Religiousness and Depressive Symptoms Among Adolescents

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Examined the relations between depressive symptoms and (a) 3 standard indicators of religiousness and (b) a potentially more age-specific indicator in a sample of 744 adolescents (M age = 13.06 years, SD = 0.45). Adolescents completed the Children’s Depression Inventory (CDI) and the Brief Multidimensional Measure of Religiousness/Spirituality. Results indicate that several dimensions of religiousness are associated with lower levels of depressive symptoms (i.e., attendance, self-ranking, and positive interpersonal religious experience), whereas negative interpersonal religious experience was associated with higher levels. These relations were not moderated by sex or ethnicity. Interpersonal religious experience had a stronger relation with depressive symptoms than did the standard dimensions of religiousness. The importance of social support during adolescence and future directions for this relatively new area of research are discussed.

Adolescence is a time marked by numerous changes, critical developmental tasks, and increased questioning and confusion about the future (Peterson, Kennedy, & Sullivan, 1991). Not surprisingly, a significant number of adolescents suffer from depressive symptoms, with estimates ranging from 2% to 18% (Silverman & Ginsburg, 1998). These numbers are troublesome considering the negative impact depressive symptoms have on adolescents’ psychological, social, and academic functioning (e.g., Gotlib, Lewinsohn, & Seeley, 1995) and the elevated risk for major depression associated with such symptoms (Harrington, Fudge, Rutter, Pickles, & Hill, 1990). The negative consequences of depression make adolescence a critical time for prevention efforts and identifying factors that promote well-being.

One relatively unexplored factor that may promote well-being in adolescence is religiousness, which is defined as the extent to which an individual is committed to the religion he or she professes and its teachings, such that his or her attitudes and behaviors reflect this commitment (Johnson, Joon Jang, Larson, & De Li, 2001). In two different samples, adolescents who frequently participated in religious activities and who reported that their religious beliefs were highly meaningful had lower depression scores (Schapman & Inderbitzen-Nolan, 1999; Wright, Frost, & Wise-carver, 1993). Similarly, in a sample of bereaved teens, those who reported having religious or spiritual beliefs had significantly lower mean depression scores than teens without these beliefs (Gray, 1987). However, of the two studies that were published (Gray, 1987; Wright et al., 1993) only one addressed religion as a primary research hypothesis and used more than one item to assess religiousness (Wright et al., 1993).

In contrast to the few studies examining the relation between religiousness and depression among adolescents, this relation has received much attention among adults. The majority of cross-sectional and longitudinal research among adults has shown an association between measures of general religious involvement (i.e., measures that combine religious belief and behavior) and a decreased prevalence of depression (zero-order correlations range from $r = -0.07$ to $r = -0.40$, with a central tendency around $r = -0.20$; see Koenig, McCullough, & Larson, 2001, for review) and quicker recovery from major depressive episodes (Koenig, George, & Peterson, 1998). A number of other factors are associated with depression and religiousness, including age, marital status, geography, race, health sta-
tus, social support, and functional disability. Such covariates need to be measured and examined in statistical analyses to determine whether they account for the relation between religiousness and depression. Although the associations become weaker after controlling for relevant covariates, the relation between religiousness and depression generally remains significant (Koenig et al., 2001).

Religiousness has typically been examined as a unidimensional construct; however, recent theorizing argues that a multidimensional conceptualization may be more accurate (Fezter & National Institute on Aging Working Group [NIA], 1999). A review of previous work suggests the presence of three dimensions of religiousness that have often been combined into a global measure of religiousness: organizational religiousness (e.g., church attendance), nonorganizational religiousness (e.g., private practices such as prayer), and subjective religiousness (e.g., self-identity, beliefs, importance). The efficacy of earlier studies may have been undermined by combining these three dimensions into a single measure of general religious involvement, given that different dimensions of religiousness correlate with depression in different directions (positively and negatively) and with variable effect sizes (Koenig et al., 2001; Mindel & Vaughan, 1978). For instance, when an individual becomes depressed, he or she may pray more but go to church less. By combining measurements of private practices with those of church attendance, the effects of each dimension may be canceled out to some degree, especially in cross-sectional analyses (Koenig et al., 2001). To elucidate the relation between religion and depression, a separate measurement of each dimension of religiousness is required.

The majority of studies examining organizational religiousness cross-sectionally and longitudinally among adults have found an inverse relation with depression (betas typically ranged from −.10 to −.18 after controlling for demographic, psychosocial, and health status variables; Koenig et al., 2001). In contrast, nonorganizational religious activity is only weakly associated with depression. Cross-sectional studies yield an average effect size of $r = −.01$ (ranging from $−.02$ to $−.14$) and $\beta = −.01$ (ranging from $−.08$ to $−.06$), when controlling for other salient variables mentioned previously (Perez, 2001). Some studies have shown that when stressors increase, especially family stressors, individuals who reported engaging in frequent private and organizational religious practices were more likely to be depressed than those who reported infrequent engagement in religious practices (Strawbridge, Shema, Cohen, Roberts, & Kaplan, 1998), whereas other studies have shown that when stress increases, those who engage in more private religious practices are less likely to be depressed than those who engage in fewer private practices (e.g., Kendler, Gardner, & Prescott, 1997).

Various measures of subjective religiousness (e.g., religious identity, importance of religion, specific religious beliefs) show a negative association with depression in cross-sectional studies, with effect sizes ranging widely from $r = −.30$ to $r = .22$ (Perez, 2001). These data suggest that certain religious beliefs can be positive, other beliefs may be harmful, and some have no association with depression. In the only published longitudinal study of subjective religiousness and depression, religiousness was a strong predictor of depression ($r = −.61$) for 30 elderly women at discharge after hip surgery (Pressman, Lyons, Larson, & Strain, 1990).

Research with adults has also shown that some types of religiousness are positively associated with depression, namely an extrinsic religious orientation (i.e., being religious to receive benefits; e.g., Rabins, Fitting, Eastham, & Fetting, 1990) and the use of negative religious coping strategies (e.g., reframing the event in terms of God’s punishment; see Pargament, 1997). These findings provide further evidence that the manner in which one operationalizes religiousness alters the relation between religiousness and depression.

Adolescence is a relevant and important time to study the relation between religion and depression for several key reasons. First, cognitive advancements allow adolescents to engage in abstract thinking about religion, facilitating greater understanding of religious concepts (Goldman, 1964). Second, U.S. youth frequently endorse religious beliefs and engage in religious activities, suggesting that religion is an important part of many adolescents’ lives. National surveys on religion (1991–1998) have revealed that 95% of American teens ages 13 to 17 believe in God or a universal spirit, 69% consider themselves to be religious, 49% attend worship services weekly, 42% pray alone frequently, and 24% read scriptures weekly (George Gallup International Institute, 1999). Finally, peer relationships become increasingly important in adolescence (e.g., Geckova, Pudelsky, & Tuinstra, 2000). Religious institutions may facilitate the development of peer relationships and provision of social support, which is associated with lower rates of depression (Koenig et al., 2001), by bringing together youth who hold similar values and beliefs. Teens who frequently attend religious services may have more opportunities to develop a supportive social network than infrequent attenders, thereby buffering against depression.

Because the phenomenology of depression in adolescents is similar to that in adults (Spitzer, Endicott, & Robins, 1977), religiousness may have the same effect on adolescents’ well-being as it does on adults’ well-being. The few studies conducted with adolescents provide some evidence for this assumption (Gray, 1987; Schapman & Inderbitzen-Nolan, 1999; Wright et al., 1993). However, a different measurement of religiousness may be necessary for research with adolescents than with adults, given the different ways the...
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two groups engage in religious activities. For example, given that teens are often taken to church by their parents, organizational religious activity (hereafter referred to as attendance) may be a better measure of the religiousness of parents than of their children (Tittle & Welch, 1983). In adolescence, interpersonal religious experience may be a more valid and accurate predictor of depression. Findings from the social support literature provide some support for this hypothesis.

Perceived low levels of social support and negative social interactions are associated with negative mental health outcomes among youth (Alloway & Bebbington, 1987; Rook, 1984, 1998). Individuals who participate in religious activities have larger social networks, more social resources, and report greater satisfaction with the support they receive (Idler & Kasl, 1997). Although some researchers have questioned whether religious social support differs from secular social support, there is a lack of research comparing the two and their associated benefits (Ellison & Levin, 1998). Thus, because global religiousness may not provide a strong or accurate assessment of adolescent religious commitment, specific dimensions such as congregational support and quality of interactions should be more informative.

Two factors that may moderate this relationship are sex and ethnicity. Female adolescents and adults are consistently more religious than their male counterparts (Gallup & Bezilla, 1992; Koenig et al., 1988). Models of religion and sex suggest that the social status, roles, and experiences of women, rather than those of men, may be more congruent with a religious orientation (Levin, Taylor, & Chatters, 1994). Because girls are at greater risk of developing depression after puberty (e.g., Stark, Sander, Yancy, Bronik, & Hoke, 2000), religious support and coping styles may be more beneficial buffers against depression for girls than for boys (Levin et al., 1994). Similarly, African American teens and adults are, on average, more religious than their European American counterparts (Donahue & Benson, 1995; Markstrom, 1999). Church community is an especially important resource for African Americans, especially during difficult or stressful times. In fact, the church is reported to be the most important community institution after the family for African Americans (Taylor, 1986).

This investigation was a preliminary attempt to examine the relations between depressive symptoms and different dimensions of religiousness among adolescents. Our first aim was to examine the relation between depressive symptoms and three main indicators of religiousness from the adult literature (i.e., attendance, private religious practices, and self-ranked religiousness). As with adults, it was predicted that higher levels of these religious dimensions would be associated with lower levels of depression in adolescence.

Our second aim was to examine a potentially more age-specific indicator of organizational religiousness among adolescents. Specifically we expected that interpersonal religious experience would be strongly associated with depressive symptoms, given that attendance was not expected to be a particularly valid or accurate indicator of adolescent religiousness. We hypothesized that the more perceived positive support teens anticipated from their congregation, the fewer depressive symptoms they would report. Conversely, the more negative interactions teens had with members of their congregation, the more depressive symptoms they would report. Because positive social support is associated with less depression (Rutter, 1979) and negative social interactions are associated with greater depression (Rook, 1984, 1998), we expected both variables to have strong associations with depressive symptoms.

The third aim of the study was to examine the moderating influence of sex and ethnicity on the relations among five dimensions of religiousness and depressive symptoms. We expected that religiousness would be associated with lower levels of depressive symptoms for girls and African Americans than for boys and European Americans, respectively.

Method

Participants

Of the 744 adolescents (50% female) who were included in the analyses, 257 were in Grade 7 (M age = 12.01 years, SD = 0.43), 284 in Grade 8 (M age = 13.09 years, SD = 0.48), and 203 in Grade 9 (M age = 14.07 years, SD = 0.43). According to school records, 14% of students were eligible for free or reduced lunch. The reported religious affiliations of the students were as follows: 61% Catholic, 13% Protestant, 6% Jewish, 10% other, and 10% no religious affiliation.

Procedures

This study was part of a larger project examining the development of personality and motivation in adolescence. Adolescents were recruited from one middle school and one high school in an ethnically and socioeconomically diverse district in a southern New England community during the 2000–2001 school year. The results presented involve the relations among the variables measured during the final wave of the project (participation rate was 81%). Because statistical power was too low to examine this relations across all races and ethnicities represented in the sample, we chose to focus on the two largest representations for all analyses: European American (n = 607; 81.6%) and African American (n = 137; 18.4%).

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Students participated in this study with active parental informed consent. Permission to conduct this investigation was provided by the school district, principal, and the individual teachers in the classrooms. Students who agreed to participate obtained active parental consent. Students then completed a battery of questionnaires during three 1-hr sessions during a 2-week period. Order effects were addressed by randomly assigning classrooms to surveys that differed in the ordering of items.

**Measures**

**Demographic information and socioeconomic status (SES).** Demographic information collected in the survey included age, sex, and ethnicity. Eligibility for free or reduced lunch, accessed from school records, was used as an index of SES. Students were eligible for free or reduced lunch if the family’s income was less than 1.85 times that of the federal poverty level. SES was dummy coded 0 or 1 based on whether participants were eligible for free or reduced lunch.

**Children’s Depression Inventory (CDI).** The CDI (Kovacs, 1985) is a widely used 27-item modification of the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), designed to measure symptoms of depression in children and adolescents ranging in age from 7 to 17 years. Responses to items are scored on a scale of 0 to 2 (range of possible scores: 0 to 54), with higher scores indicating more depressive-like symptoms. Internal consistency coefficients have been above .80, and concurrent, construct, and discriminant validity have been adequately established (Eckert, Dunn, Guiney, & Codding, 2000). Cronbach’s $\alpha$ in this study was .92. Although a five-factor model is suggested in the CDI manual, most studies have indicated that a one-factor structure, reflecting depression in general, is most parsimonious (Eckert et al., 2000). Consequently, the total CDI score for each student was used in this study. Because the distribution of scores on the CDI was positively skewed, a square-root transformation was performed (Tabachnick & Fidell, 1996).

**Brief Multidimensional Measure of Religiousness/Spirituality.** This multidimensional measure of religiousness (Fetzer & NIA, 1999) is a 54-item scale developed to examine key dimensions of spirituality and religion and how they relate to physical and mental health. Although most items have a strong Judeo-Christian focus, items that are relevant to those who have different religious and spiritual beliefs and practices are also included. This measure, unlike others in the past, taps a broad range of 14 religious and spiritual domains. Findings from the General Social Survey, an annual national survey of Americans by the National Opinion Research Center, indicated that all the domains were endorsed by the respondents, the items formed reliable indexes within each domain, and the domains were only moderately correlated with one another, indicating that they are distinct constructs (Fetzer & NIA, 1999).

The five subscales used in this study were as follows: Self-Ranked Religiousness, Private Practice, Attendance, Positive Religious Support, and Negative Religious Support (based on analysis of the item content, we refer the latter two constructs as Positive and Negative Interpersonal Experience).

Self-ranked religiousness was assessed using the two-item Overall Self-Ranking subscale. Adolescents were asked to rank the extent to which they considered themselves to be both a religious person and a spiritual person on a 4-point scale ranging from 1 (not at all) to 4 (very). The range of possible scores was 2 to 8. No previous psychometric data is available for this particular subscale, but these two questions have often been used in research on the relation between religion and mental health (see Koenig et al., 2001). The reliability coefficient (internal consistency) of the subscale in this study was $\alpha = .84$.

Private Religious Practice was measured using four items that assess the nonorganizational and informal religious and spiritual practices of the respondent. Private practice included prayer in places other than a religious institution, meditation, watching or listening to religious programs on the TV or radio, and reading religious literature, such as the Bible. The items were ranked on an 8-point scale ranging from 1 (never) to 8 (more than once a day). The range of possible scores was 4 to 32. Previous research has found adequate reliability for this subscale ($\alpha = .72$; Fetzer & NIA, 1999), which was also the case in this study ($\alpha = .74$).

Attendance was assessed using the two-item subscale designed to measure the involvement of the respondent with a formal public religious institution (e.g., a church, synagogue, temple, mosque, and so on). The items asked adolescents how often they attend religious services and other activities at a place of worship. A 6-point response option was used, ranging from 1 (never) to 6 (more than once a day). The range of possible scores was 2 to 12. Previous research has found adequate reliability for this subscale ($\alpha = .82$; Fetzer & NIA, 1999; this study $\alpha = .73$).

Positive Interpersonal Religious Experience consisted of two items designed to measure anticipated support provided to the teen by their religious congregation (i.e., degree congregation would help out if teen was sick and degree of comfort that would be given if faced with a difficult situation). Responses were rated on a 4-point scale, ranging from 1 (a great deal) to 4 (none). The range of possible scores was 2 to 8. Previous research has found adequate reliability for this subscale ($\alpha = .86$; Fetzer & NIA, 1999; this study $\alpha = .90$).
Negative Interpersonal Religious Experience consisted of two items designed to measure a negative relationship dynamic between the teen and their religious congregation (i.e., frequency congregation makes demands on teen and is critical of the things he or she does). Responses were rated on a 4-point scale, ranging from 1 (a great deal) to 4 (none). The range of possible scores was 2 to 8. Previous research has found adequate reliability for this subscale (α = .64; Fetzer & NIA, 1999; this study α = .83).

**Results**

**Analyses**

Several factors have been found to moderate the relation between religiousness and mental health, including sex, age, race, and SES (Koenig, George, Peterson, Bercedis, & Pieper, 1997). Pearson correlation coefficients were used to assess bivariate associations among all variables included in the analyses to determine which demographic we should control for in the regression models. The variables that were significantly (p < .05) correlated with the independent and dependent variables in the various analyses were controlled (i.e., sex, ethnicity, grade, and SES). A hierarchical regression analysis, using the block entry method, was conducted to test the hypotheses. Because of the overall power and the large number of predictors, we used a criterion alpha of p < .005 to control for Type I errors. In the first step, the four demographic variables were entered. In the second step, the three standard religiousness variables were added to the model. The third step consisted of the two interpersonal religious experience variables. The difference in the variance accounted for between Steps 2 and 3 was examined for significance, and β weights and significance levels were examined for the five independent variables. To test the third hypothesis that sex and ethnicity moderated the relation between the five dimensions of religiousness, interaction terms were calculated using centered variables for sex and ethnicity by each religiousness predictor and added to the regression model in a fourth step. A small number of students (8%) did not have SES data available. Missing data for these students was estimated by the predicted value from a saturated regression equation containing all other variables (Little & Widaman, 1995). This ensured that the sample size (N = 744) was consistent across all analyses.

**Descriptive Statistics and Bivariate Correlations**

Table 1 shows means and standard deviations for study variables. The untransformed mean CDI score was 5.92 (SD = 6.83) out of a possible 54 points, indicating a relatively nondepressed sample (a score of 16 for girls and 20 for boys is one standard deviation above the mean). Girls (M = 6.24, SD = 7.20) had significantly higher scores than did boys (M = 5.59, SD = 6.43): t(742) = 3.40, p < .001 (see Table 1).

The five measures of religiousness were significantly positively related, but the associations were moderate enough to consider each a unique dimension of religiousness (range of rs = .11 to .56; see Table 2). Twenty-one percent of the adolescents attended religious services and activities once a week or more, 6% engaged in private practices a few times a week or more, 45% said they were moderately or very religious/spiritual, 71% said their congregation would help or comfort them some or a great deal, and 10% said that their congregation made too many demands or were critical of them fairly or very often. At the zero-order level, all dimensions, except Private Practice, were correlated significantly with depressive symptoms.

**Hypothesis 1: Replication of Adult Findings Among Adolescents**

The demographic variables were added to the model in Step 1. They accounted for 3% of the variance in depressive symptoms (R² = .03). In Step 2, three dimensions of religiousness (Attendance, Private Practice, and Self-Ranking) were added to the model. These variables accounted for a small yet significant unique amount of variance beyond the demographic variables in the prediction of depressive symptoms (R² = .02, F incremental (3, 735) = 6.06, p < .001). However, none of these religious variables had a significant unique effect on depressive symptoms, even though Self-Ranking and Private Practice had significant zero-order correlations with Depression. This pattern of associations between depressive symptoms and the subjective and organizational dimensions of religiousness among adolescents were similar to many results found among adults.

**Hypothesis 2: Attendance Versus Interpersonal Religious Experience**

To examine whether interpersonal religious experience (i.e., positive congregational support and negative congregational interactions) was a better predictor of adolescent depressive symptoms, Positive and Negative Interpersonal Religious Experience variables were added to the model in Step 3 (see Table 3). This model accounted for a modest yet significant amount of unique variance in depressive symptoms, above and beyond that accounted for by the demographic variables and three standard dimensions of religiousness (R² = .06; F incremental (2, 733) = 25.18, p < .001). As expected, Positive Interpersonal Religious Experience was associated with lower depressive symptoms, and
Table 1. Means and Standard Deviations Among the Variables Included in the Analyses (N = 744)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Overall</th>
<th>Male</th>
<th>Female</th>
<th>EA</th>
<th>AA</th>
<th>7th</th>
<th>8th</th>
<th>9th</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Attendance</td>
<td>3.51</td>
<td>1.28</td>
<td>3.40</td>
<td>1.28</td>
<td>3.63</td>
<td>1.27</td>
<td>3.48</td>
<td>1.28</td>
</tr>
<tr>
<td>Private practice</td>
<td>2.79</td>
<td>1.44</td>
<td>2.71</td>
<td>1.51</td>
<td>2.86</td>
<td>1.36</td>
<td>2.65</td>
<td>1.37</td>
</tr>
<tr>
<td>Overall self-ranking</td>
<td>2.52</td>
<td>0.83</td>
<td>2.43</td>
<td>0.84</td>
<td>2.60</td>
<td>0.82</td>
<td>2.49</td>
<td>0.84</td>
</tr>
<tr>
<td>Positive experience</td>
<td>2.97</td>
<td>0.90</td>
<td>2.90</td>
<td>0.88</td>
<td>3.05</td>
<td>0.91</td>
<td>2.92</td>
<td>0.91</td>
</tr>
<tr>
<td>Negative experience</td>
<td>1.70</td>
<td>0.73</td>
<td>1.78</td>
<td>0.74</td>
<td>1.63</td>
<td>0.71</td>
<td>1.66</td>
<td>0.70</td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>5.92</td>
<td>6.83</td>
<td>5.59</td>
<td>6.43</td>
<td>6.24</td>
<td>7.20</td>
<td>5.95</td>
<td>6.80</td>
</tr>
</tbody>
</table>

Note: Means and standard deviations based on item averages except depression. EA = European American; AA = African American.
Negative Interpersonal Religious Experience was associated with greater depressive symptoms. Therefore, as predicted, perceived support from an adolescent’s congregation, as well as negative relationship dynamics, are stronger correlates of depressive symptoms than their frequency of church attendance.

**Hypothesis 3: Factors Moderating the Relation**

*Sex and ethnicity.* The centered interaction terms for sex and ethnicity by the five religiousness variables were added to the model in Step 4. None of the interactions terms were significant. For the sex interactions, the $t$ values ranged from −1.77 to 0.85, with $p$ values ranging from .08 to .75. For the ethnicity interactions, the $t$ values ranged from −0.66 to 1.48, with $p$ values ranging from .14 to .67. Therefore, in this sample, sex and ethnicity did not moderate the relations between the dimensions of religiousness and depressive symptoms.

**Discussion**

The first aim of the study was to examine the relation between depressive symptoms and three main in-
The findings supported the hypotheses. Both at the zero-order level and in the regression models, controlling for demographic factors, Positive and Negative Interpersonal Religious Experience had the strongest positive and negative associations, respectively, with depressive symptoms. These variables also accounted for a unique amount of explained variance of depressive scores beyond demographic and other religious variables. These findings suggest that adolescents’ psychological well-being is more strongly associated with their social experience in religious environments than with their attendance at religious services. This is congruent with previous research demonstrating the importance of supportive relationships (Alloway & Bebbington, 1987). Alternatively, depressed teens may be less likely to anticipate receiving positive social support (Katainen et al., 1999).

In contrast, teens who felt that their congregations were critical and demanding of them were most likely to report depressive symptoms. These findings are in accord with research demonstrating that negative interpersonal exchanges can have adverse effects on well-being, even canceling out positive relational aspects (Rook, 1998). The cognitive attribution theories of depression provide further explanation. Depression is characterized by cognitive disturbances, such that the depressed tend to have negative information processing about the self, the world, and the future (Beck, 2002). Depressed teens may engage in or selectively attend to negative interactions with people and interpret benign comments or requests as critical and demanding. Indeed, negative temperament may put individuals at risk of having negative social interactions with others (see Thomas & Chess, 1977), which may then contribute to the development and maintenance of depressive symptoms. Alternatively, the relations obtained may reflect common method variance and negative response bias across the interpersonal religious experience and depressive symptoms measures, rather than a true association between constructs. Although the zero-order correlations between Positive and Negative Interpersonal Religious Experience and depressive symptoms were small, in the regression analyses these variables accounted for 6% of the unique variance in depressive symptoms.

The third aim of the study was to examine the moderating influence of sex and ethnicity on the relations among the five dimensions of religiousness and depressive symptoms. Girls and African Americans are two subgroups of adolescents that report higher religious beliefs and behaviors than do boys and European Americans, respectively. As such, we anticipated that there would be a stronger association between various dimensions of religiousness and depression for these two subgroups compared to their counterparts. This hypothesis was not supported by the data in this study. The association between depressive symptoms and religiousness were not different by sex. However, because our sample consisted of relatively nondepressed youth of only two ethnicities, further exploration of these potential moderators in clinical, high-risk or highly stressed, and ethnically diverse samples is recommended.

Some limitations should be noted. First, this study was conducted as a preliminary attempt to examine whether a relation between religiousness and depression exists among adolescents as has been documented among adults and, further, whether a more age-specific measurement of religiousness is required when studying adolescents. We recognize that future research will need to include more of the known correlates of depression before firm conclusions about the relation between religiousness and depression can be drawn. Second, although we examined a type of religious social support, we did not measure social support in general. Almost all studies that have examined the relation between social support and religious activity have found a statistically
significant relation (Koenig et al., 2001). Depressed teens report fewer social resources and fewer supportive social relationships (Daniels & Moos, 1990), but even one positive relationship with a competent adult outside of the family can produce significant protective effects (Rutter, 1979). As such, including both a general social support measure and a religious social support measure in future studies would be informative. If the associations between religiousness and depression become nonsignificant, it does not necessarily mean that religion has no effect, but rather that social support may be an explanatory mechanism for religion’s effect on mental health (Levin, 1996). Third, the cross-sectional nature of the study precludes any conclusions of causal direction among the variables assessed.

Future studies should include more cognitive factors, including teens’ beliefs about God and their relationship with God. Research on coping styles and forgiveness has shown that positive and negative religious appraisals have differential effects on mental health (Pargament, Smith, Koenig, & Perez, 1998). For instance, higher levels of depressed mood were reported by adults who saw God as distant or who found it difficult to trust God (Exline, Yali, & Lobel, 1999). As mentioned previously, cognitive models of depression hold that depression is linked to negative information processing (Beck, 2002). Religion may provide a set of positive and purposeful beliefs about oneself and one’s world, reducing the likelihood of becoming hopeless or forming a negative attributional style.

In summary, the relation between adolescent religiousness and mental health is relatively unexplored. Directions for future research include (a) the development of theoretical models appropriate to adolescents (including variables that assess interpersonal religious experience, as well as beliefs and attributions about God and one’s relationship with God); (b) research on the mechanisms by which religion exerts its effects on mental health—these may include social support and negative social interactions; and (c) longitudinal analyses of the relation among the dimensions of religiousness and depression to clarify inconsistent cross-sectional results (Idler, 1995).

In corroboration with past research demonstrating the importance of interpersonal relations in models of youth depression, the findings of our study suggest that social experiences with congregations are particularly important to address when studying depression among adolescents. More research is needed before we can conclude that religiousness influences levels of depression and not vice versa. It is also possible that there is a bidirectional relation between religiousness and depression. With rates of depression rising among adolescents and the likelihood that depressed teens will become depressed adults, it is imperative that we continue to identify factors that reduce the likelihood that adolescents will become depressed, as well as means to facilitate recovery from major depressive episodes. A multidimensional approach to the study of religiousness holds such potential.

References


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