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The Relation of Religious Belief and Practices, Depression, and Hopelessness in Persons With Clinical Depression

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Religious belief and practices have been associated with lower levels of depression in persons dealing with stressful situations. In this study, researchers examined this relationship in 271 persons diagnosed with clinical depression. It was hypothesized that religious belief and practices would be associated with lower depression and that this relationship would be mediated by hopelessness. Religious belief, but not religious behavior, was a significant predictor of lower levels of hopelessness and depression beyond demographic variables. Through the relation of religious belief to lower levels of hopelessness, religious belief was indirectly related to less depression. There was also a small direct positive association of belief with depression, pointing to the complexity of the role belief plays for religious persons. Further study is needed for a better understanding of different ways religion affects depressed persons.

There is growing awareness that religion can contribute to a person's sense of well-being (Myers, 2000). Researchers exploring how religion aids in coping with stressful life events have examined religious behaviors and beliefs. Studies have shown that those who attend worship frequently are less depressed than those who rarely attend (Idler, 1987; Idler & Kasl, 1992; Koenig, 1995; Koenig et al., 1997; Nolen-Hoeksema & Larson, 1999; Pressman, Lyons, Larson, & Strain, 1990; Wright, Frost, & Wisecarver, 1993). It has been indicated that, in part, the benefits of attendance at worship are mediated by social support (McIntosh, Silver, & Wortman, 1993; Sherkat & Reed, 1992). In samples of the elderly, this aspect of religious behavior may be confounded by physical ability to attend worship (Idler, 1987; Levin & Vanderpool, 1987). A second religious behavior, private prayer and devotions, has been found to be positively correlated with depression. An interaction of private practice and negative life events points to the mobilization of private religious practices as a way of coping (C. G. Ellison, 1991).

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Researchers have shown religious belief to be related to lower levels of depression for bereaved parents (Maton, 1989; McIntosh et al., 1993). This seems to be related to religion's ability to provide individuals with a cognitive framework for finding meaning in a negative event, which leads to less depression (Blaine & Crocker, 1995; McIntosh et al., 1993).

However, to date, no one has adequately examined the role of religion for those diagnosed with clinical depression either as a single episode or as a chronic disorder. Theories of depression have described hopelessness as one of its major characteristics (Beck, 1967; Beck, Rush, Shaw, & Emery, 1979; Brown & Harris, 1978; Melges & Bowlby, 1969). Beck (1967, 1991) proposed a triad of negative thoughts about the self, world, and future as an integral part of depression. He suggested that in some depressions that are a reaction to a negative event, a schema that involves these negative thoughts may play a causal role.

The hopelessness theory of depression (Abramson, Metalsky, & Alloy, 1989) has proposed hopelessness as a sufficient cause for depression. In the presence of a negative life event, a person who attributes the event to stable, global, and internal causes (i.e., to a personal quality or temperament) is likely to become hopeless. This hopelessness leads to depression. Several studies have supported this theory (Golin, Sweeney, & Shaeffer, 1981; McCranie & Riley, 1992; Metalsky & Joiner, 1992; Reno & Halaris, 1989).

The teachings of many different faith traditions include stories or passages about desperate situations with the promise of God's support and a positive outcome. For religious people belief may play an important role in countering hopeless thoughts. Religious persons who were HIV positive had lower levels of hopelessness than nonreligious individuals (Carson, Soeken, Shanty, & Terry, 1990). In a sample of persons with clinical depression, Young et al. (1996) found that, when not depressed, those who were more religiously involved were less hopeless.

In the present study, we examined the effects of both religious practices and religious belief for patients diagnosed with clinical depression. We hypothesized that religious practices and belief

would predict lower levels of depression and hopelessness beyond demographic variables. We then used a path analysis to test the hypothesis that religious belief and practices would relate to depression indirectly through religion's inverse association with hopelessness.

Method

Participants were 196 female and 75 male psychiatric patients at a midwestern tertiary care medical center who were recently admitted for inpatient (44%) or outpatient (56%) treatment. The patients met *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994) criteria for major depression or bipolar depression as diagnosed by their attending psychiatrist (inpatient) or on the basis of their responses on the Structured Clinical Interview for *DSM–III–R* (Spitzer, 1990) which was administered by trained interviewers and diagnosed by psychiatrists (outpatient). Patients with the following conditions were excluded: mood disorder due to general medical condition, dementia, bereavement, psychotic disorders, organic mood disorder, borderline personality disorder, a history of substance abuse within the past 12 months, or a current manic episode. Seventy-six percent of the respondents were White, 11% were African American, 8% were Latin American, and 5% were other. Religious affiliation was predominantly Christian (76%), with 7% Jewish, 3% other, and 14% none.

We used two measures of religious behavior. First, we measured attendance at worship by asking how often the person attended religious services with responses indicated on a 6-point Likert scale ranging from *never* or *almost never* (1) to *more than once per week* (6). Second, to determine frequency of private religious practice, we asked participants "Aside from attending religious services, about how often do you spend time on spiritual or religious practices?" Response options were: (1) once a year or less, (2) once per month to several times per year, (3) once per week to several times per month, and (4) several times per day to several times per week.

Religious belief was assessed with the Religious Well-Being (RWB) Scale, a subscale of the Spiritual Well-Being Scale (SWB; Paloutzian & Ellison, 1982). The SWB, a 20-item scale, contains 10 items to measure existential well-being (EWB), a dimension that measures a sense of purpose in life without any specifically religious items, and 10 items to measure religious well-being (RWB), a dimension that describes well-being in relation to God. Only RWB was used to measure belief because it explicitly contains religious language. Furthermore, EWB has been shown to be correlated with personality characteristics and RWB has not (Piedmont, 1999). In our sample the correlation between RWB and EWB was .58, $p < .001$. The RWB provided information concerning the respondents' beliefs about their relationship with God, with items such as "I believe that God is concerned about my problems." We instructed respondents to use their own definition of God and to rate the statements from *strongly disagree* (1) to *strongly agree* (6). Scores can range from 10 to 60, with higher scores indicating a higher level of religious well-being. For this sample the RWB had an alpha reliability of .93. Studies demonstrate the scale's validity (C. W. Ellison, 1983).

We measured hopelessness with the Beck Hopelessness Scale (HS). Developed by Beck, Weissman, Lester, and Trexler (1974), this 20-item, true–false self-report indicates degree of hopelessness, with a possible range of scores from 0 to 20, where 20 is the highest level of hopelessness. The alpha reliability for this sample was .90. Evidence of this Scale's validity was found in correlations of the HS with clinical ratings of hopelessness of .74 in a general sample and .62 for a sample of persons with recent suicide attempts (Beck et al., 1974).

Developed by Beck, Ward, Mendelson, Mock, and Erbaugh (1961), the Beck Depression Inventory (BDI) has been widely used in research on depression. It is used to measure the depth of depression with 21 self-report items rated from 0 (*weakest presence of symptoms*) to 3 (*strongest presence of symptoms*). For our group the alpha reliability was .87. Beck, Steer, and Garbin (1988) have provided a thorough discussion of the psychometric properties of the Scale. The authors reported correlations of the BDI with a variety of other measures of depression ranging from .55 to .76.

Charts of all new admissions to the general adult inpatient psychiatric unit were reviewed to determine if the patient met the inclusion criteria of the study. After this screening, we invited eligible patients to be part of the study. For the outpatient portion of the sample, we asked patients who were screened for inclusion in other studies of depression if they would be willing to join in this study. Patients completed the instruments on their own using a single survey form.

Results and Discussion

Table 1 presents descriptive statistics for the measures used. RWB scores in this sample appeared to be lower than the scores for other psychiatric patients (46.6) or for medical outpatients (52.4) as reported by Fitchett, Burton, and Sivan (1997). On average, the respondents attended worship once every few months and participated in private religious practice about once a week. In comparison, 59% of Americans said they worship at least monthly, and 75% of Americans said they pray at least daily (Gallup, 1996). The average hopelessness score in our sample was 10.8. Scores of 9 or greater on HS have been shown to be a predictor of suicide (Beck, Steer, Kovacs, & Garrison, 1985). The average score on the BDI located the respondents in the category of moderate to severe depression (scores from 19 to 29; Beck, Steer, & Garbin, 1988).

We used hierarchical regression analyses to examine the relationship of religious practices and belief to depression and hopelessness. Demographic variables were entered simultaneously on the first step. In the second step, we entered the block of religious variables. The regression analyses for depression and for hopelessness are presented in Table 2. The religious variables added significantly to the prediction of depression and to the prediction of hopelessness beyond the variance accounted for by demographics. Of these variables, only belief had a significant relation to outcomes. Consistent with other studies, religious belief was related to less depression (Maton, 1989; McIntosh et al., 1993; Pressman et al., 1990) and to lower hopelessness (Carson et al., 1990; Young et al., 1996).

With decreased energy accompanying depression, it is reasonable that attendance at worship was unrelated to the psychological variables. One possible explanation for the lack of significance for private worship is the possibility that there may have been reciprocal effects. There is evidence that people turn to private practice in times of stress (C. G. Ellison, 1991; Idler, 1987), which results in a positive relationship between religious behavior and depres-

Table 1
Descriptive Statistics for Raw Scores of Measures

Measure	*M*	*SD*	Min.[a]	Max.[a]
Religious Well-Being Scale	36.4	14.3	10	60
Attendance at worship	2.7	1.6	1	6
Private religious practice	2.4	1.3	1	4
Hopelessness Scale	10.8	5.5	0	20
Beck Depression Inventory	27.1	10.6	2	57

Note. $N = 271$.
[a] Actual minimum and maximum scores.

Table 2
Summary of Hierarchical Regression Analysis for Depression and Hopelessness

	Depression				Hopelessness			
	Step 1		Step 2		Step 1		Step 2	
Group	*B*	β	*B*	β	*B*	β	*B*	β
Gender[a]	−4.34	−.18**	−4.35	−.18**	−0.77	−.06	−1.17	−.10
Race[b]	6.05	.24***	5.41	.22***	2.78	.21***	1.88	.15**
Age[c]	−2.40	−.22**	−2.16	−.20**	−1.01	−.18*	−0.36	−.06
Works	−3.84	−.18**	−3.98	−.19**	−0.39	−.04	−0.50	−.05
Lives alone	3.33	.15*	3.35	.15*	1.70	.14*	1.15	.10
Ever married	4.27	.19**	4.37	.20**	0.33	.03	0.46	.04
Education level	0.07	.01	−0.06	−.01	0.28	.06	0.12	.03
Religious beliefs			−0.16	−.22**			−0.18	−.45***
Attendance[c]			1.05	.05			−0.02	.00
Private practice			0.86	.10			0.17	.04
	Intercept = 42.83				Intercept = 17.51			
R^2 (ΔR^2)	.186		.211 (.025)		.095		.258 (.16)	
Significance of *F* change	.000		.044		.000		.000	

Note. $N = 271$.
[a] Male = 1. [b] White = 1. [c] Square root of variable.
* $p < .05$. ** $p < .01$. *** $p < .001$.

sion. Conversely, private religiosity may lower depression (Idler, 1987). If both effects had been present in this sample they would have offset one another leading to a nonsignificant overall relationship.

Path analysis allowes us to decompose relationships into direct and indirect components. Although path analysis does not prove causality, it does let us assess whether our causal theory is consistent with the data (Peyrot, 1996). Because private practice and attendance were not significant in the regression model they were not included in the path analysis. To avoid inflating the correlation of hopelessness and depression, we removed the BDI's item 2, which focuses on hopelessness.

The path analysis (see Figure 1) supported the proposed causal model, with hopelessness mediating the effect of religious belief on depression with an indirect effect of belief on depression of −.32, $p < .001$. This offers a clearer understanding of how religious belief offsets depression.

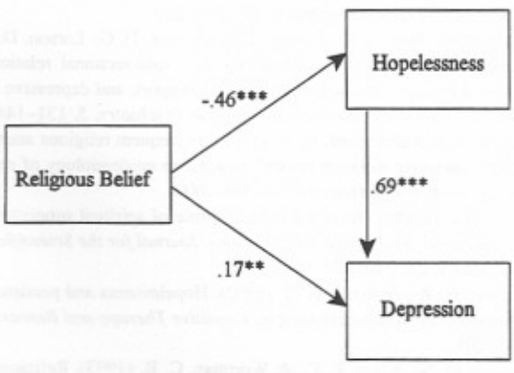

Figure 1. Path model with standardized coefficients of the relation of religious belief to hopelessness and depression. **$p < .01$. ***$p < .001$.

The path analysis revealed the complexity of the role of religious belief in relation to depression. The positive association between religious belief and depression suggests that some persons with stronger beliefs are more depressed than some who do not have religious beliefs. There are two possible explanations for this finding. It may be the result of an intensification of religious belief and practices, a turning to religion for consolation, associated with becoming depressed, as has been reported for rehabilitation inpatients (Fitchett, Rybarczyk, DeMarco, & Nicholas, 1999) and for persons experiencing negative life events (C. G. Ellison, 1991). An increase in depression and even hospitalization could lead some persons to turn to religious belief to cope. In such a case, religion not only impacts depression, but depression causes the person to strengthen religious belief.

An alternative explanation is that some religious beliefs or practices may contribute to depression. Pargament and his colleagues have noted this effect for a pattern of coping that includes beliefs that a person is being punished by God or that the devil is in control (Pargament, Smith, Koenig, & Perez, 1998).

One limitation of the study is found in the measures of religion that we used. Specifically, the SWB was developed using a sample of Christian college students and may not be an ideal measure for a more religiously diverse sample. Its items imply a belief in a personal God and, therefore, are not appropriate for all groups. Efforts should be made to develop and use more inclusive measures of religion in future studies. Measures of attendance at worship and use of private prayer might also have different nuances for different traditions.

Our study used an instrument that measures a positive aspect of religion and a supportive relationship with God. As Young and his colleagues (1996) have suggested, studies are needed that examine

specific religious beliefs. Although our study addressed that concern, it did not measure beliefs that might increase depression or hopelessness, such as teachings about sin or with negative images of God. That is a task for future research.

Because the religious instrument used in this study measured relationship with God, perhaps the results simply reflected personality traits that are present in persons who relate well to others. For example, Young and his colleagues (1996) found that the Eysenck Extroversion Scale (Eysenck & Eysenck, 1964, cited in Young, 1996) was correlated with lower levels of baseline hopelessness in their regression analysis. If religiosity is associated with extroversion, then the relationship between religion and hopelessness may be (at least partly) spurious. However, Piedmont (1999) found no relation between RWB and the Extraversion Scale, nor between RWB and the Neuroticism Scale of the NEO Personality Inventory Revised (Costa & McCrae, 1985 as cited in Piedmont, 1999). Nonetheless, it would be important in future studies to account for personality in order to examine the contribution of religious belief and practices beyond that dimension.

There were also limitations associated with the psychological measures. Both the HS and the BDI are self-report instruments and are open to response bias. That might account for some of the low BDI or HS scores. Including an item to test social desirability would be useful. We hypothesized that religious belief might offset negative attributions that lead to hopelessness. An instrument that specifically measures attributions would be necessary to support our argument.

Although our research showed that the proposed causal model is consistent with the data, the cross-sectional design does not allow a clear indication of cause and effect. Depression and hopelessness also could be causing lower levels of religious belief. A longitudinal analysis would improve efforts to identify causal order.

For patients who have a system of beliefs, incorporating those beliefs into treatment might prevent or reduce hopelessness and depression. Religious belief provides a religious person with a cognitive framework. The results suggest that a potent way of using religious belief is to draw specifically on beliefs that counter hopelessness. The positive correlation of religion with depression also points to the importance of screening for possible religious problems in the religious person.

There is some evidence that inclusion of religion in treatment for symptoms of depression may be more effective for religious persons than are standard cognitive behavioral methods, even if the therapist is not religious (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992). Whatever the ultimate causal relationship between religious belief, hopelessness, and depression, this study supports the converging evidence linking religious belief with emotional well-being and points to the potential benefits of this underutilized clinical resource. It also raises awareness of the need to address religious beliefs that might be harmful for some individuals.

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