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The Interaction Between Religiosity and Depression Among Students at Two Universities

Nils Anders Haldorsen
Eastern Illinois University

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The Interaction Between Religiosity and Depression

Among Students at Two Universities
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BY

Nils Anders Haldorsen

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The Interaction Between Religiosity and Depression Among Students at Two Universities

Nils Anders Haldorsen

Eastern Illinois University

Thesis presented in partial fulfillment of the requirements for the M.A. in Psychology at Eastern Illinois University.

Abstract

The association between religion and mental health has been a long standing topic of the debate. Some have felt that religion leads to emotional and mental disturbances and thus is detrimental to mental health (Freud, 1907/1924, 1927/1961; Ellis, 1980, 1988); while others believe religion is helpful to mental health (Jung, 1932, 1933; Bergin 1980, 1983). This study used 180 male and female (79%) college students from a Midwestern state university (62%) and a Christian liberal arts college. It was found that for women, private religiosity was negatively related to depression, as measured by the BDI. Students from the state university were more likely to be depressed than those from the Christian college. In addition, BDI score was predicted by being a lower income student from the state university.

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For decades, psychologists have debated the question of how religion relates to mental health (Bergin, 1980, 1983; Ellis, 1980, 1988; Freud, 1907/1924, 1927/1961; Jung, 1932, 1933; Martin & Nichols, 1962). Freud (1907/1924, 1927/1961) viewed religion and religiosity as being associated with maladjustment and neurosis. He believed religion was an illusion and therefore had no future (Freud, 1927/1961). Freud (1907/1924) referred to religion as "...a universal obsessional neurosis" (p. 34), or mass neurosis. Other literature supports the notion that psychiatric illnesses are more common among those who are religious (Freud, 1927/1961; Sanua, 1969).

Although this literature supports the notion that religiosity is related to mental and emotional disturbance, one must realize that the majority of the population still attended church when this theorizing took place. Freud's argument of religion as mass neurosis came from an analogy he formed from observing the behavior of neurotics and the religious person's conduct (Freud, 1907/1924). He felt the resemblances between neurotic behavior and religious

behavior allowed us to "...draw by analogy inferences about the psychological processes of religious life" (Freud, 1907/1924, p. 25). Martin and Nichols (1962) performed a meta-analysis of pertinent studies conducted in the 1950's. Their review painted religious persons as emotionally distressed, yet the results showed no correlations, positive or negative, between religiosity and emotional disturbance.

Albert Ellis (1980) stated, "Devout, orthodox, or dogmatic religion...is significantly correlated with emotional disturbance" (p. 637). He felt people are guilty for their emotional disturbances because they believe in religious absolutes. Ellis defined absolutes as "shoulds", "oughts", and "musts", and he posited these absolutes were to blame for emotional disturbances. He stated "...most people who dogmatically believe in some religion believe in these health-sabotaging absolutes" (p. 637). Thus, he concluded that "Religiosity...is in many respects equivalent to irrational thinking and emotional disturbance" (p. 637). While he supported the premise of an association between devout religiosity and mental and emotional disturbance, he admitted there could be benefits derived from religious

ideas. These benefits were derivable only when one was not dogmatic or absolutistic in their religiosity.

Jung (1932, 1933), on the other hand, concluded people actually needed the spiritual help Freud viewed as detrimental to mental and emotional health. Jung viewed religion as beneficial to a person's emotional and psychological well-being. Bainbridge (1988) believed religion offered a better response to life situations than any alternatives. Numerous studies suggest that within the elderly population, religious beliefs and behaviors are prominent and provide a coping strategy in times of distress (Gallup Poll, 1982; Koenig, Moberg, & Kvale, 1988; Koenig, Smiley, & Gonzales, 1988; Swanson & Harter, 1971; Rosen, 1982; Conway, 1985-1986).

Bergin (1980, 1983) felt religion could have positive effects and responded to Ellis' claims by reviewing the existing research on religion and mental health. His analysis revealed that, although 23% of the studies showed a negative relationship between religiosity and mental health, 30% showed no relationship, and 47% showed a positive relationship. Bergin's analysis indicated 77% of the results contradicted Ellis and belief's of others that

religion was harmful to emotional and mental stability. Many other studies support Bergin's finding that religiosity is related to physical and psychological well-being (Crawford, Handal, & Wiener, 1989; Ellison, Gay, & Glass, 1989; George & McNamara, 1984; Idler, 1987; Johnson & Mullins, 1989; Maton, 1989; McClure & Loden, 1982; Ross, 1990; Witter, Stock, Okum, & Haring, 1985). Studies have also consistently shown the conversion to religion and the related intense experiences significantly reduce pathological symptoms (Parker, 1978; Srole, Langer, Michael, Opler, & Rennie, 1962; Stanley, 1965; Williams & Cole, 1968).

Depression and Religiosity

The results of research analyzing the relationship between religiosity and depression have varied as much as studies of general psychological well-being and religiosity (Gupta, 1983; Pressman, Lyons, Larson, & Strain, 1990; Idler, 1987; Bergin, Masters, & Richards, 1987; Jensen, Jensen, & Wiederhold, 1993). Gupta (1983) studied 313 Tibetan students, ages 16-18, and their responses on the emotional stress scale of the Cornell Medical Index and a self-designed religiosity scale. Her results suggested high

religiosity leads to depression and lower mental and emotional health. Katterjohn (1993) studied 67 elderly Mexican-American women and found that the more religiously oriented were more depressed than the less religiously oriented. These results mirror Freud's conclusions, since he claimed religion offered no future, and thus offered no hope, and hopelessness can be a strong indicator of depression.

Other writers have found no relationship between depression and religiosity (Idler & Kasl, 1992; Bergin et al., 1987). Idler and Kasl (1992) analyzed data from 2,812 elderly people and compared religious measures with symptoms of depression over a period of three years. They found neither public nor private religiousness affected depressive symptoms on the whole but did suggest that religiousness benefitted different groups within the sample. Bergin and associates (1987) administered the Beck Depression Inventory, the Religious Orientation Scale (Allport & Ross, 1967), and several other personality measures to 32 college juniors and seniors. Their results showed no relationship between depression and intrinsic or extrinsic religiosity.

Still other studies have found a negative association between religiosity and depression (Park, Cohen, & Herb, 1990; Pressman et al., 1990; Idler, 1987; Genia, 1990). Park and associates (1990) performed two studies analyzing the moderating effects of intrinsic religiosity and religious coping on depression and anxiety of 166 Catholic and Protestant college students. They found depression was negatively associated with devout religiousness among Protestants. Older people who are physically ill also demonstrate a negative relationship between religiosity and depression (Pressman et al., 1990; Idler, 1987). Pressman and associates (1990) studied 30 elderly women recovering from hip surgery and found that religious beliefs were associated with lower levels of depression; they also found the stronger the religious beliefs, the less likely ill elderly patients were to be depressed. Jensen and associates (1993) echoed these results, finding non-depression was associated positively with religiosity. Their study included 3,835 students from five religiously diverse universities. Genia (1990) found, of the 309 religiously diverse people she studied, that the intrinsically religious were the least depressed, as

measured by the Beck Depression Inventory, BDI. Hong and Mayo (1988) found religiosity was not associated with depression proneness.

Risk factors for depression (e.g., gender) may moderate the relationship between religiosity and depression. For example, Idler and Kasl (1992) found private religiosity reduces risk for depression in men. Another variable which could moderate the relationship between religiosity and depression is the social support provided by religion. Koenig and associates (1992) argued that religion may strengthen social support by providing connection with peers and encouraging supportive relationships with those peers.

Church attendance has traditionally been one of the hallmark measures of religiosity. Wright, Frost, and Wisecarver (1993) examined 451 high school students using the BDI and Allport and Ross' Religious Orientation Scale (ROS). They found that males and females who frequently attended church had significantly lower depression scores than those who attended infrequently. Stark, Doyle, and Rushing (1983) found metropolitan areas in the United States with the highest church attendance showed the lowest suicide rates.

Suicide rates, along with prior attempts, are significant because depression is one of the more reliable predictors of suicide attempts. Practicing formal religion, in connection with other variables, is linked to lower suicide rates (Stivers, 1987). Frymier (1988) reported a decrease in religious observance is one of the most significant factors in adolescent suicide. Stack's (1983) research corroborated that notion by revealing suicide rates increased as church attendance decreased among people 15-29 years old, though this is only an indirect association.

Gender is also a major variable in the analysis of depression. As reviewed by Culbertson (1997), some research has found that women experience depression as much as four times as frequently as men; but more generally, the sex ratio is given as to 2:1. This ratio is indicative of developed countries, such as the U.S., where this research was performed.

Assessing Religiosity

The greatest challenge in the scientific study of religion lies in how to measure religiosity. Idler and Kasl (1992) suggested the association between religion and mental health is better described as faith than science. This is a

result of the bulk of religion being based on a belief in God; who we cannot touch, taste, smell, see, or hear. Once religion is measured, the difficulty of determining what variables of religiosity are germane to mental and emotional well-being, and what are not, becomes a factor.

Religiosity is a complex multidimensional construct which is probably associated with psychological and physical health (Wright et al., 1993; Spilka, Hood, & Gorsuch, 1985). Idler and Kasl (1992) concluded the most important aspect in studying religiosity is to use separate measures for the different factors of religiosity.

Various measures have been developed to measure religiosity. Allport and Ross (1967) created the Religious Orientation Scale (ROS) which categorizes individuals into intrinsically religious or extrinsically religious. The intrinsic religious are those who internalize their religious beliefs and live their lives based on those beliefs. Those extrinsically religious use religion to gain security, self-justification, sociability, and status. Hood (1978) doubled the categories of types in the original ROS. Since there was an intrinsic and an extrinsic scale, Hood used those as separate measures and came up with four

religiosity classifications. Intrinsic religiosity came from a high intrinsic and a low extrinsic score; extrinsic religiosity was made up of a high extrinsic and a low intrinsic score. Hood then described indiscriminately pro-religious as having high intrinsic and high extrinsic scores and indiscriminately antireligious or nonreligious as having low intrinsic and low extrinsic scores.

When religiosity measures have been analyzed, two main factors come forth, belief and practice or ritual (Willets & Crider, 1988). Belief is the acceptance of a higher power which watches over us and intervenes when necessary and appropriate. The practice or ritual of religion is church attendance and participation, and suggests social support comes from religious associations. It is important to note that church attendance alone is a generic manner of measuring religiosity since people often attend church for reasons other than being religious, such as social acceptance and support, or parental obligation (Wright et al., 1993).

The General Social Survey (GSS) is a group of cross-sectional, national probability surveys of randomly sampled subjects, which addresses many social indicators (Levin,

1993). The GSS is given annually by the National Data Program for the Social Sciences for the National Opinion Research Center. The entire GSS is not given each year, but various scales are given from year to year. Therefore, each scale is administered and updated every so many years. The latest update of the religious involvement scale was given in 1988.

In the present study, the GSS religious involvement scale was used; this is a 10-item measure which measures organizational, nonorganizational, and subjective religious behavior. Organizational behavior is the public practice of going to church and participating in its' activities; this scale consists of four questions, such as "How often do you attend religious services?" Nonorganizational behavior is the private practice of religion, such as praying, reading the Bible, and financial contributions to the church; this scale also contains four questions and a sample question is, "About how often do you pray?" The final scale of religious involvement on the GSS assesses subjective religious behavior and measures personal feelings toward religion and toward God using two questions, e.g., "How close do you feel to God most of the time?"

Compared to the Religious Orientation Scale (Allport & Ross, 1967), organizational religious behavior coincides with extrinsic religiosity, subjective religious behavior coincides with intrinsic religiosity, and nonorganizational religious behavior exists between intrinsic and extrinsic religiosity. The GSS scales can be used independently or can be collapsed into one overall religiosity scale.

The GSS was chosen here for several reasons (Chatters, Levin, Taylor, 1992). The three scales have been found intercorrelated and represent dimensions of a single, higher order construct of religiosity. The GSS has been used with a variety of populations.

Goals of this study

This study endeavored to examine several aspects of the association between religiosity and depression. First, it sought to expand existing research on religiosity and depression by studying individuals who vary along three dimensions of religiosity (cf. Bergin et al., 1987; Bergin, Stinchfield, Gaskin, Masters, & Sullivan, 1988). Second, it analyzed the association between subscales of the GSS, gender, and levels of depression (cf. Idler, 1987). Results have been varied in these areas, and even differ between the

individual dimensions of religiosity and their summary score. Finally, it investigated how religiosity varies between two colleges which differ in religious affiliation (Christian and nondenominational) to determine if that factor affects depressive levels. No formal hypotheses were tested concerning that association.

Hypotheses

This study was designed to test several hypotheses concerning the association between religiosity and depression in college students suggested by the findings of Idler (1987) with the elderly:

1) for men, both public and private religiosity are negatively related to depression.

2) for women, public--but not private, religiosity is negatively related to depression.

3) for men--but not for women, subjective religiosity is negatively related to depression.

Method

Participants

One-hundred-eighty introductory psychology students (143 females, 79.4%, and 37 males) at two Midwestern institutions of higher education volunteered to participate;

111(61.7%) students were from a medium-sized state university and 69 from a small Christian liberal arts college. The median family income was between $30,000 and $60,000; 88% percent of participants were Caucasian and 12% were ethnic minorities; 175 subject were single and five were married; 78% were freshmen and sophomores (see Table 1).

Materials

The General Social Survey, GSS, religious involvement scale, which produces scores on three separate dimensions, public, private, and subjective religiosity, was used. In addition to these three scale scores, a summary score was computed for each individual as the sum of the scores on the three dimensions. Depression was assessed using the Beck Depression Inventory, BDI (Beck, 1987), a 21-item self-report questionnaire which measures the degree of depressive symptomatology in adults; raw scores range from 0 to 63. Four diagnostic categories are derived from the raw scores: individuals scoring 0-9 are normal or asymptomatic, 10-18 indicates mild-moderate depression, 19-29 indicates moderate to severe depression, and extremely severe depression is indicated by scores of 30-63. Several sociodemographic

variables were also examined: sex, age, marital status, year in college, ethnicity and income (See Appendix B).

Procedure

Participants were recruited from introductory psychology classes at each of the colleges. They were informed that the purpose of the study was to learn more about religiosity and depression. Students were informed that their participation was completely voluntary, and there would be no penalty for nonparticipation or quitting in the middle of the administration. Consent forms were distributed and signed before the questionnaires were administered (See Appendix A). The survey was administered by the researcher in the regular classrooms at the beginning of the class period and took about 10 minutes; debriefing forms were handed out after testing was completed (See Appendix C).

Results

The results provide no support for the three hypotheses. The first hypothesis stated that for men, public and private religiosity are negatively related to depression. There were no significant correlations ($p >$ .05) and thus no support for this hypothesis. Similarly,

the second hypothesis which stated that for women, public--but not private, religiosity is negatively related to depression, was not supported ($p > .05$). Indeed the reverse was true; private--but not public, religiosity was found to be negatively associated to depression ($r = -.17$; 1-tail $p < .05$). The third hypothesis anticipated that for men--but not women, subjective religiosity would be negatively related to depression; it was not supported by the correlations (p's $> .05$).

A series of one-way ANOVAs with sex as the grouping variable revealed no significant differences between males and females on the BDI or any of the measures of religiosity (see Table 2). Further, while 16.2% of males were depressives versus 27.3% of females, the difference is not statistically significant, CHISQ (1) = 1.92, $p = .16$.

As shown in Table 3, there were 135 individuals in the normal group on the BDI, 33 who had mild-moderate depression, 11 who had moderate-severe depression, and only 1 who with extremely severe symptoms. Because of the small number of individuals in the moderate-severe and extremely severe categories the 4 categories were collapsed to 2, normal (asymptomatic, 0-9) and diagnostically depressed

(mild to extremely severe depression, i.e., anyone scoring 10 or more points on the BDI) for analysis. One-way ANOVAs revealed that normal individuals scored higher than depressives on all four measures of religiosity (see Table 4).

A series of analyses was conducted to examine the relationship between college and the dependent variables (depression and religiosity). First, a significant relationship, $r = -.20$, $p < .01$, was found between college and BDI scores which indicates students at the state university had higher depression scores. Similarly, analysis revealed that students at the state university were more likely to be diagnostically depressed, CHISQ(1) = 13.17, $p < .001$ (see Table 5).

Second, significant relationships were found between college and all four measures of religiosity, the direction of the correlations indicating that students at the Christian college scored higher on public, private, and subjective religiosity as well as on the summary score; the r's respectively are .45, .59, .33, and .54, p's < .01.

Correlations were computed for college and BDI score with the demographic variables other than sex (age, year in

college, income, ethnicity, and marital status). These revealed that both college and BDI (r = -.28 and -.18, p's < .05) were significantly related to income. The direction of the coefficients indicates that income and depression were inversely related and that students at the state university came from a slightly more affluent background (Mdn = $45,000 - 60,000) than those at the Christian college (Mdn = $30,000 - 45,000), a difference which is confirmed by analysis, CHISQ = 18.65, p < .001.

Multiple regression was used in an attempt to determine what combinations of variables might predict BDI score with college and the background variables as possible predictors. As shown in Table 6, income and college form a significant predictive combination of BDI scores; accounting, however, for only 10% of the variance. The Beta weights indicate that depression was predicted by lower income and attending the state university.

In a similar fashion, multiple regression was used to examine what possible combination of college and the measures of religiosity might predict BDI score. Only college appeared as a significant predictor; R =- .20; the Beta weight, -.2009, indicates that attending the state

university was predictive of higher scores on the BDI. This equation indicates that college was the only significant correlate of depression.

Discussion

The results of this study proved to be very interesting, despite their failing to support any of the hypotheses. Contrary to Idler (1987), no relationship was found in males between depression and public and private religiosity; there may be several explanations to this finding. First, men comprised only 37 of the sample; a sample of this size has no power to detect modest--but real, relationships. A coefficient of at least .32 is required for significance at the .05 level for a sample this size. Second, males tend to make up a smaller portion of the clinically depressed population; in this study, 16.2% of the males fell in the diagnostic group, a proportion which suggests that the disorder is over-representative among males in this sample.

The second hypothesis anticipated that for women, public but not private religiosity would be negatively related to religiosity; however, the exact opposite was found. Private, but not public, religiosity was negatively

it was a Christian college and religiosity would be strongly encouraged. It was also found that students at the state university manifested higher levels of depressive symptomology. This result was obtained when using the collapsed depression categories (normal vs diagnostic); also college and BDI raw score were significantly related. This result could also be anticipated since depression was negatively associated with religiosity and religiosity was correlated with college (Christian college higher).

Clinical Implications

The findings reported here have numerous clinical implications. First, one can consider the documented benefits which religion brings to some people: socialization and support (Wright et. al, 1993), sense that a higher power is watching over us (Willets & Crider, 1988), satisfaction that we are fulfilling obligations (Wright et. al, 1993). Second, we must consider the influence religion has in one's life. As therapist, we must use all aspects of a client's life to facilitate healing. Denying any aspect lessens the impact of therapy, and limits the scope of improvement. Third, denial or refusal to use religiosity by the therapist can also put a riff between counselor and client; such a

related to depression. This means that women who report they participate in prayer, read the Bible, give money to their church or synagogue, and participate in other private religious practices were less--not more, likely to be depressed. This means that religiosity may have had some type of positive relationship with emotional and mental health, contrary to what Freud, Ellis, Idler, and others believe. These results support the findings of Bergin and others who feel religion is beneficial to mental and emotional health.

The third hypothesis, which predicted that for men, but not for women, subjective religiosity would be negatively related to depression, found no support. The maximum score on the subjective religiosity scale is 8; the mean obtained here was 6.3 and the median 6, indicating that most of the subjects scored high on this scale. With a larger sample, there might have been more variance in the scores and perhaps a significant correlation might have been found.

Differences were found between students at the state university and the Christian college. Students at the Christian college reported significantly higher levels on all four religiosity scales. This result was expected since

response lessens the client's worth by not validating their feelings and values. Such a riff makes rapport very difficult, and consequently the therapeutic relationship is stifled from the beginning.

Westgate (1996) suggested three models of therapy to clarify values and develop spirituality. The first is experiential focusing, which addresses spiritual blocks and seeks to integrate past religious experiences and beliefs with current practice (Hinterkopf, 1994). Second, is Van Kaam's (1986) formation counseling. This Rogerian approach encourages client's to become reacquainted with the spiritual nature of their own inner wisdom. The last model is psychosynthesis, introduced by Hardy in 1987. Influenced by Jung, psychosynthesis uses techniques such as dream work and imagery to draw upon the unconscious to work through spiritual disturbances and identify their true values.

Limitations of This Study

There are several issues which may have been problematic with this research. First, the number of subjects should have been much greater, especially for males. Second, there probably should have been more diversity in the sample, ethnically as well as religiosity.

The Christian college was predominantly white and, on average, reported high religiosity. Students at the state university were more diverse, but still were mostly whites. The state university also showed a higher religiosity than a larger university might have since the students at the state university are not as diverse as one would probably find on a larger university campus.

Third, there probably should have been several different measures of depression and religiosity to assess internal validity. Fourth, the hypotheses should have been stated in a nondirectional manner. Fifth, students, particularly those at the Christian college may have answered questions in a socially desirable manner. Putting up such a facade would jeopardize the validity of the data and potentially lead the researchers to draw false conclusions; future research might include a measure of social desirability.

Suggestions for Future Research

This is an engrossing subject of research, controversial due to its very nature. It is, however, crucial to pursue scientific answers to questions of faith. It is important that one not substitute faith for knowledge,

but we can still advance studies of religious beliefs and practices. A critical area which needs further research is why and how religion is related to lower depression and other mental and emotional problems. It has been found that this phenomenon exists, but we still do not understand directionality or causality. To establish directionality would require a prospective study with people of diverse religiosity.

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Table 1

Characteristics of the Sample

Variable	
College	
State University	61.7%
Christian College	38.3%
Gender, female	79.4%
Education	
Freshman	21.9%
Sophomore	56.2%
Junior	12.4%
Senior	6.2%
Family Income	
$0-15,000	8.0%
$15,001-30,000	11.9%
$30,001-45,000	20.5%
$45,001-60,000	29.0%
$60,001 +	30.7%
Marital Status, Single	97.2%
Ethnicity, Caucasian	88.3%

Table 2

Measures of Depression and Religiosity

Scale		M	SD
BDI		7.16	6.03
GSS	Religiosity Scale		
	Organized (Public)	6.39	2.61
	Nonorganized (Private)	8.14	3.02
	Subjective	6.27	1.37
	Overall	20.81	6.30

Table 3

Depression Diagnostic Categories by Sex

	Males	Females	Both
Category (cut-off)	n(%)	n(%)	n(%)
Normal (0-9)	31(83.8)	104(72.7)	135(75.0)
Mild-Mod (10-18)	4(10.8)	29(20.3)	33(18.3)
Mod-Severe (19-29)	2(5.4)	9(6.3)	11(6.6)
Severe (30-63)	0	1(0.7)	1(0.6)

Table 4

Means and (SD) of Religiosity by Depression Diagnosis

Religiosity	Diagnositic Group		$F(1,178)$
	Normal	Diagnostic	
Organized (Public)	6.66	5.60	5.688*
	(2.62)	(2.44)	
Nonorganized (Private)	8.53	6.96	9.639*
	(3.12)	(2.35)	
Subjective	6.42	5.82	6.727*
	(1.38)	(1.23)	
Overall	21.61	18.38	9.336*
	(6.43)	(5.24)	

Note: Diagnostic Group is the diagnostic categories of the BDI collapsed into two groups: 0 - nondepressed; 1 - mild to severely depressed.

* $p < .05$

Table 5

Depression Diagnosis by College

Depression	State University	Christian College
Normal	65.8%	89.9%
Diagnostic	34.2%	10.1%

Table 6

Predicting BDI Score From Background Variables

Variable	R	R^2	R^2 Change	Beta
Income	.2018	.0407	---	-.2778
College	.3292	.1084	.0677	-.2710

Appendix A

Informed Consent Form

This is a study of the relationship between religiosity and depression. Participation in this study is completely voluntary; you may quit at any time during the research and you will not be penalized for nonparticipation. Confidentiality will be protected in any reports of this research. Your signature here indicates an understanding and acceptance of this.

Name: _____

SSN: _____

Date: _____

Appendix B

Sociodemographic Variables (Coded)

Age:_____

Sex (Circle One): M = 0 or F = 1

Years of Education: _____ 1 = Freshman

2 = Sophomore

3 = Junior

4 = Senior

Family Income: __0__ $0-15,000

(Check One) __1__ $15,001-30,000

__2__ $30,001-45,000

__3__ $45,001-60,000

__4__ $60,001-Up

Ethnicity: __0__ Caucasian

(Check One) __1__ Hispanic

__2__ African-American

__3__ Asian-American

__4__ Native American

__5__ Other

Marital Status: __0__ Single

(Check One) __1__ Married

__2__ Divorced

__3__ Separated

__4__ Widowed

Note: Numbers with options are codings.

Appendix C

Debriefing Form for State University

Thank you for your participation in this research project. It was designed to study the association between religious beliefs and practices and depression. Sometimes when participating in studies such as this one, people learn things about themselves which might raise questions. Please contact the EIU Counseling Center at 581-3413 to address any concerns this study may have raised. If you have any further inquiries regarding this research, please contact Dr. William Bailey at 581-6612 or myself at 234-2898. Upon completion of this study, a summary of the results will be availible in the Psychology Department if you are interested.

Nils Haldorsen