Shame, Faith, and Mental Health: How Religiosity and Religious Identity Shape Psychological Well-Being

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Abstract

Religion is commonly seen as a source of comfort, support, meaning and guidance for daily life; however, it is important to identify religious beliefs that may elevate risk for feelings anxiety, depression, and shame. Previous literature identifies that shame-proneness and sexual shame have been associated with detrimental psychological outcomes, such as heightened levels of anxiety and depression. The current study explores the relationship between religiosity, shame-proneness, sexual shame and mental health using a sample of 5,064 participants with diverse religious affiliations. Findings of the current study indicate a positive relationship between shame-proneness and mental health outcomes; moreover, sexual shame mediated the relationship between shame-proneness and depression and anxiety. The results of this study draw attention to certain religious affiliations with heightened sexual shame, anxiety, and depression. Moreover, for some religious affiliations, the relationships between shame-proneness, sexual shame, and mental health were exacerbated. These findings denote the importance of addressing both sexual shame and shame-proneness in mental health interventions and can inform research and practice for working with religious populations.

Keywords: religion, shame-proneness, sexual shame, depression, anxiety

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Religiosity has a complex relationship with mental health. There are potential protective effects where religiosity can promote resilience, provide emotional support, and enhance meaning in life (Koenig, 2012; Smith et al., 2003). However, it can also contribute to psychological distress, particularly when it reinforces shame, guilt, and moral incongruence (Exline et al., 2000). High levels of shame are associated with self-criticism, maladaptive coping, and psychological distress especially within religious frameworks (Tangney et al., 1992). Similarly, sexual shame has been linked to self-esteem issues, internalized stigma, and mental health struggles (Brotto et al., 2016; Grubbs et al., 2015). This study examines the effects of religious affiliation on relationships between shame-proneness, sexual shame, depression, and anxiety across ten religious affiliations: Protestant, Catholic, Non-Denominational Christian, Mormon, Muslim, Hindu, Jewish, Buddhist, New Age/Wiccan, and non-religious.

Religiosity

Religiosity influences mental health in both beneficial and adverse ways (Wilt et al., 2022), offering social support through religious activities (Smith et al., 2003), fostering coping strategies (Ladis et al., 2023; Smith et al, 2003), and providing a sense of purpose (Koenig, 2012). However, certain religious beliefs may also contribute to stress, anxiety, depressive symptoms, and psychological distresses surrounding guilt or divine punishment (Booth et al., 2024; Ladis et al., 2023; Martínez de Pisón, 2022; Park, 2016). The effects of religiosity regarding mental health often depend on religious beliefs and how they are internalized (Koenig, 2012; Wilt et al., 2022). For example, some religious teachings associate mental health struggles with moral failure, discouraging mental health treatment (Lloyd & Waller, 2020; Martínez de

Pisón, 2022; Park, 2016). Religious beliefs may also affect various attitudes towards counseling, leading to hesitancy towards engaging if therapy is perceived as conflicting with faith-based solutions (Booth et al., 2024; Kim, 2017).

Religious Beliefs

Various religious backgrounds shape faith-based beliefs about shame and influence attitudes toward seeking treatment (Booth et al., 2024; Collardeau et al., 2023; Kim-Prieto & Diener, 2009; Ladis et al., 2023). Religious beliefs can influence parenting beliefs and practices, family dynamics, and community interactions, which can subsequently interact to influence self-identity and mental health outcomes (Fung et al., 2018; Koenig, 2012). For example, Jewish culture generally views shame as facilitating self-regard and influencing perceptions of morality (Wacks et al., 2023). Help-seeking behavior may be more limited for Muslim individuals, as there is social stigma and the view of mental health as a personal failure or weakness (Dolezal, 2022;). Evangelical Christian culture may contextualize mental health as shameful or sinful (Lloyd & Waller, 2020), viewing vulnerability, and therefore help-seeking, as shameful (Kim, 2017). Considering different religious affiliations have distinct conceptualizations of sin, shame, and mental health, the implications of shame-proneness may vary across religious groups.

Shame-Proneness

While shame can develop in response to perceived personal failures, social disapproval, or moral transgressions (Hassan-Ohayan et al., 2012; Kim, 2017), shame proneness is the relatively stable tendency to experience shame (Cândea & Szentágotai-Tătar, 2018; Ladis et al., 2023). Shame-proneness can be characterized by feelings of inferiority, worthlessness, a sense of falling short, and a desire to hide self-identity (Ladis et al., 2023). Shame-proneness is also associated with poor mental wellbeing, low self-esteem, isolation, and feelings of hopelessness

(Cândea & Szentágotai-Tătar, 2018; Hassan-Ohayan et al., 2012; Ladis et al., 2023; Lundberg et al., 2009) Individuals experiencing shame will often withdraw from social interactions or conceal a mental health diagnosis to prevent judgment, rejection, and stigma related to mental health (Dolezal, 2022; Helmert et al., 2023). Religious perfectionism and scrupulosity can exacerbate psychological distress related to religiosity to intensify shame, particularly in traditions that emphasize sin and divine judgement (Kim-Prieto & Diener, 2009; Martínez de Pisón, 2023). Many individuals who have mental health conditions feel ashamed, hiding their diagnosis due to believing they have done something wrong. Shame surrounding mental health can also lead to negative self-image and humiliation causing more distress (Hasson-Ohayon et al., 2012). However, non-Western perspectives do not always perceive shame negatively (Collardeau et al., 2023), so it is important to examine interaction between shame proneness and religion, to identify potential risk or protective factors in the effects of shame proneness.

Sexual Shame

Sexual shame is a critical component of overall shame proneness and has major implications for mental health while being linked to shame proneness particularly in religious and culturally conservative contexts (Murray et al., 2007; Tangney et al., 1992). Individuals prone to shame often internalize messages that sexuality is morally impure leading to persistent feelings of guilt, self-judgment, and distress (Brotto et al., 2016; Shadbolt, 2009). Sexual shame presents and increases when individuals perceive their sexual thoughts, desires, or behaviors as sinful or socially unacceptable (Shadbolt, 2009) often being reinforced by religious teachings that emphasize sexual purity, sin, and divine judgment (Grubbs et al., 2015). Research suggests that individuals experiencing high levels of sexual shame are more likely to engage in maladaptive coping strategies such as avoidance, suppression, and self-punishment, which

contribute to psychological distress (Deguara, 2019; Estrada, 2022; Exline et al., 2000; Grubbs et al., 2015; Wacks et al., 2023).

Sexual shame has been consistently associated with adverse mental health outcomes indicating that individuals who experience intense sexual shame are at greater risk for depression, anxiety, and lower self-esteem (Brotto et al., 2016). Feelings of inadequacy, guilt, or self-judgment regarding sexual thoughts or behaviors may contribute to heightened anxiety and depression, reinforcing cycles of distress and self-criticism (Cândea & Szentágotai-Tătar, 2018). For individuals from highly religious backgrounds, these struggles are often exacerbated by conflicts between personal experiences and rigid moral expectations (Estrada, 2022; Exline et al., 2000) leading to internalized sexual shame being linked to difficulties in intimate relationships, sexual dysfunction, and feelings of isolation (Grubbs et al., 2015).

Shame and Mental Health

Mental health is a composition of emotional, psychological, and social well-being and is part of an individual's overall health and functioning (CITATION). It can affect daily decisions, emotional responses to an event, and actions when facing a difficult situation (Cândea & Szentágotai-Tătar, 2018). Research suggests increased awareness of personal mental illness had a strong correlation with shame (Hassan-Ohayan et al., 2012), and higher levels of self-compassion reduced the impact of shame-proneness (Cândea & Szentágotai-Tătar, 2018). Specifically, the more symptoms are portrayed publicly, the higher the level of shame, which can ultimately have individual and social implications (Cândea & Szentágotai-Tătar, 2018; Park, 2016;). Pursuing help-seeking behaviors is influenced by personal interpretations of vulnerability, self-stigma, and cultural attitudes surrounding mental health (Collardeau et al.,

2023; Dolezal, 2022); this reluctance to seek treatment often exacerbates stress and emotional suppression which may lead to higher levels of depression and anxiety (Helmert et al., 2023).

Shame-proneness has been previously linked with mental health outcomes. For example, self-criticism and social withdrawn can contribute to depression (Gilbert, 2017; Kim et al., 2011) and anxiety (Cândea & Szentágotai-Tătar, 2018; Fergus et al., 2010). Shame also leads to avoidant behaviors which in turn increase feelings of loneliness (Cândea & Szentágotai-Tătar, 2018), causing an individual to experience persistent self-criticism, rumination, and feelings of hopelessness (Hassan-Ohayan et al., 2012). Moreover, the maladaptive coping strategies related to shame-proneness can drive worry about judgement, rejection, or failure, thus heightening anxiety (Fergus et al., 2010). Shame is associated with increased sensitivity to perceived threats, particularly regarding personal inadequacies, fueling generalized anxiety and hypervigilance (Gilbert, 2017) and is an emotional response leading to depression, avoidance, and hyperarousal (Kim et al., 2011).

Specifically, sexual shame has been linked to both depression and anxiety among individuals from religious backgrounds (Murray et al., 2007) leading to self-stigmatization, relationship difficulties, and avoidance of intimacy, contributing to emotional distress and mental health struggles (Grubbs et al., 2015). Considering trait shame (shame-proneness) can facilitate experiences of state shame (sexual shame), both of which have previously evidenced relationships with mental health outcomes, it is possible that sexual shame plays a mechanistic role in the pathway between shame-proneness and mental health; however, little research has explored the mediating role of sexual shame.

Moreover, there is support for religiosity as a protective factor (Koenig, 2012; Pargament, 1997; Smith et al., 2003); however, there is also previous research articulating shame

and sexual shame derived from religious beliefs or perceived moral failings (i.e., Kim-Prieto & Diener, 2009; Volk et al., 2016). Differing religions, with their diverse prescriptions for behavior and contrasting perspectives on shame and mental health, may either attenuate or exacerbate the relationships between shame-proneness, sexual shame, and psychological outcomes.

The Present Study

The present study examines the relationship between shame-proneness and mental health, disentangling the mediating role of sexual shame and the moderating role of religious affiliation. The study model is provided in *Figure 1,* and the hypotheses are as follows:

H1: Shame-proneness will be positively related with sexual shame (H1a), depression (H1b), and anxiety (H1c).

H2: Sexual shame will mediate the relationship between shame-proneness and depression (H2a) and between shame-proneness and anxiety (H2b).

H3: Religious affiliation will moderate the relationship between shame-proneness and sexual shame (H3a), the relationship between shame-proneness and depression (H3b), and the relationship between shame-proneness and anxiety (H3c).

Methods

Participants and Procedures

Data was collected via Amazon Mechanical Turk (MTurk) across four years: 2017, 2018, 2019, and 2020 resulting in 9,491 individuals that were included in the data. Participants remained anonymous and were compensated $1.50 for completing the survey. Original data collection was approved through the Institutional Review Board (IRB) and adhered to ethical guidelines for informed consent and confidentiality. There were no restrictions on participant ethnicity, and demographic information was self-reported by participants.

This study included 5,064 participants representing ten distinct religious perspectives and encompassed a variety of racial, cultural, and age backgrounds. Participants were fairly equivalent in gender, with most participants identifying as white (71.2%). Ages ranged from 18 to 76 (M = 36.14, SD = 10.9) The original dataset also had participants reporting their religion as Jehovah's Witness, Taoist, or other; however, these were excluded as their small sample size (n < 30) prohibited meaningful group comparison. The demographic description of participants can be found in *Table 1*. Prior studies have pointed out the limitations of MTurk data, particularly after 2018; consequently, thorough data screening was employed to mitigate the weaknesses of MTurk, in line with recommendations (Chmielewski & Kucker, 2020).

Measures

Depression Anxiety Stress Scales

The Depression Anxiety Stress Scales - 21 (DASS-21) is an abbreviated version of the DASS-42, containing 21 items in three subscales, which assess symptoms of depression, anxiety, and stress (Lovibond & Lovibond, 1995). The 7-item depression subscale of the DASS-21 screens for depressive symptoms where respondents self-report the extent to which each statement applies during the past week. The 7-item anxiety subscale is a self-report questionnaire that consists of seven items of the DASS-21, assessing cognitive, psychological and behavioral anxiety. The 7-item stress subscale was not used in the present study. For the subscales of the DASS, participants rate to what extent they have experienced the identified symptom in the pst week on a four-point Likert scale ranging from 0 (Did not apply to me at all) to 3 (Applied to me very much). Responses to each item are summed with higher scores indicating greater levels of depression or anxiety. For example, "I felt that life was meaningless" corresponds to the depression subscale, while "I felt I was close to panic" corresponds to the anxiety subscale.

Reliability in the current study was $\alpha = .93$ for the depression subscale and $\alpha = .91$ for the anxiety subscale.

Test of Self-Conscious Affect

The Test of Self-Conscious Affect-3 (TOSCA) is a self-report scale consisting of 16 situational scenarios designed to measure an individual's proneness to shame, guilt, and anxiety related affect (Tangney et al., 2000). The present study used the shortened 11 scenario version that only includes the negative scenarios. The TOSCA-3 consists of three subscales: Shame-Proneness, Guilt-Proneness, and Externalization with higher scores indicating greater proneness to shame, guilt, or externalization. For example, in response to the scenario "you make a mistake at work and find out a co-worker is blamed for the error," participants would be presented with several responses (i.e., "You would keep quiet and avoid the co-worker") and indicate the likelihood of that response on a five-point Likert scale ranging from 1 (Not likely) to 5 (Very likely). The scale has demonstrated high reliability using the Cronbach's alpha and strong convergent validity with measures of social anxiety and depression (Tangney et al., 2000). In line with the focus of the present study, only the shame-proneness subscale was used. The shame-proneness subscale had acceptable reliability ($\alpha = .78$).

Kyle Inventory of Sexual Shame-9

The Kyle Inventory of Sexual Shame (KISS) Scale is a 20-item scale designed to measure sexual self-consciousness and interpersonal sexual sensitivity, assessing an individual's level of concern and anxiety related to sexual interactions and perceptions (Kyle, 2013). The KISS-9 scale is a shortened version consisting of 9 items (i.e., "I think people would look down on me if they knew about my sexual experiences."), which participants respond on a 5-point Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), with higher scores

reflecting greater sexual self-consciousness and sensitivity (Lim, 2019). The total KISS-9 Sexual Scale score is calculated by summing the item responses, with possible scores ranging from 9 to 45. KISS-9 had good reliability in the current study ($\alpha = .93$).

Data Analysis

Statistical analyses were conducted across four phases using IBM SPSS statistics (Version 30.0). Firstly, the data underwent thorough cleaning to ensure data quality. Participants with patterns of inattentive responding, such as excessive straight-line responses or nonsense responses, were excluded as well as multivariate outliers. Additionally, key assumptions of linear regression were evaluated. In the second phase, bivariate correlations were conducted to explore relationships between variables. Thirdly, a mediation model using Hayes Process (2022) was conducted to explore the extent to which sexual shame mediated the relationship between shame-proneness and mental health (depression and anxiety). Fourthly, a moderated mediation model was conducted to explore the moderating role of religion on the relationships between shame-proneness and the other variables.

Considering the disparate sample sizes in each of the religious groups, the moderating role of religion was explored in two sets of analyses. In the first set of analyseis, religious groups with large sample sizes were included (Protestant, Catholic, Christian non-denominational, and No Religion). The moderated mediation model was then conducted twice, once with depression as the outcome and once with anxiety as the outcome. The ‘No Religion’ group functioned as the reference group for both analyses. In the second set of analyses, religious groups with small sample sizes were included (Mormon, Muslim, Hindu, Jewish, Buddhist, New Age/Wiccan). Additionally, to facilitate comparability of analyses, a subset of the ‘No Religion’ group was included as a reference group for the second set of analyses. Specifically, 10% of the ‘No

Religion' group were randomly selected (n =117) and compared with independent-samples t-tests to ensure they were not significantly different from the larger No Religion group in the key variables of the study. This approach enabled each religious group to be compared with the 'No Religion' group while limiting detractions to statistical power due to unbalanced sample sizes of groups.

Results

Bivariate correlations were conducted using Pearson's zero-order correlations and were consistent with expectations. Shame-proneness had a significant positive relationship with sexual shame (r = .402, p < .001), depression (r = .404, p < .001), and anxiety (r = .344, p < .001), consistent with H1a, H1b, and H1c. Additionally, sexual shame had a significant positive relationship with depression (r = .633, p < .001), and anxiety (r = .679, p < .001). Moreover, depression and anxiety were strongly positive correlated with each other (r = .805, p < .001). Descriptive statistics for each scale in each religious group are summarized in Table 2.

Mediation Model

Two separate mediation models were conducted using Hayes Process (2022; v.4.3, Model 4) to evaluate the mediating role of sexual shame in the relationship between shame-proneness and depression and the relationship between shame-proneness and anxiety. Shame-proneness had a significant positive effect on sexual shame (b = .081, 95% CI = [.076, .086]), which explained 16.1% of the variance in sexual shame. Additionally, shame-proneness (b = .277, 95% CI = [.242, .313]) and sexual shame (b = 4.316, 95% CI = 4.141, 4.491]) had significant positive effects on depression. Moreover, the indirect effect was significant (b = .351, 95% CI = (.242, .313]), indicating sexual shame significantly mediated the relationship between shame-proneness and depression (H2a). The overall model explained 42.7% of the variance in depression.

Similarly, shame-proneness had a significant positive effect on anxiety (*ab* = .129, 95% CI = [.095, .162]), as did sexual shame (*b* = 4.810, 95% CI = [4.647, 4.974]). The indirect effect was also significant, supporting sexual shame as a mediator of the relationship between shame-proneness and anxiety (*ab* = .391, 95% CI = .095, .162]; H2b). The model explained 46.7% of the variance in anxiety.

Moderated Mediation Models

Building on the simple mediation models, the subsequent analyses explored the moderating role of religion on the relationships between shame-proneness, sexual shame, and depression/anxiety. As described above, the analyses were conducted separately for the religious groups based on their sample size. In the first analysis, No Religion, Protestant, Catholic, and Christian Non-denominational participants were included. In the second analysis, Mormon, Muslim, Hindu, Jewish, Buddhist, and New Age/Wiccan were included along with a subset of the No Religion group to enable each religious group to be compared to the No Religion group without unbalanced sample sizes. Continuous predictors (i.e., shame-proneness) were mean-centered prior to analyses to facilitate meaningful interpretation (Hayes, 2022).

Sexual Shame

As summarized in Table 3, for individuals with average shame-proneness, Protestants, Catholics, and Christian non-denominational participants each had significantly higher sexual shame compared to the No Religion group. Additionally, there was a significant interaction between Catholic affiliation and Shame-proneness as well as Christian non-denominational and shame-proneness. The interaction between shame-proneness and religion explained 0.7% of the variance in sexual shame and the overall model explained 30.3% of the variance in sexual shame, providing support for H3a. The conditional direct effects indicate that the effect of

shame-proneness on sexual shame for Catholic participants (b = .095, 95% CI = [.086, .103]) and Christian non-denominational participants (b = .082 95% CI = [.071, .092], was exacerbated compared to the No Religion group (b = .052, 95% CI = [.042, .062]). The effect of shame-proneness on sexual shame was not significantly different for the Protestant group (b = .067, 95% CI = [.055, .078]) compared to the No Religion group. .

When analyses were conducted with the small religious groups, for those with average shame-proneness, Mormon, Muslim, Hindu, and Buddhist affiliation was associated with higher sexual shame compared to the No Religion subset (*Table 4*). Jewish and New Age/Wiccan were not significantly different from the No Religion subset. None of the interaction effects were significant, indicating these religious did not moderate the relationship between shame-proneness and sexual shame. The model explained 24.1% of the variance in sexual shame.

Depression

For depression, Catholics and Christian non-denominational groups were not significantly different from the No Religion group (*Table 3*). However, at average levels of shame-proneness, the Protestant group had significantly lower depression compared to the No Religion group. None of the interaction effects were significant, indicating religion does not moderate the relationship between shame-proneness and depression. The overall model explained 43.7% of the variance in depression.

For the small religious groups (*Table 4*), none of the religious groups were significantly different from the No Religion subset. Additionally, none of the interaction effects were significant, indicating these religious groups were not significantly different from the No Religion subset in terms of the relationship between shame-proneness and depression. The model explained 40.4% of the variance in depression. Thus, H3b was not supported.

Anxiety

For anxiety, Catholics and Christian non-denominational groups had significantly higher anxiety compared to the No Religion group, at average levels of shame-proneness (*Table 3*). Additionally, the interaction effects between shame-proneness and the Protestants, Catholics, and Christian non-denominational groups were each significant. Specifically, Protestants, Catholics, and Christian non-denominational affiliation exacerbated the relationship between shame-proneness and anxiety. In the No Religion group, shame-proneness did not have a significant effect on anxiety. In contrast, in the Protestants, Catholics, and Christian non-denominational groups shame-proneness had a significant positive effect on anxiety. The interaction effect explained 0.4% of the variance in anxiety, with the overall model explaining 50.3% of the variance in anxiety, providing partial support for H3c.

With the small religious groups, when shame-proneness was average, Muslim, Hindu, and Buddhist affiliation was associated with higher levels of anxiety compared to the No Religion subset (*Table 4*). Mormon, Jewish, and New Age/Wiccan were not significantly different from the No Religion subset. Additionally, there was a significant interaction between Muslim affiliation and shame-proneness, indicating the relationship between shame-proneness and anxiety was significantly different for Muslims compared to the No Religion subset (H3c). Specifically, for the No Religion subset, there was not a significant effect of shame-proneness on anxiety (b = .049, 95% CI = [-.155, .253]). However, for the Muslim group, the conditional direct effect of shame-proneness on anxiety was significant (b = .409, 95% CI = [.122, .696]). The Hindu group also had a significant direct effect between shame-proneness and anxiety (b =.261, 95% CI = [.054, .468]); however, it was not significantly different from the No Religion group, as the interaction effect was insignificant (b = .212, 95% CI = [-.072, .496]).

Moderated Mediation

Table 5 summarizes the relative indirect effects for all proposed moderated mediation models. Across all analyses, each religious group had a significant indirect effect for both pathways, indicating sexual shame mediated the relationship between shame-proneness and depression, and shame-proneness and anxiety, regardless of religious affiliation. However, indices of moderated mediation were significant for Catholics and Non-denominational Christians, indicating the indirect effect of shame-proneness on both depression and anxiety, mediated by sexual shame, was exacerbated for Catholics and Non-denominational Christians compared to the No Religion group.

Discussion

This study examined the relationships between shame-proneness, sexual shame, and mental health (depression and anxiety), with particular attention to religious affiliation as a moderator. The findings provide valuable insights into the potential mechanism linking shame-proneness and mental health, as well as the extent to which religious affiliation has on effect these dynamics.

The results confirmed a strong, positive association between shame-proneness and sexual shame (H1a), suggesting individuals who experience elevated levels of trait shame are more likely to struggle with sexual shame as well; these associations have also been confirmed in Kyle (2013)'s research. Shame-proneness also had a significant positive relationship with depression (H1b), suggesting that individuals with high levels of shame proneness also have increased risk for depressive symptoms. Symptoms of depression have been associated with shame-proneness in other research (Cândea & Szentágotai-Tătar, 2018; Gilbert, 2017; Hassan-Ohayan et al., 2012; Kim et al., 2011), and this study supports the identification of shame-proneness in depression

treatment. Shame-proneness also had a significant positive relationship with anxiety (H1c), suggesting that individuals with high levels of shame-proneness have an increased risk for anxiety symptoms. This increased risk has been identified in other studies (Dolezal, 2022; Fergus et al., 2010; Gilbert, 2017; Helmert et al., 2023), and this study further suggests that shame-proneness should be addressed in the treatment of anxiety.

Sexual shame significantly mediated the relationship between shame-proneness and depression (H2a), as well as shame-proneness and anxiety (H2b), providing support for Hypothesis 2. Interestingly, sexual shame independently had a strong positive relationship with mental health indicating that individuals with higher levels of sexual shame may experience greater anxiety and depression. This further highlights the importance of addressing sexual shame independently from shame-proneness within the context of depression and anxiety treatment, a finding which has been acknowledged in other research (Adamczyk & Hayes, 2012; Cândea & Szentágotai-Tătar, 2018; Estrada, 2022; Marcinechová & Záhorcová, 2020).

Protestants, Catholics, and Christian non-denominational participants each had significantly higher sexual shame compared to the No Religion group. There were significant interactions between Catholic affiliation and shame-proneness and Christian non-denominational shame-proneness, providing partial support for H3a of the large group. The conditional direct effects indicate that the effect of shame-proneness on sexual shame for Catholic participants and Christian non-denominational participants was exacerbated compared to the No Religion group. This is consistent with the literature that supports the connection of sexual shame with Catholicism (Deguara, 2019). There is currently limited research on shame with Christian Non-denominational believers. The effect of shame-proneness on sexual shame was not significantly

different for the Protestant group compared to the No-Religion group, which is not consistent with previous research on shame in this religious group (Estrada, 2022).

Mormon, Muslim, Hindu, and Buddhist affiliations were associated with higher sexual shame compared to the No Religion subset, and Jewish and New/Age Wiccan were not significantly different from the No-Religion subset. This is somewhat inconsistent with literature that suggests Buddhism is associated with increased shame (Lipowska et al., 2019), but there was no identified research on Buddhism and sexual shame. Previous literature on Hinduism also suggests that this research is more open to sexuality, although within the context of marital relationships (Zaidi et al., 2014), which may contribute to the difference in this study's findings. Mormon and Muslim religions have been associated with increased sexual shame in the literature (Mormon: Bird, 2024; Muslim: Adamczyk & Hays, 2011), supporting the findings of this study. Surprisingly, Jewish individuals in this subset did not have a significant relationship between shame-proneness and sexual shame, which is different from previously identified research on shame in this group (Wacks et al., 2023). Followers of New Age/Wiccan belief systems typically are more open to sexuality (Harper, 2018), which is supported in this research.

Catholicism experienced a significant moderation effect between shame-proneness and anxiety, consistent with previous literature on the relationship between shame and anxiety symptoms within Catholicism (Deguara, 2019). Christian Non-denominational also experienced a significant moderation effect between shame-proneness and anxiety, which is a new result since there is no existing literature on these variables within this religious affiliation. Protestant individuals experienced a negative effect between shame-proneness and depression, suggesting that Protestant affiliation lowers depression symptoms, which is also found in literature (Lloyd &

Waller, 2020; Murry et al., 2007). These moderation effects suggest these religious affiliations are related to an impact of shame-proneness on anxiety symptoms.

The outcome of this research suggests individuals who identify as Catholic, Non-Denominational Christian, Mormon, or Muslim have an elevated risk of sexual shame influencing their mental health. Further analysis demonstrated that sexual shame mediated the relationship between general shame and mental health across all religious groups. This suggests that individuals who experience high levels of general shame have higher depression and anxiety symptoms, with sexual shame serving as a key intermediary factor in this process. Notably, the mediation effect was strongest among Mormons, indicating that sexual shame plays a crucial role in linking general shame to symptoms of depression and anxiety within this group. Given the strong moral emphasis on sexual behavior in Mormonism (Bird, 2024), these findings suggest that interventions targeting sexual shame may be especially beneficial for individuals from this religious background.

The moderated mediation model supported the consistent role of sexual shame as a mediating variable in the relationship between general shame and depression and anxiety symptoms. The varying strength of this mediation effect suggests that, while sexual shame is a universal experience influencing psychological distress, its impact may be more pronounced in religious contexts that impose rigid moral frameworks around sexuality.

Implications

The findings from this study highlight the necessity for comprehensive therapeutic approaches for addressing generalized shame and sexual shame within the context of religious belief systems. The strong connection between these two forms of shame indicates that individuals with higher levels of general shame are more prone to experience sexual shame,

which can contribute to anxiety and depression. Mental health interventions should target both types of shame to alleviate broader psychological distress.

It is important to note that there are other psychological influences shaping an individuals' experience of shame beyond religious identity, so this research only suggests one factor that may be important at addressing shame within mental health treatment.

Religious affiliation influences levels of sexual shame and has some interaction with anxiety for participants identifying as Protestant, Catholic, Christian Non-Denominational, or Muslim, which is consistent in past research in this area (Adamczyk & Hayes, 2012; Murray et al., 2007). While many religious teachings shape attitudes toward sexuality, the psychological impact of shame-proneness and anxiety is exacerbated in these religious groups, reinforcing the idea that individualized treatment is vital, even when religious identity plays a role. Overall, the results challenge the notion that religious affiliation always acts as a protective factor against shame-related anxiety, underscoring the importance of addressing shame-related issues directly in therapy, regardless of religious background, to effectively alleviate anxiety.

Limitations and Future Research

The primary limitation of the study is that cross-sectional data cannot be used to conclude any casual relationships between the constructs. The data shows that there are relationships between shame-proneness, sexual shame, anxiety, and depression that need to be explored more thoroughly to better describe the relationships. Future research could explore gender differences within a specific religious group, as well as the experiences of shame-proneness and sexual shame on the development of mental health symptoms. Additionally, longitudinal research could examine how sexual shame evolves, as well as the impact of gender and larger cultural systems.

Qualitative studies could also provide deeper insights into how religious and cultural contexts shape the experience of shame and its impact on mental health.

There is little description known regarding participant's faith other than the overall identification provided. Many religions have varying religious practices across smaller subgroups, and the intensity of religious practice was not measured in the context of this study. Subsequent studies could explore the belief systems in subsects of larger religious groups, as well as how the frequency of religious practices influences the relationships between the variables.

Future research should explore specific mechanisms underlying sexual shame, such as cognitive distortions, maladaptive coping strategies, and social avoidance behaviors, to refine interventions that target shame-related cognitions. Although the study models explored the variance in anxiety and depression, other factors like personality traits, social support, or biological vulnerabilities may also contribute to psychological outcomes. Future studies should incorporate these variables into more comprehensive models and should explore additional religious populations that are less studied in the literature.

Conclusion

Mental health practitioners must be aware of the elevated risks for some religious groups to experience increased sexual shame, which has a direct effect on depression and anxiety symptoms. This study highlights the impact of shame-proneness and sexual shame on depression and anxiety symptoms, specifically identifying the increased risk for Catholic, Protestant, Christian Non-denominational, Hindu, and Muslim participants.

These findings highlight the importance of exploring not only shame-proneness but also sexual shame within the context of treating depression and anxiety for individuals who engage in

religious practice. Past research describes how religious beliefs and values influence individuals' experiences of sexual shame; this study highlights the importance of acknowledging religious identity and sexual shame while treating mental health, without the assumption that religious identity lowers the risk of mental health symptoms.

This study offers meaningful insights into the complex relationships among general shame, sexual shame, and anxiety. The findings emphasize the significant role of sexual shame in psychological distress and illustrate how religious affiliation shapes the extent to which individuals experience it. These results highlight the importance of addressing shame, particularly sexual shame, in mental health interventions, with a focus on individuals from religious backgrounds that enforce strict moral codes regarding sexuality. A deeper exploration of the interactions between personal religious commitment, doctrinal beliefs, and cultural influences in shaping the experience and psychological impact of shame with a larger population is essential for effective mental health treatment.

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Figure 1

Proposed Moderated Mediation Model

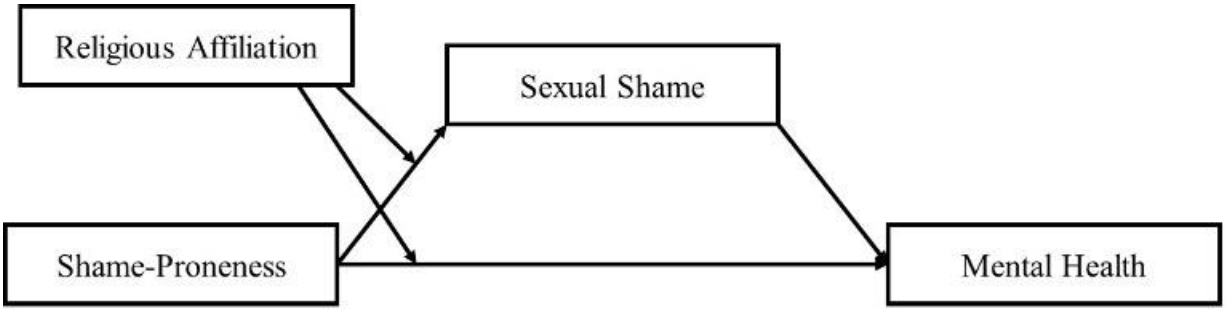

Table 1
Demographic Description of Participants

	N	%
Religion		
Protestant	824	16.3
Catholic	1699	33.6
Non-denominational Christian	959	18.9
Mormon	36	0.7
Muslim	67	1.3
Hindu	88	1.7
Jewish	76	1.5
Buddhist	64	1.3
New Age/Wiccan	74	1.5
No Religion	1177	23.2
Gender		
Male	2519	49.7
Female	2516	49.7
Other	25	0.5
Missing	4	0.1
Race/Ethnicity		
White	3608	71.2
Black or African American	760	15.0
American Indian/Alaska Native	63	1.2
Asian	277	5.5
Native Hawaiian or other/Pacific Islander	9	0.2
Hispanic, Latino, or of Spanish Origin	283	5.6
Other	60	1.2

Missing	4	0.1

Table 2
Descriptive Statistics of Study Variables by Religious Affiliation

		Shame-Proneness		Sexual Shame		Depression		Anxiety	
Religious Group	N	M	SD	M	SD	M	SD	M	SD
Protestant	824	36.61	7.80	3.15	1.48	12.40	11.56	10.44	10.65
Catholic	1699	38.55	7.55	4.39	1.50	21.18	11.16	20.81	11.34
Christian Non-denom	959	37.35	8.03	3.69	1.57	17.06	12.40	15.27	11.76
Mormon	36	36.14	8.38	3.36	1.55	16.89	12.50	14.06	11.49
Muslim	67	36.63	7.24	4.11	1.60	20.84	10.09	18.36	11.46
Hindu	88	34.65	8.87	3.65	1.49	16.95	11.26	17.61	10.44
Jewish	76	36.47	9.72	3.07	1.59	14.79	12.08	11.53	10.61
Buddhist	64	35.11	9.30	3.20	1.41	15.97	11.90	13.22	10.89
New Age/Wiccan	74	38.12	8.47	3.07	1.31	16.59	14.45	12.03	11.59
No Religion	1177	37.21	7.60	3.62	1.59	13.74	11.85	9.17	9.17
Total	5064	37.50	7.84	3.62	1.59	16.90	12.20	14.87	11.84

Table 3
Moderated Mediation Model Results for Large Religious Groups

Source	b	se	t	p	LLCI	ULCI
Sexual Shame R=.550, R^2=.303, MSE=1.768, F(7,4651)=288.313, p<.001						
Shame-Proneness (SP)	**.052**	.005	10.224	<.001	.042	.062
Protestant	**.330**	.061	5.430	<.001	.211	.449
Catholic	**1.423**	.051	28.112	<.001	1.324	1.522
Christian non-denom	**.833**	.058	14.383	<.001	.719	.946
SP x Protestant	.015	.008	1.861	.063	-.001	.030
SP x Catholic	**.042**	.007	6.378	<.001	.029	.056
SP x Christian non-denom	**.030**	.007	3.992	<.001	.015	.044
Depression R=.661, R^2=.437, MSE=83.926, F(8,4650)=451.757, p<.001						
Shame-Proneness (SP)	**.243**	.036	6.840	<.001	.173	.313
Sexual Shame	**4.199**	.101	41.558	<.001	4.001	4.397
Protestant	**-2.398**	.420	-5.713	<.001	-3.221	-1.575
Catholic	.639	.377	1.694	.090	-.101	1.379
Christian non-denom	-.194	.408	-.476	.634	-.993	.605
SP x Protestant	-.013	.054	-.239	.811	-.119	.093
SP x Catholic	.051	.046	1.103	.270	-.040	.141
SP x Christian non-denom	.050	.051	.985	.325	-.050	.150
Anxiety R=.710, R^2=.503, MSE=70.226, F(8,4650)=589.318, p<.001						
Shame-Proneness (SP)	.007	.033	.229	.819	-.056	.071

Sexual Shame	**4.223**	.092	45.694	<.001	4.042	4.404
Protestant	.177	.384	.461	.645	-.576	.930
Catholic	**4.921**	.345	14.260	<.001	4.244	5.598
Christian non-denom	**2.633**	.373	7.059	<.001	1.901	3.364
SP x Protestant	**.107**	.049	2.160	.031	.010	.203
SP x Catholic	**.252**	.042	5.983	<.001	.169	.335
SP x Christian non-denom	**.167**	.047	3.571	<.001	.075	.258

Note. Bold denotes significant effects.

Table 4
Moderated Mediation Model Results for Small Religious Groups

Source	b	se	t	p	LLCI	ULCI
Sexual Shame R=.491, R^2=.241, MSE=1.744, F(13,508)=12.388, p<.001						
Shame-Proneness (SP)	**.070**	.016	4.421	<.001	.039	.101
Mormon	**.624**	.252	2.474	.014	.129	1.120
Muslim	**1.339**	.203	6.596	<.001	.940	1.738
Hindu	**1.046**	.189	5.527	<.001	.674	1.418
Jewish	.315	.195	1.613	.107	-.069	.699
Buddhist	**.533**	.207	2.569	.011	.125	.940
New Age/Wiccan	.207	.199	1.040	.299	-.184	.598
SP x Mormon	-.001	.031	-.037	.971	-.062	.060
SP x Muslim	.008	.028	.272	.786	-.047	.061
SP x Hindu	.014	.023	.615	.539	-.030	.058
SP x Jewish	-.002	.022	-.098	.922	-.046	.042
SP x Buddhist	-.003	.024	-.120	.905	-.050	.044
SP x New Age/Wiccan	-.008	.024	-.325	.746	-.055	.040
Depression R=.636, R^2=.404, MSE=90.771, F(14,507)=24.593, p<.001						
Shame-Proneness (SP)	**.393**	.116	3.381	<.001	.165	.622
Sexual Shame	**3.712**	.320	11.592	<.001	3.082	4.340
Mormon	1.698	1.832	.927	.354	-1.901	5.297
Muslim	2.607	1.526	1.708	.088	-.391	5.606
Hindu	1.055	1.406	.750	.454	-1.708	3.818
Jewish	.494	1.412	.350	.727	-2.281	3.269
Buddhist	1.715	1.506	1.139	.255	-1.244	4.674
New Age/Wiccan	1.429	1.438	.993	.321	-1.397	4.255
SP x Mormon	.113	.224	.507	.613	-.326	.553
SP x Muslim	.163	.198	.824	.410	-.226	.553
SP x Hindu	-.096	.162	-.591	.555	-.415	.223
SP x Jewish	-.101	.161	-.628	.531	-.417	.215
SP x Buddhist	-.019	.172	-.108	.914	-.357	.320
SP x New Age/Wiccan	.146	.174	.837	.403	-.196	.488
Anxiety R=.653, R^2=.426, MSE=72.197, F(14,507)=26.922, p<.001						
Shame-Proneness (SP)	.049	.104	.470	.639	-.155	.253

Sexual Shame	**3.783**	.286	13.250	<.001	3.222	4.344
Mormon	3.139	1.634	1.921	.055	-.071	6.348
Muslim	**4.432**	1.361	3.256	.001	1.758	7.107
Hindu	**5.959**	1.254	4.751	<.001	3.495	8.423
Jewish	1.586	1.260	1.259	.209	-.889	4.061
Buddhist	**3.092**	1.343	2.302	.022	.453	5.731
New Age/Wiccan	1.748	1.283	1.363	.174	-.772	4.268
SP x Mormon	.278	.199	1.394	.164	-.114	.670
SP x Muslim	**.360**	.177	2.038	.042	.013	.707
SP x Hindu	.212	.145	1.466	.143	-.072	.496
SP x Jewish	.057	.143	.399	.690	-.224	.339
SP x Buddhist	.166	.154	1.079	.281	-.136	.468
SP x New Age/Wiccan	.169	.155	1.086	.278	-.137	.474

Note. Bold denotes significant effects

Table 5
Relative Indirect Effects

	Effect	SE	LLCI	ULCI	Index of Moderated Mediation	
					Index	95% CI
Shame-Proneness → Sexual Shame → Depression						
No Religion Group	**.219**	.020	.179	.258	(Reference group)	
Protestant	**.280**	.028	.224	.336	.061	(-.004, .128)
Catholic	**.397**	.020	.357	.436	**.178**	(.127, .229)
Christian Non-denom	**.343**	.025	.294	.392	**.124**	(.064, .185)
No Religion subset	**.260**	.059	.145	.381	(Reference group)	
Mormon	**.255**	.114	.016	.463	-.004	(-.271, .227)
Muslim	**.287**	.101	.078	.483	.028	(-.205, .237)
Hindu	**.311**	.058	.197	.426	.051	(-.101, .205)
Jewish	**.251**	.071	.118	.397	-.008	(-.175, .168)
Buddhist	**.249**	.067	.130	.394	-.011	(-.173, .159)
New Age/Wiccan	**.230**	.057	.116	.339	-.029	(-.183, .118)
Shame-Proneness → Sexual Shame → Anxiety						
No Religion Group	**.220**	.021	.181	.262	(Reference group)	
Protestant	**.282**	.027	.229	.335	.062	(-.005, .126)
Catholic	**.399**	.020	.361	.439	**.179**	(.128, .230)
Christian Non-denom	**.345**	.025	.295	.395	**.125**	(.064, .184)
No Religion subset	**.265**	.060	.145	.383	(Reference group)	
Mormon	**.260**	.120	.001	.479	-.004	(-.285, .224)
Muslim	**.293**	.101	.087	.489	.028	(-.207, .246)
Hindu	**.317**	.057	.208	.428	.052	(-.098, .202)
Jewish	**.256**	.073	.121	.405	-.008	(-.181, .170)

Buddhist	**.254**	.068	.130	.397	-.011	(-.175, .161)
New Age/Wiccan	**.235**	.057	.120	.347	-.030	(-.187, .125)

Note. Bold denotes significant effects