

# Subjective Religiosity and Depression in the Transition to Adulthood

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*Does being more religious make one less susceptible to depression? We consider the association between subjective religiosity (religious self-perception and coping) and depression in the context of social support (from family and friends) and stress exposure (recent negative life events, chronic stress, lifetime trauma, and discrimination). Data come from a sample of 1,803 Miami-Dade County young adults interviewed between 1997 and 2000. We find higher levels of depression among the moderately religious than among either very religious or nonreligious respondents. Interestingly, when observations are made within gender, this relationship applies only to females. Controlling for socioeconomic status and social support largely accounts for the link between religiosity and depression. However, controlling for stress exposure reveals a suppressor effect wherein religiosity once again emerges as significant. Our interpretation is that, while established patterns of religious coping can routinely mitigate distress, heightened stress exposure may elicit increased prayer among the less religious.*

## INTRODUCTION

There is growing consensus that religious commitment and practice can be beneficial to physical and psychological well-being (Ellison and Levin 1998; Koenig, McCullough, and Larson 2001). Despite some notable exceptions (e.g., Ellison 1995; Sorenson, Grindstaff, and Turner 1995), the balance of evidence points to salutary influences of religiosity (Ellison 1991; Strawbridge et al. 2001). Recent research has linked aspects of religious involvement to a broad array of health outcomes; see Koenig, McCullough, and Larson (2001) for an overview.

Religious involvement, variously defined, has been shown to be an important predictor of psychological distress in particular (Ellison et al. 2001; Ross 1990; Schnittker 2001). However, findings have been inconsistent, and vary according to the aspects of religiousness that are measured and the populations studied. Some investigations have suggested a curvilinear relationship between religiosity and depression (Ross 1990; Schnittker 2001; Shaver, Lenauer, and Sadd 1980), but, surprisingly, the direction of this relationship has differed by study. Accordingly, more work is needed to clarify the social mechanisms underlying this association.

Our study provides a rare opportunity to refine the knowledge of who stands to benefit from religion and under what circumstances. From a wide array of earlier studies, we know that young adults repeatedly report higher levels of social stress than do older populations (Turner and Avison 2003). How, then, might a religious upbringing help (or perhaps hinder) them in meeting the multiple challenges of young adulthood? Unlike the samples spanning a wider age range used in most previous studies relating religiosity to depression (e.g., Ross 1990; Schnittker 2001; Shaver, Lenauer, and Sadd 1980), our large and ethnically diverse sample of college-age young adults allows us to assess psychological correlates of early religious exposure at this pivotal juncture in the life course, apart from potentially confounding effects of later life experience.

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In this article, we test for the presence and nature of linear and curvilinear relationships between subjective religiosity (religious self-perception and coping)<sup>1</sup> and depressive symptoms among youths in the transition to adulthood. In line with recent work suggesting that the functions and health relevance of religiosity vary by gender (Krause, Ellison, and Marcum 2002; Miller and Stark 2002; Mirola 1999), we consider gender differences in the contribution of subjective religiosity in accounting for psychological distress.<sup>2</sup> We also examine whether the contribution of subjective religiosity is unique or is merely an artifact of shared association with social integration and social support. Finally, we assess how the observed associations vary in the context of a relatively comprehensive assessment of stress exposure.

### BACKGROUND

The mental health benefits of religiosity have variously been tied to the stress buffering and social support properties of religious involvement. Those who emphasize the stress buffering aspects point out the utility of religious belief and practice as a source of meaning and a way to reframe difficult predicaments. As Ellison and Levin (1998:708) put it:

Prayer and other intrapsychic religious coping efforts may alter primary appraisals, leading religious persons to reassess the meaning of potentially problematic conditions as opportunities for spiritual growth or learning, or as part of a broader divine plan, rather than as challenges to fundamental aspects of personal identity.

From this perspective, the central focus is on religion's capacity to direct the vision of the faithful beyond immediate obstacles toward a higher purpose. In the words of Musick (2000:269), "It is religion's ability to provide meaning and hope for the future, even in the face of current life adversity, that may have such powerful effects for well-being."

Indeed, some (Ellison et al. 2001; Levin and Chatters 1998) have suggested that salutary effects of religion may be suppressed or hidden in the absence of statistical controls for stress exposure. Thus, either no association or even a positive relationship between religiosity and psychological distress may be observed when increased religious involvement is a *consequence* of unmeasured stress exposure. Failure to account for deleterious effects of stress exposure can therefore obscure or suppress beneficial effects of religion on mental health, since positive associations between religiosity and psychological distress could arise with heightened religious coping efforts (e.g., increased frequency of prayer) in response to adversity.

In this regard, it is widely accepted that many of religion's benefits to mental health result from the social integration and the instrumental and emotional support afforded by participation in or identification with a religious community (Ellison 1991; Ellison and Levin 1998; Kress and Elias 2000). While it is possible to separate the public and personal aspects of religiosity at a *conceptual* level, it is difficult to do so in real life. After all, religious institutions provide a substantial part of the context within which young people form their subjective sense of religious identity (Kress and Elias 2000) while developing social ties with others who share and reinforce their basic values and beliefs. Religious communities also provide extensive formal and informal support networks available to members in times of need (Maton 1989). Thus, the question arises whether *any* kind of religious involvement makes a unique contribution to psychological well-being, over and above that of general social integration (as measured by indicators such as perceptions of connectedness with and support from family and friends).

### Religious Commitment and Depression in the Transition to Adulthood

Given that most of our respondents in this study were between 19 and 21 years of age at the time of interview, their religiosity can be regarded as largely a matter of free choice insofar as many of them were by that time no longer living under direct parental authority. Yet their religiosity

must also be seen as subject to powerful constraints of personal history. Most had not yet had time to build up the variety of life experiences (e.g., marriage and child-rearing, geographic and socioeconomic mobility, changes in health circumstances) that can produce extensive variation in religious commitment—which, in turn, can confound the relation of religiosity to depression. As such, religiosity in late adolescence and early adulthood can be thought of as constituting either a reflection of, or a reaction to, the beliefs and practices of parents or other childhood caregivers (Miller et al. 1997; Wallace and Forman 1998). While a sizable majority of individuals in this age range report having religious beliefs similar to their parents' (Smith et al. 2003), this stage of life is also when religious conversion is most likely to occur (Smith et al. 2002). It may also mark a juncture in the life course when familial religious beliefs and practices are reduced or abandoned; for whatever reasons, rates of religious activity reported by American youth decline with age (Smith et al. 2002). In any case, whatever salience religion holds for young people as they leave the family of origin may depend to a large extent on exposure to religious practice during the formative years (Eliassen, Lloyd, and Taylor 2004).

Family routines experienced in day-to-day living, beginning as early as infancy, are thought to be crucial to the development of *basic trust*—that fundamental sense of permanence and stability indispensable to effective social intercourse and the creation of protective affiliations throughout life (Boyce 1985; Erikson [1959] 1980). Among such family routines are religious or spiritual activities that cultivate “the consciousness of principles or a being that underlie the sense of universal permanence” (Boyce 1985:164). Indeed, religion's protective aspects relative to psychological distress may be directly tied to just such an extension of the childhood sense of security to cosmic dimensions (Bjarnason 1998). A firmly grounded religious outlook can mitigate the impact of adversity (eventful or chronic stressors) on health outcomes such as depressive symptomatology at various points in the stress process described by Pearlin and colleagues (Pearlin 2002; Pearlin et al. 1981).

In contrast, a disorganized, disrupted, or under-routinized early home life can be a potent risk factor for adverse health outcomes later on (Boyce 1985; Lundberg 1997). Religious commitment that is associated with adverse mental health outcomes typically involves negative coping patterns characterized by callousness, anger, and conflict. Such coping patterns are thought to arise out of an initial failure to establish basic trust and the absence of predictable family routines. They often reflect a theodicy that explains suffering in terms of divine retribution for sin (Musick 2000; Pargament et al. 1998).

Because the transition to adulthood is a time of elevated stress and distress relative to other stages of the life course (Turner and Avison 2003), religion may turn out to be an especially important factor in well-being, especially for women. Religion may also serve as an important source of role identity (Kress and Elias 2000), acting as a psychosocial anchor in the face of transitioning into more permanent romantic relationships, parenting, and full-time paid employment.

### **Depressive Symptoms, Religiosity, and Gender**

The literature has repeatedly and consistently noted higher rates of depressive symptoms in females than in males (Avison and McAlpine 1992; Simon 2002; Turner and Lloyd 1999), often interpreted in terms of a tendency for females to internalize, whereas males tend to externalize, their reactions to adversity (Aneshensel, Rutter, and Lachenbruch 1991; Rosenfield 1999). Also repeatedly and consistently noted are higher rates of religious participation among females than among males. Differential gender socialization is the usual explanation (Miller and Hoffmann 1995; Thompson 1991), but the discrepancy may reflect a greater propensity for risk-taking among males (Miller and Hoffmann 1995; Miller and Stark 2002). Gender differences in religious activity, particularly service attendance, may also be one reflection of women's capacity for experiencing higher levels of social support relative to males (Turner and Turner 1999). Additionally, the

presence of a significant relationship between depression and religiosity has been demonstrated more consistently among females than among males (Miller et al. 1997).

### **How Does Religiosity Relate to Psychological Distress?**

In line with earlier results reported by Shaver, Lenauer, and Sadd (1980), Ross found an inverse U-shaped curvilinear relationship wherein the extremes of strong religious belief and complete nonbelief were associated with lower levels of psychological distress, while “[t]he highest distress levels were found among those who [had] not made a commitment, who belong[ed] to a religion not out of choice but out of indifference” (1990:243). In contrast, Schnittker (2001) arrived at a U-shaped effect wherein either very low or very high levels of religious salience were related to higher levels of depressive symptoms. While Schnittker was unable to tie this result to religious undermining of mastery or self-esteem, it is possible that the shape of the effect reflects varying degrees of the existential security or threat that may result from taking religious claims seriously (Ellison 1991; Ellison and Levin 1998; Miller and Stark 2002). Schnittker (2001) also found that some forms of religious involvement (religious salience and spiritual help-seeking) buffer the adverse effects of stress, but only in the presence of multiple negative life events. One possible explanation for the inconsistency of previous findings is that Schnittker controlled for stress exposure while Shaver et al. and Ross did not. Another is that divergent paths of adult life experience can have differential impact on both religious commitment and depression in samples that span a wide age range.

In this study, we extend the research done by Ross (1990) and Schnittker (2001) by focusing more closely on the relationship between religiousness and depression at a critical early stage in the life course—namely, the sometimes awkward time of taking on and adjusting to multiple new and unfamiliar adult roles. We use a scale of subjective religiosity that includes measures of religious salience (perception of self as religious) and religious coping to show how religious commitment relates to depressive symptomatology among young people as they enter adulthood. The aim of this study is to refine our understanding of how other potential risk or protective factors (sociodemographic status, social support, and stress) can work together with religiousness in mapping out who stands to benefit from (or perhaps be handicapped by) religious involvement at this crucial transition point. The results will have broad implications as to who may be most likely to continue, resume, or initiate religious participation later on in life.

## **DATA AND METHODS**

### **Sample**

Our data come from 1,803 young adults interviewed between 1997 and 2000 in the Transitions study (Life Course and Health Research Center (LCHRC) 1997), a new investigation built upon a previous three-wave (1990–1992) study of adolescents (originally 6,760 boys and 626 girls in Grades 6 and 7) from different racial and ethnic backgrounds in the Miami-Dade County public school system (Vega and Gil 1998). Unfortunately, parallel measures of religiosity and depression were not available from the earlier three waves of data. All female participants in the earlier study who met ethnicity criteria, and a random sample of 1,273 males, were selected for follow-up. To supplement the female sample, 888 new girls from the 1990 Miami-Dade Grades 6 and 7 class rosters were randomly selected and stratified to achieve target ethnic distributions. Turner and Avison (2003) provide a complete description of the sampling procedure.

Overall, 70.1 percent of those sought out for the Transitions study were interviewed. By far the greatest loss (41.8 percent) occurred in the new sample of females, who had no previous involvement in the investigation. To correct for a significant bias toward lower parental SES

associated with this loss, female respondents have been differentially weighted in all analyses to achieve an SES distribution approximating that observed for males (Turner and Avison 2003).

Although a significant number of the target sample had left the area to attend college or for other reasons, 76.4 percent of subjects studied previously were successfully reinterviewed. At the time of interview, 93 percent of respondents were between 19 and 21 years old. The final sample achieved roughly equal representation of non-Hispanic whites ( $n = 463$ ), African Americans ( $n = 434$ ), persons of Cuban heritage ( $n = 435$ ), and non-Cuban Hispanics ( $n = 453$ ). Because ethnic contrasts are integral to the present analyses, we exclude those 18 respondents who self-reported some other ethnic status (e.g., African Haitian or African Caribbean).

## Measures

### *Depressive Symptomatology*

The Transitions study measure was a modification of the highly reliable 20-item Center for Epidemiology Studies Depression Scale (CESD) (Radloff 1977). This measure differed from the original in addressing experiences over the preceding month rather than the preceding week and in its use of the response categories “not at all,” “occasionally,” “frequently,” and “almost all of the time.” A one-month time frame provides a larger sample of recent experience, and we believe it should reduce the influence, on responses, of short-term mood variations. With the present data, internal reliability for this scale is 0.82.

In the analyses to be presented here, we score the four response categories 0, 0, 1, and 2, respectively, thereby combining the “not at all” and the “occasionally” responses. We do this based on two considerations; see Turner and Avison (2003) for a detailed accounting of our rationale. First, we believe that occasional emotional discomfort most likely does not importantly undermine the performance of core social roles. And second, we have evidence that minority and low-SES adolescents are less likely than others to report occasional symptoms.

### *Subjective Religiosity*

Our scale assesses the degree to which respondents reported (1) looking upon themselves as being religious; (2) turning to their religion or spiritual beliefs to help deal with daily problems; (3) seeking comfort from their religion in times of difficulty or stress; and (4) praying more than usual in times of difficulty or stress. Possible scores on each of the four items range from 1 (usually not at all) to 4 (usually a lot). A respondent's subjective religiosity score is the sum of the item scores. Internal reliability for this scale is 0.84.

### *Social Support*

Our measures are parallel eight-item indexes of perceived *family support* and *friends' support*. Respondents were asked how much they agreed with listed statements adapted from a modified and shortened version of the Provisions of Social Relations Scale (Turner and Marino 1994). Some of these are: “You feel very close to your family [friends]” and “You have family [friends] who would always take the time to talk over your problems should you want to.” Item scores (0 to 4 for increasing levels of family support and 0 to 3 for increasing levels of friends' support) are averaged to arrive at scale scores for these two dimensions of social support. Internal reliability is 0.90 for family support and 0.91 for friends' support.

### *Stress Exposure*

Our measures involve four dimensions of stressful experience: recent life events, chronic stress, lifetime major and potentially traumatic events, and perceived discrimination. We assess *recent life events* (in past 12 months) using a 33-item checklist of negative events common to many life event indices (e.g., serious accidents or injuries, deaths, and relationship or financial crises). See Turner and Avison (2003) for a complete list of these and the other stress items.

Our *chronic stress* measure consists of nine items designed to capture enduring general and residential/neighborhood stressors ("Too much is expected of you by others," "The place that you live is too noisy or too polluted," etc.) that young persons are likely to encounter in their transition to adulthood. These items are selected from a larger 36-item chronic strain inventory<sup>3</sup> designed to reflect the experience of young people.

We measure *lifetime exposure to major and potentially traumatic events* (things such as serious illness, violence, abuse, or disaster happening to or witnessed by respondent) with a relatively comprehensive set of 41 questions. Participants were asked whether each event had ever occurred, how many times, and their own age at first and last occurrence.

In these analyses, the measures of recent life events, of chronic stress, and of lifetime major/traumatic events are each simple counts of the number reported. Multiple occurrences of the same event are not added to the count.

We assess *perceptions of discrimination* in terms of both major events and day-to-day experiences. Major discrimination encompasses events that can be expected to interfere with social and economic achievement, such as being unfairly fired or denied a promotion, refused a job, or discouraged from seeking further advancement. Day-to-day discrimination consists of character assaults such as being treated with a lack of courtesy or respect, or as though one were dangerous, dishonest, or not smart. Major discrimination scores are simple counts of the number of items reported as ever having occurred; the internal reliability for this scale is 0.88. Day-to-day discrimination is estimated by the sum of Likert scores across the nine items; the internal reliability for this scale is 0.85.

### *Sociodemographic Variables*

In the analyses we present below, females are coded 1 and males 0. A set of race/ethnicity variables (with non-Hispanic whites as the reference category) includes African Americans, persons of Cuban heritage, and non-Cuban Hispanics, each coded 1. Because individuals in the sample were still making the transition to adulthood, we estimated their socioeconomic status with a composite score based on parents' income level, occupational prestige category (Hollingshead 1957), and educational attainment. We gathered these data from parents' rather than young adults' reports, except where interviews with parents could not be obtained. Scores on these three status dimensions were standardized, summed, and divided by the number of status dimensions on which data were available.

## RESULTS

Our initial descriptive analyses present the social distribution of depressive symptoms and subjective religiosity. In Table 1, we compare mean scores on depressive symptomatology and religiosity by gender, ethnicity, and socioeconomic level. In every case, we find significant differences. For instance, young women are, on average, both more depressed and more religious than young men—and the same holds true for African Americans as compared with non-Hispanic whites. Socioeconomic status is inversely related to depressive symptoms, and nearly so to religiosity. But how do depressive symptoms and religiosity relate to one another?

**TABLE 1**  
**SOCIAL DISTRIBUTION OF DEPRESSIVE SYMPTOMS**  
**AND SUBJECTIVE RELIGIOSITY**

Mean Depressive Symptoms <sup>a</sup> and Subjective Religiosity by Gender, Ethnicity, and Parental SES		
	Mean Depressive Symptoms ( <i>SD</i> )	Mean Subjective Religiosity ( <i>SD</i> )
Male	2.850 (3.453)	9.425 (3.579)
Female	4.519 (4.995)	10.449 (3.317)
	$p < 0.001^b$	$p < 0.001$
Non-Hispanic white	2.886 (4.375)	8.436 (3.401)
African American	4.354 (4.262)	11.644 (2.907)
Cuban	3.433 (3.902)	9.638 (3.375)
Non-Cuban Hispanic	4.003 (4.590)	10.202 (3.451)
	$p < 0.001$	$p < 0.001$
Lowest SES quartile	4.585 (4.812)	10.289 (3.237)
Second SES quartile	3.936 (4.318)	10.388 (3.536)
Third SES quartile	3.339 (3.768)	9.827 (3.549)
Highest SES quartile	2.662 (4.115)	9.119 (3.535)
	$p < 0.001$	$p < 0.001$

Mean Depressive Symptoms <sup>a</sup> ( <i>SD</i> ) (Valid Cases) by Level of Subjective Religiosity		
	Males ( $n = 942$ )	Females ( $n = 837$ )
Low religiosity	2.769 (3.914) ( $n = 398$ )	3.939 (4.808) ( $n = 253$ )
Medium religiosity	2.786 (3.068) ( $n = 246$ )	5.394 (5.925) ( $n = 247$ )
High religiosity	3.007 (3.088) ( $n = 297$ )	4.288 (4.209) ( $n = 337$ )
		$p < 0.01$

<sup>a</sup>Moderate to severe; CES-D symptoms reported as occurring "frequently" or "almost all the time."

<sup>b</sup>One-way ANOVA tests for differences across categories of gender, ethnicity, SES, and religiosity.

To test the possibility of curvilinear relationships, we examine mean levels of depressive symptoms by level of subjective religiosity (low, medium, or high). Because preliminary analyses have already ruled out race/ethnicity and parental socioeconomic status as potential moderators of the association between subjective religiosity and depressive symptoms (see note 2), we limit this stage of the investigation to gender. Here, we find substantial differences between young women and young men. Depressive symptomatology differs by degree of religiosity for females, but not for males. The pattern of variation among the young women in our sample—with highest depressive symptoms among respondents in the *middle* of the religiosity distribution—suggests an inverse U-shaped relationship between religiosity and depressive symptomatology, similar to that described by Ross (1990).

OLS regression confirms this relationship. Regression analyses summarized in Table 2 demonstrate a significant association between subjective religiosity and depressive symptoms—an association that characterizes the entire sample (Model 1) and is curvilinear in form (Model 2). A significant interaction between gender and quadratically specified religiosity (Model 3) indicates that the curvilinear relationship applies to females only. Separate regressions for females and males (Models 4 through 7) confirm that subjective religiosity is significantly associated with depressive symptoms, but only in its quadratic specification (inverse U-shaped curve) and

**TABLE 2**  
**DEPRESSIVE SYMPTOMS REGRESSED ON SUBJECTIVE RELIGIOSITY,**  
**GENDER, AND INTERACTION TERMS**

	Full Sample ( <i>n</i> = 1,779)			Females Only ( <i>n</i> = 837)		Males Only ( <i>n</i> = 942)	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Subjective religiosity	0.065*	0.433*	0.003	0.026	0.709*	0.036	0.003
Subjective religiosity squared		-0.019*	0.002		-0.033*		0.002
Female Religiosity * female			5.463**				
Religiosity squared * female			0.707*				
Religiosity squared * female			-0.035*				
Intercept	2.982	1.387	2.650	4.242	1.113	2.510	2.650
<i>R</i> <sup>2</sup>	0.003	0.005	0.041	0.000	0.006	0.001	0.001
<i>R</i> <sup>2</sup> change		0.002	0.036				
<i>F</i> change		4.490	21.950				
Sig. <i>F</i> change		0.034	0.000				

\**p* < 0.05; \*\**p* < 0.01; \*\*\**p* < 0.001 (two-tailed tests).

Note: Unstandardized OLS regression coefficients.

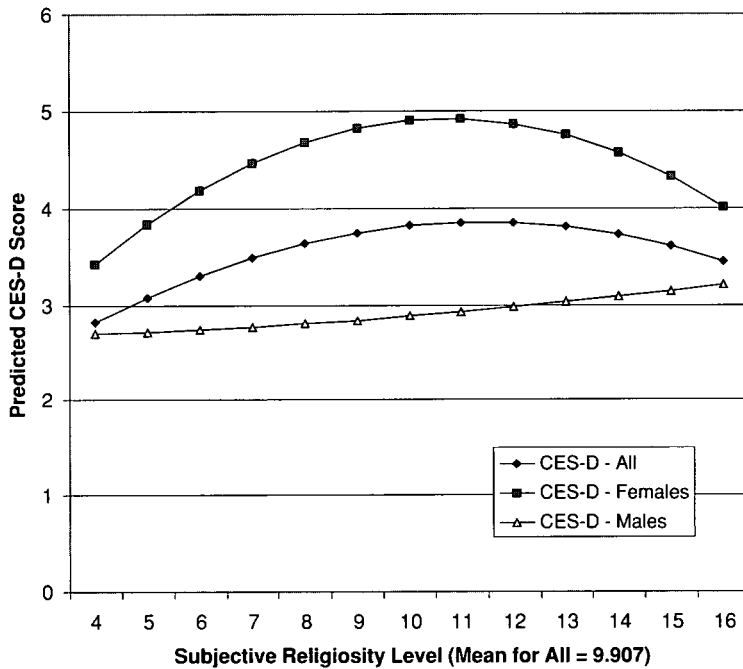
only for young women. This functional form of the modeled relationship (see Figure 1) implies that subjective religiosity is positively associated with depressive symptoms among young women in the lower half of the religiosity distribution, but negatively related to depressive symptoms among those who are more religious.

Table 3 presents (for females only) expanded regression models of the subjective religiosity—depressive symptomatology relationship, controlling for sociodemographics, social support, and stress exposure. In Model 1, when we add sociodemographic controls to the baseline regression shown in Table 2, Model 5, the religiosity coefficients are reduced to marginal significance. While controlling for race/ethnicity has no effect, higher socioeconomic status does predict a significantly lower level of depressive symptomatology—and controlling for parental SES accounts for a sizable proportion of the depression-religiosity association.

Further controlling for family support and friends' support, both associated with lower levels of depressive symptoms (Model 2), accounts for about 34 percent of the protective SES influence on predicted levels of depressive symptomatology. The parental SES coefficient declines in absolute value from -0.811 to -0.532. Religiosity coefficients (marginally significant) are also reduced, suggesting that social support and religiosity are distinctly related to distress.

In Model 3, we additionally control for stress exposure. Chronic stress, recent life events, and day-to-day discrimination emerge as potent risk factors positively associated with depressive symptoms. The apparent protective effects of family support are reduced by nearly 32 percent (with coefficient change from -2.101 to -1.431) and those of friends' support by nearly 38 percent and to significance only at the 0.10 level (with coefficient change from -0.766 to -0.476). The net result is that, with SES, social support, and social stress all held constant, higher levels of subjective religious practice tend to accompany higher levels of depressive symptoms among young women who are less religious overall, but predict lower levels of depressive symptoms among those who are more religious.

**FIGURE 1**  
**CES-D (MODIFIED) BY SUBJECTIVE RELIGIOSITY, FOR FULL SAMPLE**  
**AND BY GENDER (VALUES PREDICTED BY REGRESSION**  
**MODELS 2, 5, AND 7 IN TABLE 3)**



## DISCUSSION

The purpose of this study was to assess the nature of the relationship between subjective religiosity and psychological distress in a context of other well-established risk and protective factors. Our findings suggest that the links between religiosity and depression may be more complex than previously proposed. Our finding of an inverse U-shaped curvilinear relationship, with moderately religious respondents reporting the highest levels of depressive symptoms, is generally in accord with Ross's (1990) interpretation that persons firm in their belief or nonbelief are better off psychologically than those who are uncertain or wavering in their religious commitment. An alternative explanation is that persons whose lives are somehow in conflict with religious values that still hold sway over them may be at increased risk of depression (Sorenson, Grindstaff, and Turner 1995; Strawbridge et al. 1998).

Since initially controlling for SES and social support seems to explain most of the relationship between subjective religiosity and depressive symptoms, one might be tempted to conclude that the contribution of religiosity is largely an artifact of these social influences. However, the curvilinear relationship persists once stress exposure is also controlled. This points to independent influences of (or on) subjective religiosity that are not unidirectional. For instance, a positive association may be found between religious coping efforts and depressive symptoms among persons who are normally not very religious but who turn to religious practices in response to difficult or challenging situations. Indeed, when we regress depressive symptoms on separate *components* of subjective religiosity (Eliassen, Lloyd, and Taylor 2004), we find that young women who are less religious overall do tend to increase their frequency of prayer when depressed. In contrast, religiosity is negatively related to depressive symptoms, and thus may be protective against depression, for highly religious persons. Presumably, their firmly established patterns of religious coping lead

**TABLE 3**  
**DEPRESSIVE SYMPTOMS REGRESSED ON SUBJECTIVE RELIGIOSITY,**  
**DEMOGRAPHICS, SOCIAL SUPPORT, AND STRESS EXPOSURE**  
**(FEMALES ONLY)**

	(1)	(2)	(3)
Subjective religiosity	0.578 <sup>†</sup>	0.548 <sup>†</sup>	0.701*
Subjective religiosity squared	-0.031*	-0.026 <sup>†</sup>	-0.033*
African American	0.740	0.717	-0.424
Cuban	-0.108	-0.233	0.097
Non-Cuban Hispanic	0.511	0.342	0.338
Parental SES	-0.811***	-0.532**	-0.553**
Family support		-2.101***	-1.431***
Friend(s) support		-0.766**	-0.476 <sup>†</sup>
Chronic stress			0.374***
Life events			0.293***
Life traumas			-0.019
Major discrimination			-0.082
Day-to-day discrimination			0.120***
Intercept	1.966	10.724	0.635
R <sup>2</sup>	0.042	0.156	0.274

<sup>†</sup> $p < 0.10$ ; \* $p < 0.05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$  (two-tailed tests).

Notes: Unstandardized OLS regression coefficients.  $n = 819$ .

them, as a matter of course, to seek out and eventually find positive meaning within whatever adverse circumstances they may encounter.

Although gender differences have long been a prominent theme in the sociologies of both religion and mental health, this is one of the first studies to bridge the two areas of inquiry. Our finding that the curvilinear relationship between subjective religiosity and depression applies to young women but not to young men in our sample should not be surprising, given that—at least in Western industrialized societies—women are much more likely than men both to be religiously active and to suffer from depression. Future research into the religiosity-depression link might profitably draw upon suggestions that personality characteristics conventionally thought of as masculine or feminine might be more reliable predictors of religiousness than is gender per se (Thompson 1991; Miller and Hoffmann 1995). Also, further investigations might seek to document life course processes connecting observed gender differences in religious coping during the transition to adulthood with higher rates of religious participation by women than by men later on in life.

The uniqueness of our sample—young adults from an urbanized setting that is highly diverse racially, ethnically, and linguistically—makes it difficult to generalize our findings to older or more rural populations. For instance, in light of significant associations reported elsewhere (e.g., prior to controls in Schnitker 2001), our failure to find any relationship between religious service attendance and depressive symptoms may be an artifact of the point in the life course at which we took our measurement. The divergence of our findings from Schnitker's (2001) noninverted U-shaped relationship *within a large national probability sample* reflects, at the very least, a profound difference in study subjects. Indeed, the fact that we observe any relationship at all between religiosity and depressive symptoms within our largely secularized Miami-Dade young adult sample suggests that such a relationship might be stronger in a population with higher mean age or more traditional orientation (e.g., southern or rural).

A further limitation of this study is its cross-sectional design. Without comparable data collected at multiple time points, it is impossible to establish the temporal sequence necessary to infer direction of causality between religiosity and level of depressive symptoms.<sup>4</sup> Also, looking at additional dimensions of religiosity, and at outcomes other than depressive symptomatology (e.g., substance use), might shed more light on what is increasingly being recognized as a bewildering maze of pathways by which religious involvement may influence mental health.

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#### NOTES

1. Measures of public religiosity available in the data set (membership in religious organizations and attendance at religious services) were not significantly related to depressive symptoms in our preliminary analyses (not reported).
2. Our preliminary analyses rule out race/ethnicity and parental socioeconomic status as additional moderators of the association between subjective religiosity and depressive symptoms. While non-Hispanic whites exhibit the lowest mean levels of both subjective religiosity and depressive symptomatology, and African Americans the highest (see Table 1), race/ethnicity does not make a difference in the way subjective religiosity relates to depressive symptoms. Similarly, despite the noted SES differences in both depressive symptomatology and subjective religiosity, the relationship between them is not contingent on social class. In regression models (not shown) incorporating interactions between race/ethnicity and religiosity, and between parental SES and religiosity, the interaction terms do not come close to statistical significance.
3. We use Items 1–3 and 18–23 from the 36-item Chronic Strain Inventory reprinted in Turner and Avison (2003:502). The items that we omit are the ones designed to measure chronic stress related to specific roles. As specified in the interview design, many of our respondents were skipped over those questions pertaining to employment, marriage/partnership, parenthood, or school. Presumably, any given item of this sort will not yet (or no longer) be applicable for a substantial number of young people in transition to adulthood.
4. Although the larger investigation on which this article is based was longitudinal, it did not employ parallel measures of religiosity and depression that would have allowed us to extend analyses beyond a single wave of data.

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