Religion's Impact on the Mental Health of Seventh-Day Adventist College Students

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ABSTRACT

Depression and anxiety rates among college students are increasing around the world. This paper will examine results of a 2018 survey that found high rates of depression and anxiety among Adventist College students as well as results from a focus group follow-up study that helped to explain those results. Our objective is to examine the positive and negative influence of religion on the mental health of Seventh-day Adventist college students.

Approximately a third of young adults (ages 18–24 years) in the United States attend college, representing a critical mass of the young adult population (VanKim and Kelson 2013). A critical transition for many late adolescents is the move from one's childhood home to college (Paul and Brier 2001). Life transitions, such as moving away from home to college, create valuable opportunities or growth and change while also potentially heightening self-doubt and disappointment and even encouraging self-defeating habits (Compas, Wagner, Slavin, and Vannatta 1986; Felner, Farber, and Primavera 1983). The transition to college puts students at risk for increased problematic behaviors for several reasons including the initiation of new roles; the development of new friendship networks; separation from families and old friends; more academic choices and opportunities; more academic demands; increased independence; and less parental support, guidance, and monitoring (Schulenberg and Maggs). The individual and contextual changes that occur throughout college push to the forefront a number of behaviors that can increase risk for negative mental health outcomes (2002Braithwaite, Delevi, and Fincham 2010). Religiosity is often used as a coping tool to help address emotional distress (Folkman 2011). As students enter their college years, there can be a transition period in how they relate to religiosity (Lee 2002), thus changing the dynamic between religiosity and mental health.

This paper presents results from a youth health risk survey conducted on a Seventh-day Adventist college campus in 2018. Previous research has found that overall, religion can have a positive or negative social and mental health impact (Giem and McBride 2006). In addition, a recent issue of the *Adventist Review* noted that religion could be toxic (Klingbeil 2019). This study will examine the positive and negative influence of religiosity on mental health among Adventist college students.

Counseling centers on college campuses in the United States have reported a concern of increasing students accessing their services for depression and anxiety disorders (Center for Collegiate Mental Health 2016). A high percentage of college students report experiencing depression and anxiety so severely in the past year that it affected their functioning, with 39% reporting depression and 50% reporting anxiety (American College Health Association 2017). The negative effects of psychological problems on the society and economy could interfere in everyday life and frequently causes pain to the sufferers and their family. Severe depression could affect the daily life of the individuals and their family members, and it could also have influence on their friends and affect their studies, if they are students (Armento, McNulty, and Hopko 2011).

In recent years, religion has been investigated more thoroughly in relation to mental well-being (Kolchakian and Sears 1999). Religiousness is multi-dimensional in nature and may play an important role in moderating the effects of major life events (Park, Cohen, and Herb 1990; Young, Cashwell, and Shcherbakova 2011). Much research implies a positive relationship between extrinsic religiousness and depressive symptoms and a negative relationship between intrinsic religiousness. Extrinsically-motivated individuals regard religion as a means to an end whereas

intrinsic religion is often perceived as a means in itself (Bergin 1991; Allport 1966).

METHOD

A youth health risk survey has been distributed at Andrews University about every five years since 1990 using a purposive sample of representative classes through the university; the N each time is around 700. The goal is to examine health risk behaviors (substance use, sexual behavior, abuse, and mental health) as well as risk and protective factors. This paper presents results from the survey conducted in 2018 with an N of 650. Trained student workers entered into the chosen classrooms at the beginning of class and wrote a link on the board for students to enter into their chosen device. Most students chose to use their cell phone. The link was through the online survey company Survey Monkey. The student workers read a description of the study and the consent information. Students did not have to participate in the survey. When students chose to participate in the survey they gave consent. There was IRB approval and support of Andrews University administration.

We used the shortened, 21 question version of the Depression, Anxiety, and Stress Scale (DASS) to measure depression and anxiety levels for our mental health questions (Lovibond and Lovibond 1995). The scale questions were rated on a four-point Likert scale of frequency or severity of the participants' experiences over the last week. The scores ranged from 0, meaning that it "did not apply to them at all," to 3, meaning that the participant considered the item to "apply to them very much, or most of the time." The scale has been found to be reliable and valid in a wide variety of international populations (Beaufort, DeWeert-Van Oene, Buwalda, de Leeus, and Goudriaan 2017). The scale is not meant to diagnosis any particular form of depression or anxiety, but does identify typical symptoms of these conditions.

The religiosity questions are from different sources. The religiosity internalization questions are from the Christian Religious Internalization Scale (CRIS) (Ryan, Rigby, and King 1993). This scale measures two types of internalization of religion. Introjection represents a partial internalization of religious beliefs and is characterized by self- and other-approval-based pressure. Identification represents adoption of religious beliefs as personal values. The question regarding commitment to Christ is just one question where the participant identifies their level of commitment to Christ from "None" to "Fully Developed" on a four point Likert scale.

The purpose of the qualitative study was a follow up to help understand the results from the youth health risk survey. The questions examined wellness behaviors that included physical health, mental health, and substance use of college students and the role played by religiosity, peers, media, and parents. This study focuses on the mental health and the role that religiosity plays. Students were recruited to participate in the study as part of a requirement to choose a research study as part of a course requirement for some of the Behavioral Sciences Department general education courses. This study was one of many they could choose. Students were each given $20 as an honorarium for their time. There were five focus groups with 4-10 participants in each one. Participants could leave at any time, but none did. Each group was audio-recorded. The principle investigator asked the open-ended questions and the graduate assistant took notes of non-verbal communication.

The N was 565 of those who answered the mental health questions in the survey. A vast majority identified as Seventh-day Adventist (89%), 7% were other Christian, 1% other religion (Islam, Hinduism, and Buddhism), and 4% identified as no religious affiliation. This study is focusing just on the Seventh-day Adventist participants. The Seventh-day Adventist participants were very ethnically diverse with 15% identifying as African American, 6% as West Indian, 20% Asian/Pacific Islander, 26% White (non-Hispanic), 15% Latino, 10% Multi-ethnic, and 7% as other. The ages ranged from 18-59, but 88.4% were ages 18-25 with an average of 21.9 years old. There were more female than male participants (60% female, 40% male).

A total of 39 participants took part in the qualitative portion of the study. The focus group participants were restricted to be self-identifying as Seventh-day Adventist, single, living on campus, and ages 18-25 in order to get a more homogeneous group of college students. The study population was comprised of 38% males, 62% females. Ethnic representations included 18% African American, 10% Asian/Pacific islander, 28% White, 28% Latino, and 16% Multi-ethnic with the ages ranging from 18-24.

ANALYSIS

The raw data from the survey was downloaded into Statistical Package for the Social Sciences (version 24) from Survey Monkey for analysis.

To examine mental health questions, we calculated depression and anxiety levels and placed the scores into categories from none, mild, moderate, severe, and very severe. The religion variable was split to compare religious groups in order to specifically examine just the Seventh-day Adventist participant depression and anxiety levels.

Mental health was analyzed in the context of religiosity. All religiosity questions were examined with mental health as the dependent variable using Pearson chi square, odds ratios, and correlations. The religiosity questions were categorized as measuring level of commitment to Christ and internal or externally motivated religiosity. Only the statistically significant results are reported.

The focus groups were audio recorded to allow transcription. The principle investigator and graduate assistant then reviewed the transcripts independently and came up with a code book. The initial analysis was accomplished by coding participants' themes throughout the data. The team used the classic constant comparison approach (Glaser and Strauss 1967). This was facilitated with the qualitative software, QDA Miner. As the analysis progressed, researchers examined specific instances of the codes to clarify similarities and differences between the researchers' use of these codes. Then the top themes were identified. This procedure helped to increase inter-coder reliability.

RESULTS

The mental health of the Seventh-day Adventist participants was as follows and can be seen in Table 1: Depression—None 62%, Mild 13%, Moderate 13%, Severe 5%, Very severe 7%; Anxiety—None 67%, Mild 14%, Moderate 8%, Severe 4%, Very Severe 6%; Stress—None 75%, Mild 10%, Moderate 6%, Severe 8%, Very Severe 2%.

In examining levels of commitment to Christ and mental health, only depression was statistically significant using chi square and odds ratios. For those who were (1) Not committed to Christ, 16% were moderately to very severely depressed, (2) Not sure if they were committed to Christ 47% were depressed, (3) Committed life to Christ at a specific time 33% were depressed, and (4) Commitment to Christ has developed 19% were depressed.

Pearson correlations revealed the strength and direction of the relationship between religiosity and mental health. Three variables that represented external (imposed by others) religiosity were positively related to higher stress, anxiety, and depression levels. See Table 2. Sharing faith for approval of others had a very small but statistically significant relationship with stress (.12, p≤.05), anxiety (.13, p≤.01), and depression (.16, p≤.01). Praying to avoid God's disapproval had a small statistically significant relationship with stress (.12, p≤.01), anxiety (.20, p≤.01), and depression (.16, p≤.01). Attending church to avoid disapproval of others had a very small statistically significant relationship with stress (.14, p≤.01), anxiety (.13, p≤.01), and depression (.10, p≤.05). The mental health variables were not statistically significant with any of the other religiosity variables so focus groups were used to better explain the results.

UNDERSTANDING OF MENTAL HEALTH FOCUS GROUP RESULTS

We assessed how mental health is understood by students at Andrews University. This section further reviews the findings of students' perception on mental health.

The major theme identified by participants in this section was: Resources for addressing mental health and wellness are available on campus. Participants noted that the availability of the counseling and testing center on campus

Table 1: Mental Health of SDA College Students

MENTAL HEALTH	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
DEPRESSION	62%	13%	13%	5%	7%
ANXIETY	67%	14%	8%	4%	6%
STRESS	75%	10%	6%	8%	2%

Table 2: Religiosity and Mental Health

EXTERNAL RELIGIOSITY CORRELATIONS	STRESS	ANXIETY	DEPRESSION
Sharing faith for approval of others	.12 p≤.05	.13 p≤.01	.16 p≤.01
Praying to avoid God's disapproval	.12 p≤.01	.20 p≤.01	.16 p≤.01
Attending church to avoid disapproval of others	.14 p≤.01	.13 p≤.01	.10 p≤.05

plays a major role in assisting students dealing with stress and other mental disorders. Following are anonymous statements from focus group members (FG#).

> I think that most of them feel that there is support, like they can go to the Counseling and Testing Center. Like there are signs everywhere that say, "If you are feeling blue," whatever. I feel like people know they have a place they can go for free and in the dorms, they always have a lady from Counseling that you can go and see confidentially talk to her. I know some people who like to do that. It is like an awareness, like you know it is there. (FG5)

Another point raised was the promotion of the Counseling and Testing Center on campus grounds. This was identified as beneficial for students as helping in creating awareness on mental health.

> Um, I think overall, I have seen that, compared to my high school back home...um, Andrews actually cares about people's mental health like they want you to... ahh, have good sleeping hours and they want you to be social and have a good like eating...eating habit just be healthy all around, and it's not just do the work we give you and succeed no matter what, it's do the work but also take care of yourself. I feel like that's...that's everywhere, because they have all the signs up, they have it at the cafeteria. Everywhere you go you see something about taking care of yourself, or being like yourself along with others, like along with the community. (FG2)

The third major theme that participants reported to was: Stigma in the community makes it difficult for students to admit that they need help. Even though resources are available on campus, participants reported that factors such as stigma cripples the chances of them getting help.

> ...I feel like our society or our country almost has a stigma against mental health care and I feel people view mental health as a hoax. Like physical health like, when your nose runs you go to the doctor, but your brain is never gonna like have a runny nose, it doesn't work like that, so I feel like people just think it's kinda like a hoax, made up by a bunch of people that wanna like not go through the work to become like actual, like physical doctors, so they are just gonna be like mental doctors and then like that's their deal and I feel like, that also is in part due to like religion, cuz I feel like sometimes in like more conservative religious circles we don't feel like psychology and things like that are very accurate and good, and so, as a result we experience bad mental health problems. (FG1)

ROLE OF RELIGION

The responses gathered from the five focus group discussions conducted with Andrews students suggest that there is a relationship among religion, substance use, and mental and physical health. This section further assess the question: What role might religious beliefs, religious involvement, and one's relationship with Christ play in the mental health, physical wellness, and substance use behaviors of Andrews University students?

One of the major themes identified from the focus group discussions under the role of religion was, religion sets standards and helps to resist the temptation and to cope with stress.

The participants further reported that if a student has internalized religion, it helps in setting a standard, which can help them make smart decisions when it comes to living a healthy life.

The focus group participants further identified another theme to the role of religion which was, it can cause guilt and/or lead to rebellion if a person has not internalized this value. Participants stated that if religion is not well understood and internalized by college students it can often lead to a feeling of guilt and shame.

In addition to this, participants stated that a feeling of religion being pushed down on them can often have an oppressive feeling on college students. Thus, these types of feelings can further lead a student to rebel against the standards set by religion, or cope by participating in other activities that go against these standards.

I think the church tends to shame people into doing things a lot of the time. It is not "do this because it is good for you". It is more "do this because if you don't you aren't doing good—you aren't going down the right path and you are bad because of it." I think there are lots of things that should be approached differently from a religious aspect. Instead of shaming someone into doing it, just encourage them to live a Godly life, a Christian life, whatever. (FG4)

DISCUSSION

Depression and anxiety rates are increasing among college students around the world (Oswalt, Lederer, Chestnut-Steich, Day, Halbritter, and Ortiz 2018). There are multiple reasons for this. A large recent study of college students examined the multiple social and psychological

risk factors for students' suicidal behaviors. It found that financial stress, problem drug use, experiencing violent victimization, and being depressed were all risk factors (Assari 2018). A sizable amount of participants (25%) in this study reported moderate to very severe levels of depression, and nearly one out of five (18%) had anxiety. It is a concern that the depression levels are as high as they are. With depression at these levels, one out of four students would benefit from taking an anti-depressant medication to address their symptoms because of how much the depression may affect their functioning. There is still a societal stigma against getting help for mental health challenges. This is especially true within the conservative Christian context.

Though religiosity is typically seen to have a positive influence on mental health, there have been studies that have found some negative influence (Levin 2010). The Andrews University study supports both types of findings. It depends on how religiosity is approached. The statistically significant religiosity variables measured introjection. Introjection is when religious beliefs have only been partially internalized and is characterized by self- and other-approval-based pressure. That pressure is related to higher depression rates. Religiosity does set standards as found in the focus group, but if those standards are not internalized, it can lead to an individual struggling to meet those standards. When that does not happen it could have a negative effect on one's mental health. The higher the individual's commitment was to Christ, the lower the depression rates, except for those who have no commitment at all—a group with the lowest depression rates at 16%. Those identified as having no religious affiliation had a 13.5% depression rate compared to 25% of Seventh-day Adventist participants. It should be noted that the N for the non-believers was only 22 participants. According to research, non-believers typically have higher rates of suicide and depression, but a recent research study found that those who are non-believers for intellectual reasons, as opposed to emotional reasons, had lower rates of depression (Baker, Stroppe, and Walker 2018). Those who had doubts about their commitment to Christ had the highest levels depression at 47%. It is hard to know if the depression caused an individual to doubt their commitment to Christ or if the doubts led to a lack of certainty about their world that could worsen depression. Of those who reported their commitment to Christ was developed, only 19% were depressed. Being committed to Christ could give a sense of purpose and certainty about their world, though still one out of five of them suffered from depression.

CONCLUSIONS AND RECOMMENDATIONS

Religious faith and belief can be helpful to mental health. But this study found higher rates of depression and anxiety if it feels forced or the individual has doubts. There is still a lot we don't know about the psychology of religion and its effect on mental health. Religiosity and psychology are complex concepts that intertwine in interesting ways. The focus groups helped to shed light on the importance of internalizing religiosity. Though a lot of religiosity at a Seventh-day Adventist university is external with its expectations—attending church, taking required religion courses, attending the required amount of chapels, and external pressure to live up to Seventh-day Adventist standards of living—those standards do help a person live a healthier lifestyle according to the focus groups. That external pressure becomes a problem when the individual hasn't completely internalized the beliefs that led to those standards and expectations. These results were supported by both the survey and the focus groups.

Spiritual growth is a process that needs support and guidance. Young adults are trying to figure this out. Their generation is coming of age in a world with ever increasing rates of those who do not have any religious affiliation (Pew Research Center 2015). They are trying to figure out where they fit. Forcing them into a preconceived notion of what it means to be a Seventh-day Adventist is making them feel restricted. Standards are important, but these university students need to understand where these standards come from and how they fit into today's society. This will aid in spiritual growth that can lead to a commitment to Christ which was linked to lower depression rates.

The focus group participants felt Andrews University's counseling center did a good job of that by talking about mental health issues openly. All church educational institutions and congregations should do the same. But the stigma remains an issue. Adventist educational institutions should consider linking their students with online counseling services (face-to-face or through texting) where there is a less of a stigma having to possibly see your counselor on campus or be seen going to a session by classmates.

According to this study, even those who have a strong faith commitment still struggle with depression. Faith doesn't negate all illness. Because of the association with being

a Christian and the perception of lower depression and anxiety rates, those who do struggle with these issues are often afraid to reach out for help since others will doubt their faith. The reality of mental illness, even within the faithful, needs to be accepted. Committed Christians also suffer from the same ailments that non-Christians experience. Though research has found that Seventh-day Adventists do have lower rates of many lifestyle related diseases, they still do suffer from them nonetheless. There are many factors associated with mental illness. As a church we need to be more supportive and understanding of those who struggle with depression and anxiety and encourage them to get help from trained mental health professionals.

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