIKEO study. *BMC Public Health*, 22, 2441. <https://doi.org/10.1186/s12889-022-14830-1>
- Fischer, P et al., (2010). The Relationship between Religious Identity and Preferred Coping Strategies: An Examination of the Relative Importance of Interpersonal and Intrapersonal Coping in Muslim and Christian Faiths. *Review of General Psychology*, 14(4), 365–381. <https://doi.org/10.1037/a0021624>
- Folkman, S et al., (2004). Coping: pitfalls and promise. *Annual Review of Psychology*, 55(1), 745–774. <https://doi.org/10.1146/annurev.psych.55.090902.141456>
- Gillath, O et al., (2016). *Adult attachment: A concise introduction to theory and research*. Academic Press.
- Goldberg, D et al., (1988). *A user's guide to the General Health Questionnaire*. NFER Nelson.
- Guo, Y et al., (2022). The relationship between coping styles and mental health among college students: The mediating role of resilience. *Frontiers in Psychology*, 13, 871532. <https://doi.org/10.3389/fpsyg.2022.871532>
- Hartley, C. Et al., (2019). Perceived and Received dimensional support: Main and Stress Buffering effects on dimensions of burnout. *Frontiers in Psychology*, 10. <https://doi.org/10.3389/fpsyg.2019.01724>
- Heaney, C. A et al., (2008). Social networks and social support. In K. Glanz, B. K. Rimer, & K. Viswanath (Eds.), *Health behavior and health education: Theory, research, and practice* (4th ed., pp. 189-210). Jossey-Bass. (Secondary because instrumental support as a subtype is well-defined in these sources.)
- Hill, A., et al. (2022). General psychological distress: Assessed using the DASS-21. *BMC Psychology*, 10, 19. <https://doi.org/10.1186/s40359-022-00728-5>
- Hofmann, S. G et al., (2012). The effect of mindfulness-based therapy on anxiety and depression. *Journal of Consulting and Clinical Psychology*, 78(2), 169–183. <https://doi.org/10.1037/a0018555>
- Hood, R. W et al., (2009). *The Psychology of Religion, Fourth Edition: An Empirical Approach*. Guilford Press.
- House, J. S. (1981). *Work stress and social support*. Addison-Wesley.
- Javaid et al., (2024). Religious Coping and Mental Well-being: A Systematic Review on Muslim University Students.
- Kendler, K. S et al., (1995). Stressful life events and major depression. *American Journal of Psychiatry*, 156(6), 837–841. <https://doi.org/10.1176/ajp.156.6.837>
- Kessler, R. C et al., (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine*, 32(6), 959–976. <https://doi.org/10.1017/S0033291702006074>
- Kim, H. S et al., (2008). Culture and social support. *American Psychologist*, 63(6), 518–526. <https://doi.org/10.1037/0003-066X>
- Koenig, H. G. (2012). Religion, Spirituality, and Health: the research and Clinical Implications. *ISRN Psychiatry*, 2012, 1–33. <https://doi.org/10.5402/2012/278730>
- Koçar, H et al., (2024). The structure of the multidimensional scale of perceived social support: a meta-analytic confirmatory factor analysis. *Cambridge Prisms Global Mental Health*, 11. <https://doi.org/10.1017/gmh.2024.118>
- Krause N. (2011). Religion and health: making sense of a dishevelled literature. *J Relig Health*. 2011 Mar;50(1):20-35. doi: 10.1007/s10943-010-9373-4. PMID: 20614186.
- Lakey, B. Et al., (2000). Social support theory and measurement. In S. Cohen, L. G. Underwood, & B. H. Gottlieb (Eds.), *Social support measurement and intervention: A guide for health and social scientists* (pp. 29–52). Oxford University Press.

- Lakey, B et al., (2008). Low social support and major depression: Research, theory and methodological issues. In K. S. Dobson & D. J. A. Dozois (Eds.), *Risk factors in depression* (pp. 385–408). Elsevier.
- Lakey, B et al., (2011). Relational regulation theory: A new approach to explain the link between perceived social support and mental health. *Psychological Review*, 118(3), 482–495. <https://doi.org/10.1037/a0023477>
- Lazarus, R. S et al., (1984). *Stress, appraisal, and coping*. Springer.
- Liu, J et al., (2021). The association of positive or negative religious coping methods with psychological distress and quality of life among parents of infants with congenital heart disease. *Frontiers in Pediatrics*, 9, 753032. <https://doi.org/10.3389/fped.2021.753032>
- Liu, S. M et al., (2025). Religious coping, social support, and resilience: a comparison of older and younger adults during the COVID-19 pandemic in the United States. *Journal of Religion Spirituality & Aging*, 1–21. <https://doi.org/10.1080/15528030.2025.2530391>
- Lovibond, P. F et al., (1995). The structure of negative emotional states. *Behaviour Research and Therapy*, 33(3), 335–343. [https://doi.org/10.1016/00057967\(94\)00075-U](https://doi.org/10.1016/00057967(94)00075-U)
- Mahfoud, D et al., (2023). The co-moderating effect of social support and religiosity in the association between psychological distress and coping strategies in a sample of Lebanese adults. *BMC Psychology*, 11, 61. <https://doi.org/10.1186/s40359-023-011029>
- Mesidor, J. K et al., (2019). Religious coping, general coping strategies, perceived social support, PTSD symptoms, resilience, and posttraumatic growth among survivors of the 2010 earthquake in Haiti. *Mental Health, Religion & Culture*, 22(2), 130–143. <https://doi.org/10.1080/13674676.2019.1580254>
- Mikulincer, M et al., (2016). *Attachment in adulthood: Structure, dynamics, and change* (2nd ed.). Guilford Press
- Mirowsky, J et al., (2002). Measurement for a human science. *Journal of Health and Social Behavior*, 43(2), 152–170. <https://doi.org/10.2307/3090194>
- Mirowsky, J et al., (2003). *Social causes of psychological distress*. Aldine de Gruyter.
- O'Brien et al., (2018). Positive and negative religious coping as predictors of distress among minority older adults. *International Journal of Geriatric Psychiatry*, 34(1), 54–59. <https://doi.org/10.1002/gps.4983>
- Özbayir, T. (2019). Influence of demographic factors on perceived social support. *Northern Journal of Nursing and Midwifery Research*, 22(2), 80-87. https://doi.org/10.4103/njnmr.njnmr_114_18
- Pargament, K. I. (1997). *The psychology of religion and coping: Theory, research, practice*. Guilford Press.
- Pargament, K. I. (2002). God Help Me: Advances in the Psychology of Religion and Coping. *Archive for the Psychology of Religion*, 24(1), 48-63. <https://doi.org/10.1163/157361203X00219> (Original work published 2002)
- Pargament, K. I. (2011). *Spiritually integrated psychotherapy: Understanding and addressing the sacred*. New York, NY: Guilford Press.
- Pargament, K. I et al., (2022). *Working with spiritual struggles in psychotherapy: From research to practice*. Guilford P
- Pargament, K. I et al., (2013). Understanding and addressing religion among people with mental illness. *World Psychiatry*, 12(1), 26–32. <https://doi.org/10.1002/wps.20005>
- Pargament, K. I et al., (2007). A decade of research on the psychology of religion and coping: Things we assumed and lessons we learned. *Psychology of Religion and Spirituality*, 1(1), 5–20. <https://doi.org/10.1037/1941-1022.S.1.5>

- Pargament, K. I et al., (2011). The Brief RCOPE: Current psychometric status of a short measure of religious coping. *Religions*, 2(1), 51–76. <https://doi.org/10.3390/rel2010051>
- Pargament, K. I et al., (2000). The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology*, 56(4), 519–543. [https://doi.org/10.1002/\(SICI\)1097-4679\(200004\)56:4<519::AID-JCLP6>3.0.CO;2-1](https://doi.org/10.1002/(SICI)1097-4679(200004)56:4<519::AID-JCLP6>3.0.CO;2-1)
- Pargament, K. I et al., (2000/2001). *The many meanings of religious coping*. American Journal of Community Psychology / Journal of Clinical Psychology.
- Pargament, K. I et al., (2000). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion*, 39(4), 710–724. <https://doi.org/10.1111/0021-8294.00071>
- Pargament, K. I et al., (2011). The brief RCOPE: Current psychometric status of a short measure of religious coping. *Religions*, 2(1), 51–76. <https://doi.org/10.3390/rel2010051>
- Park, C. L. (2005). *Religion and meaning*. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 295–314). Guilford Press.
- Park, C. L. (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. *Psychological Bulletin*, 136(2), 257–301. <https://doi.org/10.1037/a0018301>
- Park, C. L. (2013). Religion and meaning. In K. I. Pargament (Ed.), *APA handbook of psychology, religion, and spirituality* (Vol. 1, pp. 357–379). American Psychological Association. <https://doi.org/10.1037/14045-019>
- Park, C. L. (2022). Meaning making in the context of stressful life events: Progress and unresolved issues. *Current Directions in Psychological Science*, 31(4), 311–317. <https://doi.org/10.1177/09637214221083094>
- Park, C. L et al., (2020). Americans' COVID-19 stress, coping, and adherence to CDC guidelines. *Journal of General Internal Medicine*, 35(8), 2296–2303. <https://doi.org/10.1007/s11606-020-05898-9>
- Pirutinsky, S. (2024). Negative religious coping versus spiritual struggles: Moderator or main effect? *Journal of Clinical Psychology*, 80(8), 1780–1796. <https://doi.org/10.1002/jclp.23694>
- Quek, T. T. Et al., (2019). The global prevalence of anxiety among medical students: A meta-analysis. *International Journal of Environmental Research and Public Health*, 16(15), 2735. <https://doi.org/10.3390/ijerph16152735>
- Rashid, I. A et al., (2025b). Religious coping and perceived social support in explaining effects of trait emotional intelligence to ameliorate the psychosocial stress among students. *Mental Health Religion & Culture*, 1–15. <https://doi.org/10.1080/13674676.2024.2425995>
- Rathakrishnan, B et al., (2022). Perceived social support, coping strategies and psychological distress: A study among young adults. *Sustainability*, 14(6), 3250. <https://doi.org/10.3390/su14063250> MDPI
- Reblin, M et al., (2008). Social and emotional support and its implication for health. *Current Opinion in Psychiatry*, 21(2), 201–205. <https://doi.org/10.1097/YCO.0b013e3282f3ad89>
- Ridner, S. H. (2004). Psychological distress: Concept analysis. *Journal of Advanced Nursing*, 45(5), 536–545. <https://doi.org/10.1046/j.1365-2648.2003.02938.x>
- Rotenstein, L. S et al., (2016). Prevalence of depression, depressive symptoms, and suicidal ideation among medical students: A systematic review and meta-analysis. *JAMA*, 316(21), 2214–2236. <https://doi.org/10.1001/jama.2016.17324>

- Rueger, S. Y et al., (2016). A meta-analytic review of the association between perceived social support and depression in childhood and adolescence. *Psychological Bulletin*, 142(10), 1017–1067. <https://doi.org/10.1037/bul0000058>
- Santini, Z. I et al., (2015). The association between social relationships and depression: A systematic review. *Journal of Affective Disorders*, 175, 53–65. <https://doi.org/10.1016/j.jad.2014.12.049>
- Sarason, I. G et al., (2009). Social support: Mapping the construct. In S. Cohen & D. L. McKay (Eds.), *Social support and health* (pp. 45–68). Academic Press.
- Saroglou, V. (2011). Believing, bonding, behaving, and belonging. *Journal of Cross-Cultural Psychology*, 42(8), 1320–1340. <https://doi.org/10.1177/0022022111412267>
- Stallman, H. M et al., (2017). The role of social support, being present, and self kindness in university student psychological distress. *Australian Psychologist*, 53(1), 52–59. <https://doi.org/10.1111/ap.12271>
- Stansfeld, S et al., (2006). Psychosocial work environment and mental health. *Scandinavian Journal of Work, Environment & Health*, 32(6), 443–462. <https://doi.org/10.5271/sjweh.1050>
- Stroebe, M et al., (2017). Health outcomes of bereavement. *The Lancet*, 370(9603), 1960–1973. [https://doi.org/10.1016/S0140-6736\(07\)61816-9](https://doi.org/10.1016/S0140-6736(07)61816-9)
- Sujadi, E et al., (2023). Posttraumatic stress disorder among sexual harassment victims: the role of social support, resilience, and religious coping. *International Journal of Public Health Science (IJPHS)*, 12(2), 846. <https://doi.org/10.11591/ijphs.v12i2.21952>
- Szkody, E et al., (2020). Appraisal and social support as moderators between stress and physical and psychological quality of life. *Stress and Health*, 36(5), 586–595. <https://doi.org/10.1002/smi.2957>
- Taylor, S. E. (2011). Social support: A conceptual analysis. *Journal of Advanced Nursing*, 48(3), 254–264. (Note: Although the original “appraisal/informational” taxonomy is older, this review offers a recent analysis.)
- Thoits, P. A. (2010). Stress and health. *Journal of Health and Social Behavior*, 51(1_suppl), S41–S53. <https://doi.org/10.1177/0022146510383499>
- Thoits, P. A. (2011). Mechanisms linking social ties and support to physical and mental health. *Journal of Health and Social Behavior*, 52(2), 145–161. <https://doi.org/10.1177/0022146510395592>
- Trevino, K. M et al., (2011). Religious coping and psychological distress in military veteran cancer survivors. *Journal of Religion and Health*, 51(1), 87–98. <https://doi.org/10.1007/s10943-011-9526-0>
- Uchino, B. N. (2009). Understanding the links between social support and physical health: A lifespan perspective with emphasis on the separability of perceived and received support. *Perspectives on Psychological Science*, 4(3), 236–255. <https://doi.org/10.1111/j.1745-6924.2009.01122.x>
- Van Dyke, C. J et al., (2009). The relationship of religious coping and spirituality to adjustment and psychological distress in urban early adolescents. *Mental Health Religion & Culture*, 12(4), 369–383. <https://doi.org/10.1080/13674670902737723>
- Watson, D et al., (1984). Negative affectivity. *Psychological Bulletin*, 96(3), 465–490. <https://doi.org/10.1037/0033-2909.96.3.465>
- Wethington, E et al., (1986). Perceived support, received support, and adjustment to stressful life events. *Journal of Health and Social Behavior*, 27(1), 78–89. <https://doi.org/10.2307/2136504>
- Wortmann, J. (2013). Religious Coping. In: Gellman, M.D., Turner, J.R. (eds) *Encyclopedia of Behavioral Medicine*. Springer, New York, NY https://doi.org/10.1007/978-14419-1005-9_665
- Xu, J. (2015). Pargament’s theory of religious coping: Implications for spiritually sensitive social work practice. *British Journal of Social Work*, 46(5), 1394–1410. <https://doi.org/10.1093/bjsw/bcv080>

- Yang, C et al., (2021). How do specific social supports (Family, friend, and specialist) reduce stress in patients with substance use disorders: a Multiple mediation analysis. *Frontiers in Psychiatry*, 12. <https://doi.org/10.3389/fpsy.2021.618576>
- Ye, X et al., (2008). Effect of social support on psychological-stress-induced anxiety and depressive symptoms in patients receiving peritoneal dialysis. *Journal of Psychosomatic Research*, 65(2), 157–164. <https://doi.org/10.1016/j.jpsychores.2008.04.007>
- Zabora, J et al., (2001). The prevalence of psychological distress by cancer site. *Psycho Oncology*, 10(1), 19–28. [https://doi.org/10.1002/1099-1611\(200101/02\)10:1<19::AID-PON501>3.0.CO;2-6](https://doi.org/10.1002/1099-1611(200101/02)10:1<19::AID-PON501>3.0.CO;2-6)
- Zhang, M et al., (2018). Prevalence of psychological distress and the effects of resilience and perceived social support among Chinese college students: Does gender make a difference? *Psychiatry Research*, 267, 409–413. <https://doi.org/10.1016/j.psychres.2018.06.038>
- Zimet, G. D et al., (1988). The Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment*, 52(1), 30–41. https://doi.org/10.1207/s15327752jpa5201_2
- Drageset, J. (2021). *Social support – Health promotion in health care* [Chapter]. In NCBIBookshelf. <https://www.ncbi.nlm.nih.gov/books/NBK585650/>