THE RELATIONSHIP BETWEEN

RELIGIOUS ORIENTATION AND DEPRESSION

by

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Table of Contents

List of Tables

List of Diagrams

1. Introduction

Few issues in human existence are as important as religion and spirituality, which pervades every stage of human development and provides meaning to the mysteries of existence. Religion not only brings out the best in people in the form of mystics, saints, cathedrals, music and literature, but has also been used throughout human existence to rationalise and justify inhumane treatment of others, persecution, intolerance of different belief systems, exploitative labour relations and political systems (Belzen, 1996, p. 23). When one considers that the vast majority of the earth's population subscribes to some form of religion, despite the notable decrease in formal church attendance, the importance of religion in promoting mental health and facilitating recovering from illness needs to be examined (Spilka, Hood, Hunsberger, & Gorsuch, 2003, p. 122).

Humans are not only complex systems comprising physiological, social and psychological interdependent and interactive subsystems. Historically, it has been observed that state of mind and beliefs influence susceptibility to, recovery from, prevention and reoccurrence of illnesses (Solomon, 2002, p. 31). A frequently neglected aspect of modern humanity is the spiritual subsystem, a part of human potential that has persisted throughout human history, an aspect important for the holistic view of patients (Wikstrom, 1994, p. 30).

Modern society is characterised by rapid industrialisation and greater wealth, but this has not led to greater happiness and contentment, rather to increases in the levels of depression, anxiety, alienation, violence, selfishness, hostility, despair, isolation, excessive individuality, and loss of courtesy and sense of community (Bergin, 1986, p. 95; Thoresen, Harris & Oman in Plante & Sherman, 2001, p. 18). Berger (1980, p. 132) points to secularisation, "a progressive loss of plausibility (delegitimisation – own addition) to the religious views of reality".

In response, in recent decades there has been an explosion of religious renewals and increasing interest in the experiential and existential aspects of religion, such as the effects meditation and yoga have on the mind-body relation, in finding the meaning and purpose of life, and being able to cope constructively with daily challenges (Berger, 1980, p. 132; Chirban, 2001, p. 267; Solomon, 2002, p. 37). Furthermore, Pargament (1997, p. 3) argues that all the world's religions acknowledge that human existence originates from a state of suffering and is a response to how to alleviate human suffering.

Spiritual inclinations are expressed in various ways, with various motivations, cognitions, perceptions and behaviours, and these can be empirically studied through observation, and the acquisition of objective knowledge and information using scientific methods (Spilka et al, 2003, p. 2-3). These behaviours, motivations, perceptions, cognitions, attitudes and values determine relations to the self, others and the universe (Spilka et al, 2003, p. 1-3).

In the past approximately four decades, there has been a rise in the study of the interactive effects between religion and various forms of health. Although research findings to date generally show that religion is related to positive psychological health, there is as yet no clear consensus, as religion is mostly examined as included in social science indicators (Koenig, 1997, p. 104; Levin, 1994, p. 1475). Batson, Schoenrade and Ventis (1993) compiled a meta-analytic study of the relation between religion and mental health from studies conducted in the United States, United Kingdom, Netherlands and Australia. A literature search on Medline, Social Sciences Index and PsychInfo between the years 1973 and 2002, revealed only two published articles in 1963 and 1995 on the relation between religion and mental health in Africa, and one masters dissertation using phenomenological methodology, completed in 1991, on the relation between melancholy and religion in South Africa.

In 2002, Edwards and Besseling, published an article on the relationship between depression and religious *involvement*, but to date no psychological studies could be found that studied the relation between religious *orientation* and depression in South Africa. Due to various limitations, a convenience sample was chosen from the Western Cape region of South Africa. This region is regarded as closely resembling a Western European ociocultural character, which was effected by Western rather than African ociocultural historical and religious influences, and which facilitates comparison to previous studies in the Western milieu.

As the concepts required for the study are multidimensional, the various definitions of the concepts will be discussed in chapter 2. Current research literature on the relationship between depression and religious orientation is outlined in chapter 3, and a study designed to address these problems is described in Chapter 4. The analysis of the data and the obtained results are described in Chapter 5 and 6. Chapter 7 gives a discussion and chapter 8 contains concluding remarks as well as an evaluation of the strengths and limitations of the present study.

2. The concepts of religion, religious orientation, and depression

Psychology of religion is defined as "an application of scientific methods to enhance our psychological understanding of religion" (Spilka et al, 2003, p. 13). The main sources of theory have been the fields of personality and social psychology. These fields include examining the relation between personality characteristics and psychosocial variables, as well as social identity, perception, cognitions, group dynamics and interpersonal relationships to religious variables (Spilka et al, 2003, p. 5). A subgroup of researchers has also examined the relationship between religion and various aspects of health, taking personality and social psychology variables into account. However, there is little agreement among researchers on the relation between religious orientation and depression. This is largely the result of lack of consensus regarding the definition of concepts. The various definitions of the concepts of religion, religious orientation and depression need to be outlined in order to assess their impact on research findings.

2.1. Concepts of religion

A popular view among anthropologists, sociologists and social psychologists is that human religion has a genetically determined, innate basis or instinct as revealed in cross-cultural research that proves the universality of religion (Batson et al, 1993, p. 53; Spilka, Hood, & Gorsuch, 1985, p. 12). Despite being a universal phenomenon, religion has different meanings to different people, defined differentially and partially in terms of, for example, altruism, doctrinal orthodoxy or experiences (Pargament, 1997, p. 23; Spilka et al, 2003, p. 6). The construct of religion is not uniform and unidimensional (Bergin, 1991, p. 299; Masters & Bergin, 1992, p. 221).

Originally derived from the Latin word *religio*, there is disagreement as to what the term originally meant: superhuman power, the feelings and actions associated with the experience of this power, or rituals? During the ages, the term has referred to inner piety, to a reified system of ideas, or was used in a generic sense. More recently, religion has been conceptualised in the West in terms of the institutional structure, comprising the adherence to the beliefs and practices of the institution, the meaningful and transcendent cumulative tradition and faith, which is the orientation to the self, others and universe that is unique, comprehensive, central, complex and diverse (Batson et al, 1993, p. 6; Fallot, 1998, p. 4; Wulff, 1991, p. 3-4).

Furthermore, researchers have tended to distinguish between religion, religiosity and spirituality. The meanings of these terms are multidimensional and controversial, where religion has generally come to refer to social institutions, such as, rituals and theology, spirituality to the personal experience of connection to the transcendent, and religiosity to the experience of organised religion, which is organised, identifiable and individualised (Ellison & Levin, 1998, p. 708; Pargament, Sullivan, Balzer, Van Haitsma, & Raymark, 1995, p. 969; Pargament, 1997, p. 38; Plante & Sherman, 2001, p. 22).

Spirituality can refer to the immaterial, animated beliefs, experiences and aspects of religion and may include religion. Religion can also include spirituality, where "religion is a search for significance in ways related to the sacred" (Pargament in Plante & Sherman, 2001, p. 22). Spilka et al (2003, p. 9-10) regard the term spirituality to referring to personal, immaterial, psychological processes and the term religion to refer to institutional and therefore sociological processes. However, definitions of religion, which focus on either institutional or personal factors, give an incomplete picture of the richness and complexity of the religious experience.

Within the field of the psychology of religion, theorists and researchers focus on questions of: the meaning of religion to individuals, the meaning and expression of core values, the relationship to the transcendent, the expression of religion, religious beliefs, behaviours and experiences, the functions of religion in shaping thought and behaviour, the human source of religion, sense of sacredness, and how humans relate to their faith (Fallot, 1998, p. 4; Hood, Spilka, Hunsberger, & Gorsuch, 1996, p. 2-3). A distinction can be made between substantial, functional, operational, processes and interactional definitions of religion.

Substantive definitions refer to the quality of religious phenomena, a transcendental reality or expression of beliefs, emotions, experiences, practices and rituals, and the Judaeo-Christian content (Berger, 1980, p. 126; Pargament et al, 1995, p. 956; Van Uden & Pieper, 1996, p. 36). Substantive definitions state that:

- Religion "introduces a personal divinity...it is a God who reveals himself, who speaks...who makes known wishes that are psychologically differentiated or capable of differentiation from the typical human wishes of spontaneous religiosity" (Godin, 1985, p. 260),
- A religion is a network of pronouncements about a supernatural and/or divine being(s), about ethics, about prayers, and about symbolic signs and actions through which the person comes into living community with the divine" (Vergote, 1990, p. 76), and that
- Religion is "the inner experience of an individual who senses a Beyond and attempts to harmonise her life with it" (Clark in Van Wicklin, 1990, p. 27).

These definitions, with their emphasis on and internalisation of an external divinity, do not address the question of what intra-psychic meanings; processes and functions religious belief and action have to the individual and group. This limitation is addressed instead by the functional, process and interactional definitions.

Functional definitions refer to the results of following a religion in order to find meaning in the issues of human existence or to the place religion has in the psychosocial system (Berger, 1980, p. 126; Pargament et al, 1995, p. 956; Van Uden & Pieper, 1996, p. 36). Functional definitions of religion, which define what religion does for the dilemmas of individual and social life, how religion operates in the social world, serves ociocultural and individual needs, and shapes belief and practice, rather than the content of religion (Roof, 1979, p. 31; Spilka et al, 2003, p. 2). These definitions state that religion consists of:

- "The beliefs, prayers, mythical tales, and conduct regulated by religious institutions insofar as they accomplish wishes, fill deficiencies, and calm anguish in individual or group life" (Godin, 1985, p. 259)
- "A set of symbolic forms and acts which relate man to the ultimate condition of his existence" (Bellah in Berger, 1980, p. 127)
- "A system of symbols which acts to establish powerful, pervasive, and long-lasting moods and motivations in men by formulating conceptions of a general order of existence and clothing these conceptions with such an aura of factuality that the moods and motivations seem uniquely realistic" (Geertz in Berger, 1980, p. 127)
- "*The feelings, acts, and experiences of individual men in their solitude, so far as they apprehend themselves to stand in relation to whatever they may consider the divine*" (James, 1987, p. 36)
- "*Any system of thought and action shared by a group which gives the individual a frame of orientation and an object of devotion*" (Fromm, 1950, p. 21, italics in original) in order to transcend the isolation of existence, focus the meaning of existence and thereby obtain meaning in life (Fuller, 1994, p. 216; Spilka, Hood, & Gorsuch, 1985, p. 5; Wulff, 1991, p. 593), and that

- "... Where one finds awareness of and interest in the continuing, recurrent *permanent* problems of human existence – the human condition itself, as contrasted with specific problems; where one finds rites and shared beliefs relevant to that awareness, which define the strategy of an ultimate victory; and where one has groups organised to heighten that awareness and to teach and maintain those rites and beliefs – there one has religion." (Yinger in Spilka et al, 1985, p. 6),
- Beliefs regarding the transcendent, and the private and communal rituals that represent devotion to these beliefs (Koenig, 2002, p. 11),
- The experience of safety and shelter found in transcendence (Frankl, 1986, p. 270), and
- "A generalized, abstract orientation through which people see the world; it defines their reality, provides a sense of significance, and receives their fundamental allegiance and commitment." (Paloutzian, 1996, p. 13).

However, Berger (1980, p. 127) has criticised the use, or misuse, of functional definitions, and even definitions in general, as they tend to compartmentalise reality and to be used for ideological purposes in the "*quasiscientific legitimation of the avoidance of transcendence*" and to legitimise a secular worldview (Berger, 1980, p. 128, italics in article). Berger has proposed that a phenomenological approach be used to the study of religion, which emphasizes the meanings of the religious consciousness in everyday reality.

Theorists disagree about the type of definition, whether theoretical or operational, that should be applied to the study of religion. Many theorists state that a specific definition relevant to a phenomenon should be given (Pargament, 1997, p. 24). Others state that an operational definition be given of a complex subject (Hood et al, 1996, p. 4).

Spilka et al (1985, p. 31) regard giving a theoretical definition of religion as an exercise in futility, and instead propose that in order for psychologists to study religious phenomena, that they give operational definitions, that is, establish the instrumental procedures of study. As an example, Malony (1996, p. 247-8) devised a operational definition on the basis of Paul Pruyser's conception of functional theology in which religion was defined in terms of awareness of God, acceptance of God's grace and steadfast love, being repentant and responsible, knowing God's leadership and direction, involvement in organised religion, experiencing fellowship, being ethical and affirming openness in faith.

There are various ways in which religion can be measured: comparing religious- to non-members, degree of participation in religious activities, attitudes regarding the salience of religion, belief in traditional creeds, and typologies (Gartner, Larson & Allen, 1991, p. 7). In correspondence with this bipolar definition of religion, Allport distinguished between interiorised and institutional orientations towards religion (Levin & Schiller, 1987, p. 11). Operationalisation of behaviour and function renders phenomena empirically measurable. However, these operational definitions have a tendency towards reductionism and compartmentalisation of concepts that includes some and excludes other aspects of phenomena being studied.

Bridging the differences between these definitions of religion, Pargament (1997, p. 4, 25, 30) defines religion as a process, "*a search for significance in ways related to the sacred*" (Pargament, 1997, p. 32, italics in original). This comprises both private expression and experience, and institutional involvement, dogma and ritual, which is based on the humanly constructed understanding of the concept or attributes of God or the divine, attributes which are sacred and significant, in response to the need to find meaning in the tragic events of existence (Pargament & Park, 1996, p. 16).

Similarly, Thoresen et al (in Plante & Sherman, 2001, p. 22-23) have adopted a view that regards religion and spirituality as overlapping Venn circles, and define spirituality as a search for meaning and purpose in life, a finding supported by Zinnbauer and colleagues (in Pargament, 1997, p. 38), who found that people tend to describe themselves as both spiritual and religious, and Hilton (2002, p. 33), who regards religion as a component of spirituality.

Instead of focusing on whether a person is religious or not, or defining religion in terms of involvement, religion will be defined in the present study as the orientation the individual has towards God and others. In other words, on how and why people are religious and to what extent religion influences daily living (Rabin & Koenig, 2002, p. 216). In acknowledgement of the limitation of the operationalisation of concepts, this study emphasizes a functional, that is, a motivational and dimensional approach. The importance or meaning that religion holds for the individual is considered in terms of three dimensions of intrinsic, extrinsic and quest religious orientations. Consequently, for the purposes of this study, religion will be defined as: "*whatever we as individuals do to come to personal grip with the questions that confront us because we are aware that we and others like us are alive and that we will die*. Such questions we shall call *existential questions*" (Batson et al, 1993, p. 8, italics in original).

2.2. Concepts of religious orientation

The difficulty in establishing a clear definition of the term "religious orientation" revolves around whether it is a personality variable, cognitive style, way of viewing religion, or motivation for religious beliefs and behaviours (Hoge, and Hunt & King in Kirkpatrick & Hood, 1990, p. 444)? The term may involve a part of each, or reflect a deep personality structure. It is restricted to religious populations whereby, given that one is religious, the question is one's position on the bipolar continuum of intrinsic-extrinsic orientation (Hunt & King, 1971, p. 355; Kirkpatrick & Hood, 1990, p. 444-445, 455). Various theoretical perspectives emphasize a range of models, which includes uni-, bi- and multi-dimensional approaches to defining the term "religious orientation".

2.2.1. Unidimensional Definitions

Religious orientation differs from religious affiliation, which refers to theological categories of, for example, Catholic, Protestant, Pentecostal, Jewish, Orthodox, Reformed, Conservative, Fundamentalist or Liberal (Levin & Schiller, 1987, p. 13). The earliest studies of religiousness emphasized unidimensional measures using the variables of: religious belief, frequency of religious behaviours, and self-rating scales of religiousness. However, religion needs to be a central and integrating value, personally meaningful and satisfying regardless of religious affiliation (Batson et al, 1993, p. 157; Malony, 1994, p. 20).

Wright, Frost and Wisecarver (1993, p. 561) point out that there are various intrinsic and extrinsic motivations for church attendance, including the motivations to gain social support and find meaning in life (Meadow & Kahoe, 1984, p. 301-302). Religion can be measured in terms of styles, attitudes or "*evaluative* reactions" (Rabin & Koenig, 2002, p. 214, 217).

Involvement or participation in the religious community can be defined and measured in terms of organised and private activities, frequency of attendance, extent of social support given or received, religious experience, coping, religious maturity and development, and meaning and salience of religion (Paloutzian, 1996, p. 200). Despite evidence of a neurophysiological basis for religion (De Vetta, 2002), there are different development-related responses towards the existential questions that result in a religious orientation (Batson et al, 1993, p. 53). Thoresen et al (in Plante & Sherman, 2001, p. 23) regard some religious phenomena as observable and others as unobservable, some as fixed and others constantly changing, requiring multiple assessments. Furthermore, various psychologists of religion have proposed that the qualities of the religious person be examined and not just theories developed on the basis of religious behaviour and experience (Wikstrom, 1994, p. 30). Bergin (1991, p. 399) points out that there has been a gradual development in greater specificity in forming typologies of the complex religious dimensions than in measuring religion as unidimensional.

2.2.2. Bipolar Definitions

Bipolar definitions were a next step in the development of a definition for religious orientation. These definitions are based on the extent of the internalisation of belief or motivational systems, or centrality of the divine being or humanistic conceptions.

2.2.2.1. Centrality of Belief Systems

Throughout the history of the Judaeo-Christian tradition, theologians, religious leaders and prophets have distinguished between the true and false believers, sincere or superficial religion. Old Testament prophets attempted to turn people away from superficial religion to a sincere devotion, and Jesus spoke out against his contemporary Pharisees for practicing a false and hypocritical religion (Batson et al, 1993, p. 156).

This conception has persisted into modern times, Kierkegaard referring to official versus radical Christianity, Bonhoeffer and Barth on devout versus superficial "religionless Christianity", having faith and being religious, daily and Sunday Christianity, which refers to institutional and personal distinctions in the conception of religious orientation (Batson et al, 1993, p. 156; Roof, 1979, p. 35). Within Christianity, and indeed each religion, there are differences of emphasis, in that some Christians emphasize conscientiousness-based values, such as justice, and adhere to strict behaviours, whereas others emphasize warmth-based virtues of compassion, and yet others integrate both into their belief systems (Worthington, Berry & Parrot, 2000, p. 123).

As an example, Dewey (in Meadow & Kahoe, 1984, p. 273-274) differentiates between truly religious people, who strive towards and/or adhere to a pervasive life ideal and deeply personal moral values based on experience, intelligence, truth and human powers; and the religiously-observant, who conform to existing institutional practices that offer them peace and security. However, this conception of religious orientation may be over-simplistic, as many devout, inclusive, spiritual people do not attend religious institutions, and many people who do attend spiritual institutions are not spiritual, but may attend for social reasons, or for reasons of canon law.

With this last argument in mind, Gordon Allport and Michael Ross (1967), using motivation theory, distinguished between the extrinsic and intrinsic religious orientation. The extrinsic orientation serves instrumental and utilitarian interests, motivated by the egocentric needs to provide superiority, security, comfort, self-service, compartmentalisation, wish-fulfilment, solace, distraction, serves status and social functions, rationalises self-interest and self-justification. Doctrine is selected to fit the individual's needs, is more close-minded, exclusionary, compartmentalistic, inflexible, powerless, dogmatic and ethnocentric.

It is a used, or misused, casual and peripheral religion, which centres on the self and prevents growth (Allport & Ross, 1967, p. 434; Allport, 1968, p. 149; Fuller, 1994, p. 119; Grzymala-Moszczynska & Beit-Hallahmi, 1996, p. 190; Hood et al, 1996, p. 35; Hunt & King, 1971, p. 342; Meadow & Kahoe, 1984, p. 292, 415; Pargament, 1997, p. 60-61; Rabin & Koenig, 2002, p. 216).

The intrinsic orientation is end-orientated. These individuals are motivated towards growth, faith, humility and perfection. They find their religion personally relevant, salient and meaningful, have internalised doctrine, values and beliefs, are more orthodox and humble, empathic, sacrificial, loving, and empowered. Their religious beliefs are integrated into all internal and external aspects of life, in that they show devotion and commitment to traditional beliefs and practices, tend to be more educated, differentiated, subscribe to universal ethics, are reflective, compassionate, unselfish and attend church frequently.

The intrinsically orientated live their religion, which centres around God and transcends the self, but also tends to produce believers who are fanatical and homeostatic (Allport & Ross, 1967, p. 434; Allport, 1968, p. 150; Argyle, 2000, p. 31; Batson et al, 1993, p. 161, 168, 188; Bergin et al, 1987, p. 198; Fuller 1994, p. 119; Grzymala-Moszczynska & Beit-Hallahmi, 1996, p. 191; Hood et al, 1996, p. 35; Hunt & King, 1971, p. 342; Masters & Bergin, 1992, p. 222; Meadow & Kahoe, 1984, p. 287, 292; Nelson, 1990, p. 30; Pargament, 1997, p. 61, 64; Plante & Sherman, 2001, p. 19; Rabin & Koenig, 2002, p. 216; Ryan et al, 1993, p. 587; Sherman & Simonton, 2000, p. 145). Salisbury (in Lea, 1982, p. 337) found that religious orthodoxy reflects a religious orientation that is a personal and private internalisation of doctrine, which does not reflect social behaviour.

In order to clarify the cultural values and cognitive differences in religious orientation that shape cognition and beliefs, Allen and Spilka (1967) distinguished between consensual and committed religiousness, where the former refers to non-internalised, socially-accepted forms of religion, which is detached, acquiescent, tangible, restrictive, concrete, conventional, vague and simplistic (Plante & Boccacini, 1997, p. 278; Roof, 1979, p. 20; Van Wicklin, 1990, p. 29). Consensual religiousness is associated with higher levels of prejudice, anxiety and inadequacy.

Committed religiousness refers to the personal forms of religion, which is authentic, internalised, "discerning, highly differentiated, candid, open, self-critical, abstract and relational" (Batson et al, 1993, p. 165; Meadow & Kahoe, 1984, p. 304; Van Wicklin, 1990, p. 29). During the 1970s positive correlations were found between Allport's extrinsic-intrinsic distinction and consensual and committed religion leading to Spilka's distinction between the Intrinsic-Committed and Extrinsic-Consensual orientations (Batson et al, 1993, p. 165; Spilka et al, 1985, p. 19). Following from this model, Stiffoss-Hanssen (1994, p. 139) made a distinction between rigid and flexible religiosity. Table 2.1. is a summary of these theorists views on the centrality of belief systems as growth-orientated or –inhibiting.

Table 2.1. Summary of Centrality of Belief Systems

Theorist	Growth-Orientated RO	Growth-Inhibiting RO
Dewey	Truly religious	Religiously-Observant
Allport and Ross	Intrinsic	Extrinsic
Spilka et al	Inside	Outside
Allen & Spilka	Committed	Consensual

2.2.2.2. Centrality of the Divine

Various theorists, including William James, Maslow, and more recently Lenski (in Meadow & Kahoe, 1984), have based their definitions of religious orientation on the central or peripheral role that the divine plays in religious or spiritual life. Regarded as a pioneer in the field of the psychology of religion, William James set the basis for the study of religious orientation in psychology in his "*Varieties of Religious Experience*" (1987) by continuing the age-old distinction between "true and false believers". James studied the essential elements of the inner religious experience: expansive emotions, feelings, behaviours, symbols, destiny, actions and origins primarily of the individual towards the divine.

James distinguished between the ordinary believer, and the spiritual "geniuses" or saints, the trendsetters. The ordinary believer internalises tradition and emphasizes the religious institution, the divine thus playing a peripheral role. Centrality of the divine is shown by the saints, characterised by the importance and variety of religious experience and product in the lives of articulate and highly developed believers, asceticism, strength, purity and charity of soul, magnanimity, humility, task-orientation, a unified state of mind, tenderness, and experience. The saints experience the divine while living in a wide world, experience "voluntary and passionate abandonment of self" to the divine, "diminution of self, accompanied by great elation and freedom", but at the same time James warns against the unbalanced fanaticism and intolerance of saintliness (Fuller, 1994, p. 10-12, 20-21; Shackle & Brown, 1994, p. 120; Wulff, 1991, p. 480, 491).

James proposed that the truly religious individual demonstrates the characteristics of feelings of safety and peace, interpersonal relations determined by love, joy, vitality, acceptance of reality, sacrifice and surrender, characteristics which give mastery over and richness to life and are essential for the world as they provide the "genuinely creative social force" (Fuller, 1994, p. 16, 22; Pargament, 1997, p. 7).

The religion of the saints invokes goodness, sympathy, trust and the worth of others, and fires human imagination, virtue and worth (Wulff, 1991, p. 492). James (in Malony, 1994, p. 21) noted that there was a distinction between the saint and fanatic, where the former was based on a religion that was based on love and leads to personality integration, and the latter was based on compulsive self-preoccupation and guilt, which leads to disintegration.

Following from James, and like many other phenomenologist theorists in the field of psychology of religion, Maslow distinguishes sharply between formal, institutional religion and the private religious experience. Private religious experience is seen as a "direct experience of the divine" (Fuller, 1994, p. 175), sensitivity to illumination, revelation and ecstasy found in isolation, which he regards as being the primary realm of spirituality (Fuller, 1994, p. 170). Institutional religion is the result of codification and dissemination of private religious experience, which tends to become formalised, bureaucratic and dogmatic, to reify symbols and to compartmentalise and separate the sacred and profane (Fuller, 1994, p. 175-176).

In an attempt to reconcile these forms of religion, Maslow notes that the truly religious or actualised are able to integrate the mystical and institutional elements of religion, religion can be defined as the experience of unity with the cosmos, that God could be defined in impersonal terms as "the Gestalt quality of the totality of reality", and that core values can be embraced by the religious (Fuller, 1994, p. 177, 178).

A summary of the theories that emphasize the central or peripheral role of beliefs in religious experience is given in Table 2.2.

Table 2.2. Summary of Theories Emphasizing Central and Peripheral Religious Beliefs

Theorist(s)	Centrality of the Divine in Personal Religious Life	Peripheral Belief of the Divine in Personal Religious Life
William James (1987)	Saints	Ordinary believers / Fanatics
Abraham Maslow	Private religious experience	Formal, institutional religion
Lenski (in Meadow & Kahoe, 1984)	Devotionalism	Doctrinal Orthodoxy

These theories discussed so far distinguish between the role internalisation versus externalisation of the divine plays in religious orientation. However, there are predominantly humanistic theories, which place man in the centre of religious life. They focus on the latent "divinity" or potential within man.

2.2.2.3. Centrality of Man: Internal versus External Conceptions

The humanistic school of thought emphasizes the centrality of man in religious belief. Religion is based on a distinction between authority and doctrinal adherence. Foci of study is the authoritarianism of Fromm, the Outside perspective of Spilka et al, doctrinal orthodoxy of Lenski, and the humanism of Fromm, which can be seen to correspond with Spilka et al's Inside perspective and Lenski's Devotionalism.

Describing himself as a humanistic psychoanalyst, Erich Fromm emphasized the capacity of humans to actualise their inherent and unique potential and divine inner self, and thereby gain freedom, inner harmony and consciousness, which is the basis of happiness (Fromm, 1950, p. 5; Fuller, 1994, p. 212, 213; Pargament, 1997, p. 51).

Like Carl Jung, Fromm believes that humans have a basic need towards religion, for love, happiness, belonging, unity with others and freedom. This need is shown by the universality of religion, the search for inner peace, love, truth, justice and harmony with others and nature. The latter is a consequence of the emergence of human reason and consciousness and its resultant lack of balance, and the modern trend of alienation, emptiness and anxiety. Fromm warns against the development of self-glorification in the self-actualisation process (Fromm, 1950, p. 63; Fuller, 1994, p. 216 – 217, 228, 235; Pargament & Park, 1995, p. 17). In keeping with the prevailing bipolar conception of religious orientation (Fromm, 1950, p. 34-38; Fuller, 1994, p. 224; Spilka et al, 1985, p. 9; Wulff, 1991, p. 593-594), Fromm distinguished between authoritarian and humanistic religion. Authoritarian religion is a religious philosophy that stresses that it is the *authority* that determines good and evil in order to promote its own interests by suppressing conscience and reason (Fromm 1950, p. 36, 52, 85; Fuller, 1994, p. 228, 235; Pargament & Park, 1995, p. 17). This orientation describes man as controlled by an external, higher power.

This higher power is entitled to obedience, reverence and worship to an external authority, and doctrinal orthodoxy. The main virtue is obedience, its cardinal sin, is disobedience. People submit to an external god, who is all-powerful and provides security and comfort. Redemption is found only on condition that there is total surrender to the god, whether sacred or secular, onto whom the best human characteristics of love, truth and justice are projected and denied to human nature. Human nature needs to be repressed, the promises of happiness located in the distant future.

People are dominated by feelings of guilt, powerlessness, insignificance, hatred, intolerance, and sadness (Fromm, 1950, p. 36; Fuller, 1994, p. 220 – 222, 228; Pargament, 1997, p. 52). Religions that become allied to secular power, or organised and bureaucratic, tend to suppress freedom, demean humans by emphasizing human weakness and powerlessness.

As a result, humans become attached to an idol and alienated from their essential nature, which is capable of faith and love, and which unites the sacred and profane (Fromm, 1950, p. 51; Fuller, 1994, p. 222). This orientation corresponds with Fromm's religious orientation of "having". The having orientation is associated with the values of the Western industrialized society, which centres around greed, selfishness, possession, objects, fear of death, wanting, consumption, happiness achieved through superiority, faith based on prestige and authority, which involves manipulation and control of the love object (Fuller, 1994).

Humanistic religion describes religion as centred around man and his (used in the generic sense) strength, in which virtue is self-realisation and the commitment to becoming fully human. This religious orientation focuses on:

- Human life, strength and abilities,
- The divine spark within the person that includes
- The ability to love selflessly, feel joy, find meaning in life, self-actualise,
- To understand human strengths and limitations,
- Develop reason in the pursuit of truth through which freedom, love of self and others,
- The ability to follow the conscience, achievement of independence, and
- Awaken liberation of human life.

God is a symbol of the ideal self towards which humans strive, the symbol of all that humans are capable of becoming, rather than a transcendent, external being (Fromm, 1950, p. 37, 49; Fuller, 1994, p. 223, 235-236; Pargament, 1997, p. 52; Pargament & Park, 1995, p. 17). According to Fromm, the teaching of a religion that leads to love, truth, justice, affirmation, respect, autonomy, happiness and freedom is based on love (Fromm, 1950, p. 63, 86-87; Fuller, 1994, p. 235).

This orientation corresponds to Fromm's orientation of "being", which refers to authentic relations with the world, renewal, growth, transcendence, interaction with the external world, aliveness, faith based on an inner experiential orientation. This requires autonomy, productivity and critical thinking. According to Fromm, it is the latter orientation, which is proposed in the Bible (Fuller, 1994).

Similarly, Hood et al (1996, p. 5-6) and Spilka et al (1985, p. 4-5) distinguish between the "Outside" and "Inside" perspectives of religion. The Outside perspective refers to an emphasis on religion as institution or collective organization with a doctrine, history, liturgy, ritual and other spiritually meaningful practices and beliefs. This conception corresponds to Fromm's religious orientation of authoritarianism. The Inside perspective, which corresponds to Fromm's humanism, is defined as the personal, subjective and transcendent sphere of religious faith, knowledge, beliefs, behaviour, attitudes, perceptions and experiences. These researchers regard the latter as the subject of interest of psychology. Lenski (in Meadow & Kahoe, 1984, p. 304; Spilka et al, 1985, p. 10; Roof, 1979, p. 21) distinguished between doctrinal orthodoxy, which stresses the "intellectual assent to prescribed doctrines" and devotionalism, which "emphasizes the importance of private, or personal communion with God". A summary of the centrality of man or the institution in religious orientation is given in Table 2.3.

Table 2.3. The Role of Man and the Institution in Religious Orientation

Theorist	Centrality of Man	Centrality of Institution
Erich Fromm	Humanism	Authoritarianism
Spilka et al	Inside	Outside
Lenski	Devotionalism	Doctrinal Orthodoxy

2.2.2.4. Centrality of Man: Personality Conceptions

While Fromm based his theory on the potential of humans to develop their full internal potential in relation to external reality and the divine being, Gordon Allport based his theory on motivations, in other words, between different personality characteristics within man rather than between internal and external religious practices or beliefs. In 1950 Gordon Allport distinguished between institutionalised and interiorised religion, and between mature versus immature religion (Roof, 1979, p. 20).

The mature religious sentiment is dynamic, unique, varied, well differentiated and pervasive. Mature religion produces a consistent morality, a continuous and fundamentally heuristic belief system, complex, comprehensive, integral, universally compassionate and altruistic, and individualistic or personal. It integrates ideas and experiences into a meaningful whole or system that directs lives towards the infinite or Creator. Mature religion is functionally autonomous, reflective, tolerant of ambiguity, doubts, has a widened range of interests, insight into the self and unifying philosophy of life, shapes external reality, and is directed towards the future and self-extension. The mature religious orientation bases life on faith, which is a tentative working hypothesis or belief, based on probability rather than certainty (Fuller, 1994, p. 117, 121, 124-125; Meadow & Kahoe, 1984, p. 391-395; Roof, 1979, p. 20).

Other theorists, who have studied the concept of the mature religious orientation, characterise mature religion as:

- The presence of: mystical unity, openness to experience, serenity, elation, freedom, productivity, humility, sense of responsibility, resilience, sense of majesty and mystery, conviction of a transcendental being and tendency to critical thought, introspection, and the ability to integrate science and religion (Strunk in Lea, 1982, p. 340-341, and in Meadow & Kahoe, 1984, p. 391, 393),
- Rationality and awareness of relatedness to the cosmos and transcendental meaning found in this relationship (Feinsilver in Lea, 1982, p. 341, and in Meadow & Kahoe, 1984, p. 391),
- Purity and asceticism (James in Meadow & Kahoe, 1984, p. 393),
- Acceptance of insecurity (Watts in Meadow & Kahoe, 1984, p. 394),
- Resistance to cultural pressure (Meadow & Kahoe, 1984, p. 397),
- Self-knowledge and a unitive consciousness: " the simultaneous perception of the sacred and the ordinary ... a constantly high level in the sense of illumination or awakening" (Maslow in Meadow & Kahoe, 1984, p. 392-393, 396).

At the opposite end, the immature religious personality is characterised by impulsive self-gratification, magical thinking, self-justification, wish-fulfilment, self-centred interests, un-reflexivity, failure to provide a context of meaning for beliefs, and lack of integration and unification of personality structure or insight into behaviour (Allport, 1950, p. 60-62, 64-65, 67; Batson et al, 1993, p. 158-160; Meadow & Kahoe, 1984, p. 291; Sherman & Simonton, 2000, p. 145; Wulff, 1991, p. 583).

2.2.3. Dimensional Definitions of Religious Orientation

Dimensional definitions arose from both theory and factor analytical studies, and show a bias in conception to humanistic and existential philosophies, personality and social psychological theory. Many of the theories can be seen to be an extension of the bipolar theories.

2.2.3.1. Centrality of the Divine

Clark, Glock and Stark separately distinguished various levels of internalisation of belief and experience, an extension of the bipolar model. They emphasize the centrality of the divine in religious orientation. Primary religious behaviour is "an authentic inner experience of the divine combined with whatever efforts the individual may make to harmonise his life with the divine" (Clark in Spilka et al, 1985, p. 9).

This conception corresponds to Glock's mythological religion, which is a reinterpretation of religious statements to seek their deeper symbolic meanings, which lie beyond their literal wording. This enables assimilation of the intention of religious orthodoxy and the realities of the contemporary world (in Meadow & Kahoe, 1984, p. 305; Roof, 1979, p. 21; Hood et al, 1996, p. 73; Spilka et al, 2003, p. 28-29).

Clark describes secondary religious behaviour as a "routine and uninspired carrying out ... of an obligation" and tertiary religious behaviour as "a matter of religious routine or convention accepted on the authority of someone else" (in Spilka et al, 1985, p. 9). This conception corresponds to Glock's concept of literal religion, which emphasizes the literal, unquestioning acceptance of any religious statement (in Meadow & Kahoe, 1984, p. 305; Roof, 1979, p. 21; Hood et al, 1996, p. 73; Spilka et al, 2003, p. 28-29).

However, Glock includes a different dimension, namely, anti-literal religion, which emphasizes the rejection of literalist religious statements (in Meadow & Kahoe, 1984, p. 305; Roof, 1979, p. 21; Hood et al, 1996, p. 73; Spilka et al, 2003, p. 28-29). Glock's conception was extended to include intensity of experience. The latter describes confirmation of the holy, responsivity, ecstasy, and relation to God (Stark in Meadow & Kahoe, 1984, p. 305). These conceptions of religious orientation can be seen to correspond to theological conceptions of religion. However, psychologists of religion have also tended to focus on within- and between- person conceptions.

2.2.3.2. Centrality of Man

Based on motivational theory, Allport extended his bipolar typology to a fourfold typology, as summarised in table 2.4 (Donahue, 1985, p. 401; Kirkpatrick & Hood, 1990, p. 449-451).

Table 2.4. Allport's Extended I-E Typologies

		Intrinsic	
		High Scores	Low Scores
Extrinsic	High Scores	Indiscriminately proreligious	Extrinsic
	Low Scores	Intrinsic	Indiscriminately antireligious or nonreligious

Allport's conception was not without its critics. Hunt and King (in Donahue, 1985, p. 401) regarded the intrinsic scale as too metaphysical, whereas Dittes (in Donahue, 1985, p. 401) criticized the conceptualisation of the concepts as loaded with value judgments. Despite the criticism, Allport's conception of religious orientation has been used and extended by several theorists.

Batson et al (in Paloutzian, 1996, p. 225-226) found a moderate correlation between the intrinsic religious orientation and social desirability. This indicated a need for a measure of religious orientation that predicts pro-social behaviour, where researchers need to distinguish between the various ways of being religious. Furthermore, it reflects a mixture of means and ends, in order to ascertain the impact of religion on people's physical and emotional lives. The different orientations of being religious are a cognitive-phenomenological response to existential questioning by, for example, demonstrating selfless love and concern for those in need (Batson et al, 1993, p. 157).

Batson et al (1993, p. 166; Fuller, 1994, p. 285; Pargament, 1997, p. 64) believed that the intrinsic orientation also contained an element of dogmatic orthodoxy. They point out that the mature orientation of Allport included a tendency to doubt, tentativeness, flexibility, incompleteness and existential searching, tendencies that are missing from the intrinsic measure that he developed. This suggests an alternative way of being religious, namely, religion-as-quest.

The Quest orientation has both theological and psychological bases. Theologically, Niebuhr described a religious individual as engaged in dialogue with the social and physical environment. Batson emphasized this dialogue by stating that Christian direction is outward towards others and love (Wulff, 1991, p. 236). Psychologically, Reich Fromm stated that humanistic religion is a creative questioning, and Pratt and Goldman that religion is an active search that involves a life of commitment with the goal of finding and realising destiny that has great scope, experience and depth (Batson et al, 1993, p. 167; Wulff, 1991, p. 241).

Hood et al (1996, p. 27) and Spilka et al (2003, p. 40) regard these three dimensions of religious orientation as motivations to find ultimate meaning, control and esteem. The latter processes occur particularly when "meanings are unclear, control is in doubt, and self-esteem is challenged."

The resulting Religious Life Inventory consists of the scales of:

- Intrinsic/Means dimension, characterised by freedom from guilt and worry, uncritical bondage to doctrine, simplistic and rigid beliefs, religious involvement, needs for strength, certainty and direction, a desire to appear tolerant, sensitive and loving,
- The Extrinsic/End dimensions refers to the influence of the external social environment on religious orientation, and
- A Quest/Interactional dimension, which is an open-ended, cognitively-based questioning and continuous, flexible search for existential and religious answers to the complexities of life without adhering to clear doctrine and finding definitive answers, competent self-reliance and self-actualisation, openness to change, situational sensitivity, tolerance towards others, pro-social motivation and sensitivity to their needs, thus the basis of 'true' religion (Burris, Jackson, Tarpley, & Smith, 1996, p. 1068; Hood et al, 1996, p. 36; Meadow & Kahoe, 1984, p. 318; Wulff, 1991, p. 237).

Further extending Allport and Ross's Intrinsic-Extrinsic conception of religious orientation and based on attachment theory, Kirkpatrick (Loewenthal, 2000, p. 85; Masters & Bergin, 1992, p. 222) divided the extrinsic orientation into the extrinsic-social, which indicates using religion for social gain, and extrinsic-personal dimensions, which uses religion to gain security and protection. This factor analytic structure is supported by findings by Echemendia and Pargament (in Pargament, 1997, p. 66-67), who identified an intrinsic scale and three extrinsic dimensions of Social Support, Obligation and Social Gain.

Similarly, Brown (in Meadow & Kahoe, 1984, p. 316) proposed a four-fold typology, summarised in the following Table 2.5:

Table 2.5. Brown's Conception of Religious Orientation

	Intrinsic	Extrinsic
Individualised	Mystic	Self-serving
Institutional	Religious	Conventional Acceptance

Meadow and Kahoe (1984, p. 280-281, 319) extended Allport's distinction between the extrinsic-intrinsic orientations, which they associated with personality characteristics, and included the autonomous-observance and extrinsic-intrinsic dimensions. They outlined a dimensional typology as given in Table 2.6.

Table 2.6. Meadow and Kahoe's Conception of Religious Orientation

	Introversion	Extraversion
Active	Discipliner	Zealot
Receptive	Communer	Neighbour

This conception reflects the examination in the 1980s of a wide variety of humanistic and existential conceptions of religious orientation and development in the various fields of psychological theory other than I-E motivational theory.

By defining personality and religious orientation in humanistic-existential terms, McConahay and Hough (in Spilka et al, 1985, p. 10), provided a personality theory basis for definition when they distinguished between:

- Guilt-oriented, extrapunitive religion in which religious belief emphasizes punishment for wrong doers;
- Guilt-oriented intropunitive religion where there is a sense of one's own unworthiness and a need for punishment and conviction that it will inevitably come;
- Love-oriented, self-centred religion, which is oriented toward the forgiveness of one's own sins, in which God is seen as benevolent;
- Love-oriented, other-centred religion, which emphasizes on the common humanity of all persons as creatures of God, and God's love is related to the redemption of the whole world, and
- A culture-oriented, conventional religion, in which values which are more culturally than theologically oriented.

Based on deprivation theory, the notion that religion compensates for deprivations in life, and in studying the dimensions of religious commitment, Glock (in Meadow & Kahoe, 1984, p. 305; Roof, 1979, p. 21; Hood et al, 1996, p. 73; Spilka et al, 2003, p. 28-29) distinguished between the:

- Experiential dimension where religious people achieve direct knowledge of ultimate reality or experience religious emotion;
- The ideological dimension, which describes the belief systems held by religious people;
- The ritualistic dimension, which describes the expected religious practices;
- The intellectual dimension, which refers to the information and knowledge about the basic tenets of faith and scripture; and

- The consequential dimension, which refers to the secular effects of religious belief, practice, experience and knowledge, the actions and attitudes they ought to hold as a consequence of their religion.

However, empirically, these dimensions are highly intercorrelated (Spilka et al, 2003, p. 29).

2.2.4. Factor Analytic Studies: Operationalisation and Measurement

Ellison and Levin (1998, p. 710) believe that behavioural and functional aspects of religious involvement need to be defined and operationalised. Miller and Thoresen (in Plante & Sherman, 2001, p. 24) have outlined four dimensions through which religious orientation can be measured, namely:

- Overt behaviours or religious practices;
- Beliefs or perceptions of God, self and others;
- Motivations, values and goals; and
- Subjective experiences.

Factor analysis has been used extensively to ascertain the various dimensions of religious orientation, and have extracted numerous and diverse factors.

This can be explained through use of a variety of measurement instruments, including:

- Religious attitude items (Allen & Hittes; Keene)
- Religious behaviour (Keene)
- Participation and frequency (Allen & Hittes; Spilka, Armatas & Nussbaum)
- Personality tests (Cline & Richards)
- Model characteristics of clergy, Protestants and Catholics (Brown, and Maranell)
- Religious content: omniscient God, free will, healthy-minded vs sick soul, cognitive rigidity and flexibility (James; Meadow; Allen & Hittes)

- Knowledge, Intrinsic-Extrinsic dimensions, intolerance of ambiguity; Purpose-in-Life Scale (Spilka, Armatas & Nussbaum).

The various measuring instruments have led to extraction of the factors outlined in Table 2.7 (from Meadow & Kahoe, 1984, p. 306-309; Spilka et al, 2003, p. 33-34).

Table 2.7. Conception of Religious Orientation Extracted from Factor Analyses

Researcher	Factors
Allen & Hittes	God-relation, Duty, Scepticism, Security need, tradition, humanism, secularism
Keene	Loyalty / participation, Orthodoxy, Questioning, customs vs autonomy
Nudelman	Involvement, devotion, ethics, social care, organisational activities
Cline and Richards	Participation / activity, Compassionate Samaritan, Dogmatic authoritarian, tragedy and suffering
Tapp	Theological/Institutional values and Social/ethical values
Brown	Nearness to God, Fundamentalism- Humanitarianism
Maranell	Fundamentalism, theism, superstition / Altruism, idealism, church orientation, mysticism
Meadow	Christian God, Sacred monism, Deterministic fatalism, Stoic will, human goodness, religious grief, truth-seeker and belief rigidity, church traditionalism and individual autonomy
Strommen, Brekke, Underwager and Johnson	Spiritual believers and Law-orientation
King-Hunt	Credal assent, devotionalism, church attendance, organisation activity, financial support, religious despair, orientation to growth, salience of behaviour, salience of cognition, ambiguity intolerance, purpose in life
Spilka, Armatas & Nussbaum	Positive God, Benevolent Ruler, Timeless Father, Harsh God, Impersonal God, Supreme Ruler, Omni-God, Formal Ruler, Psalmist's God
Gorsuch	Traditional Christian; Benevolent Deity, Companionable; Kindliness, Omniness, Wrathfulness, Evaluation, Deisticness, Eternality
Kunkel et al	Nurturant vs Punitive; Mystical vs Anthropomorphic

No studies could be found, which extract second-order factors from these studies. Definitions of religious orientation have been given in terms of personality, motivation, attitude and cognitive style. Corresponding to the humanistic-existential philosophy, religious orientation for the purposes of this study will be defined as ***"general dispositions to use particular*** (sacred – own addition) ***means to attain particular ends in living***" (Pargament, 1997, p. 59).

2.3. The Concept of Depression

The definition of depression varies in the neuro-physiological, pharmacological, psychological and psychiatric professions (Klerman & Weissman, 1980, p. 60). Depression can be regarded as a mood, symptom or syndrome (Weissman & Klerman, 1977, p. 98). Temporary signs and symptoms of depression are a reality of everyday life, which can pose challenges to diagnosing normal and abnormal depression, and which are defined in terms of intensity, pervasiveness, persistence and interference with social and bodily functioning (Klerman & Weissman, 1980, p. 61; Rothblum, 1983, p. 84; Beck, 1967, p. 6). The disorder or syndrome has been studied in terms of somatic, affective and cognitive aspects, yet the growing interest in holistic medicine indicates that the spiritual dimension of depression also needs to be studied (Westgate, 1996, p. 26).

Various schools of thought have proposed different theories for the aetiology and symptomatology of depression:

(1) The somatogenic school regards depression as distinct from normal mood and as a well-defined biologically based illness (Beck, 1967, p. 8).

(2) Cognitive theories propose that cognitive insufficiencies, faulty interpretation of data or processes cause depression, resulting in cognitions of a sense of inadequacy and failure, shame and humiliation, boredom, frustration, low self-esteem, pessimism and apathy.
This results in what Beck called the "cognitive triad" or schema of negative view of the self, outside world and the future (Beck, 1967, p. 262; Klerman & Weissman, 1980, p. 68).

Beck defined the depressed person as "generally drawn to the most negative meanings that can conceivably be attributed to ...events" (Frost, 1985, p. 189). The self is viewed as defective, inadequate, diseased, deprived, lacking in attributes necessary for happiness, while the environment is interpreted in a negative manner and the future is viewed as presenting long-term suffering and difficulties (Frost, 1985, p. 189-190).

(3) Loss theory proposes that depression relates to loss and separation. This is characterized by grief and mourning to the loss of a loved one, self-esteem, interpersonal relations, which if unresolved leads to clinical depression (Klerman & Weissman, 1980, p. 65). Depression results from real or imagined loss in which there is an ambivalent reaction to the lost love object (Crockett, 1977, p. 48), which Kierkegaard defined as the loss over ourselves, particularly as Fenichel stated, the loss of self-esteem, which in turn leads to feelings of helplessness and hopelessness. The loss itself can be from death of a loved partner, love relationship, failure, loss of prestige and money, goal fulfilment, inability to cope and fatigue, and role change (Crockett, 1977, p. 48).

In terms of Loss theory, of particular note are the role changes faced particularly by women in the middle-ages when they need to adapt to the loss of children, adjust to their husband's careers, widowhood, menopause or loss of the ability to bear children, and loss of their beauty (Crockett, 1977, p. 49-50). Poor interpersonal relations within a marriage in which the husband fails to provide a supportive relationship in particular working-class women is highly associated with depression among these women (Weissman & Klerman, 1977, p. 107).

(4) Hopelessness theory proposes that hopelessness is a sufficient cause for depression to occur, whereby the individual, who attributes a negative life event to stable, global and internal causes. These attribution are a personal quality or temperament, are likely to become hopeless, and in turn lead to depression (Murphy et al, 2000, p. 1102). However, for religious people their belief may counteract the thoughts of hopelessness, based on faith teachings of desperate events with the promise of God's support (Murphy et al, 2000, p. 1102). For example, religious people who were HIV positive were found to suffer less from hopelessness and depression than nonreligious people who were HIV positive (Murphy et al, 2000, p. 1102).

(5) Seligman's Learned Helplessness Theory (in Klerman & Weissman, 1980, p. 70; Rothblum, 1983, p. 89) proposes that depression arises when humans learn that they are unable to control reinforcement contingencies in their environment. This results in hopelessness and helplessness, passivity, lower initiative, negative cognitions and fewer voluntary responses, and the perception that the individual does not have the skill or influence to change the environment. Depression is thus a learned habit, a socially conditioned, stereotypical cognitive set generalised to new situations (Radloff, 1980, p. 103 – 104; Weissman & Klerman, 1977, p. 106).

McLean (in Radloff, 1980, p. 104) proposed that depression results from repeated goal frustrations and chronic failure leading to feelings of lack of control. However, the theory of learned helplessness has been challenged by research findings that learned helplessness is accompanied by lower levels of norepinephrine in animal's brains caused by environmental stress, thus indicating a biochemical rather than learning basis to learned helplessness (Klerman & Weissman, 1980, p. 71). Seligman (in Westgate, 1996, p. 31) further proposes that the cult of individualism in which people form attachments to themselves rather than a transcendent meaning, which results in greater vulnerability to depression.

Beck (1967, p. 10) points out that the symptomatology of depression has remained consistent since ancient times. The symptoms of unipolar major depression, the emphasis of this study, include:

- Dysphoric mood or loss of interest and pleasure is present and relatively persistent;
- Four of eight symptoms of poor appetite, weight loss, insomnia or increased sleep, psychomotor agitation or retardation, loss of interest in usual activities, loss of energy or fatigue, feelings of worthlessness, diminished concentration, and suicidal ideation are present for at least two weeks;
- There is no evidence of mania, psychosis, organic mental disorder or normal bereavement (Rothblum, 1983, p. 84).

Beck (1967, p. 6) challenged the classification of depression as a mood and affective disorder. He believes that depression comprises more than just emotions, but instead involves a complex pattern of feelings, cognition and behaviour. Beck describes depression as a syndrome rather than as a disorder. Additional noted symptoms include:

- Change to the negative in actions, attitudes and reactions towards life,
- Negative view of the present and future,

- Sense of failure,
- Negative attributions and cognitive style,
- Among women a concern about physical looks, self-dislike,
- Feeling of pain,
- Loss of emotional attachment,
- Crying spells,
- Loss of a sense of humour,
- Distorted cognitions of self, experience and future,
- Low self-evaluations,
- Helplessness,
- Distorted body-image,
- Emptiness, gloominess, self-blame and negative expectations,
- Indecisiveness, passivity, dependence, lack of control and loss,
- Immediate gratification or hedonism,
- Avoidance of responsibility and escapism,
- Thinking patterns are nondimensional, absolutistic, moralistic, invariant and irreversible (Beck, 1967, p. 12, 18-33, 255-258; Frost, 1985, p. 188; Loewenthal, 2000, p. 101-102; Spilka et al, 2003, p. 510; Westgate, 1996, p. 29).

Other individual factors outlined by Freden (in Frost, 1985, p. 187, 191) as contributing to depression include:

- The experience of being dominated,
- Lack of play experiences,
- Lack of self-trust and –confidence,
- Reactivated memory of previous trauma and unrealistic aspirations.

Patients suffering from major depression with psychosis experience delusions of worthlessness, expectation of punishment, nihilism, somatic disturbances, poverty and hallucinations (Beck, 1967, p. 37-39).

Another form of depression is religious melancholia, which differs from clinical depression. Religious melancholia, described as the "dark night of the soul" by St. John of the Cross, is a depression that is characterised by sadness and loneliness, but which can be distinguished from clinical depression in that religious melancholy is:

- Brief,
- Does not hinder effective functioning,
- Is balanced with joy,
- Is a source for growth, and
- Does not show excessive guilt and despair (Andreasen, 1972, p. 157-158).

It should be noted that depression in the Sub-Saharan continent has been found to differ from the Western symptomatology of depression in that there are greater symptoms of persecutory delusions, hypochondriasis, anorexia, somatic complaints and unspecific physical symptoms. Urban Africans demonstrate the same symptoms as shown in Western populations. These symptoms of the latter are particularly fatigue, feelings of worthlessness, irritability, crying, guilt and sadness, leading researchers to propose that depression is a culturally- and socially-based syndrome precipitated by stress, and moderated when there is social support (Shisana & Celentano, 1985, p. 1251-1254).

Depression for the purposes of this study will be defined in cognitive-phenomenological terms as "an abnormal state of the organism manifested by signs and symptoms such as low subjective mood, pessimistic and nihilistic attitudes, loss of spontaneity and specific vegetative signs" (Beck, 1967, p. 201-202). Thus far, the definitions of the concepts of religion, religious orientation and depression have been outlined separately. However, the next chapter focuses on the theories and research findings that centre on the main question of the study, namely, that of the relationship between these concepts.

3. The relationship between religion and depression: theories and research findings

The study of the relation between religion and psychological health has progressed substantially and empirically since the Enlightenment. The latter view was interspersed with propositions by Hippocrates and Albertus Magnus that mental illness possibly had somatic origins, and a debate between the Psychicists and Somaticists about the nature of the relation (Belzen, 1992, p. 34-36). Throughout human history, religion and spirituality have been associated with healing practices in which supernatural treatment methods, such as, rituals, prayers and pilgrimages, have been used (Koenig, 2002, p. 11). However, very little empirical research has been conducted on the relationship between religious orientation and depression.

The relationship between religious orientation and depression has variously been described as:

- Non-existent,
- That religion is a major pathogenic factor,
- Is a prophylactic in that it prevents mental illness, or
- Is a symptom of mental disorder (Belzen, 1992, p. 33; Belzen, 1996, p. 23, 32; Park, Cohen, & Herb in Hood et al, 1996, p. 385).

Religion is related to psychological strain and illness in various ways, namely, that religion allows the masked expression of psychological abnormality through glossolalia or scrupulosity, or is a risk factor for stress-related disease that results from excessive guilt, anxiety and doubt, and a conception of a God, who is hostile, punitive and distant.

This may result in poor social adjustment, as religion acts as a socializing control, which restricts or suppresses pathological behaviour and thought, and serves as a refuge from the difficulties of coping with life. Religion may be therapeutic in providing directions for more effective interaction with the world, or may act as a stressor that exacerbates existing weaknesses, but, conversely, depression can trigger religious experience (Chirban, 2001, p. 269; Exline, Yali & Sanderson, 2000, p. 1482; Levin & Schiller, 1987, p. 11; Spilka et al, 1985, p. 291; Spilka & McIntosh, 1995, p. 439; Van Uden & Pieper, 1996, p. 44-45).

Freud and Ellis equate religion with psychological illness, emotional disturbance and irrationality. This view is supported by cases of neurotic and psychotic disturbance involving religious content. This content reflects the dogma of their respective traditions, compulsive confession and atonement for transgressions, hostility to science and modern medicine, pathological levels of guilt, use of superstition, and religiously-motivated violence, fanaticism and persecution in which inhumane cruelties are inflicted in the name of religion (Allport, 1968, p. 144; Beit-Hallahmi & Argyle, 1990, p. 192; Bergin, 1991, p. 399; Chirban, 2001, p. 268; Malony, 1994, p. 17; Plante & Sherman, 2001, p. 70). The views of Freud and Ellis have, however, been questioned. Malony (1994, p. 24) pointed out that their theories of religion are mainly based on prejudicial views of religion, and Paloutzian (1996, p. 235-237), that they are based on generalisation of cases of psychological disturbance in religious leaders. The occurrence of religious content in delusions has been shown to be the result of socio-cultural factors, such as, social learning, being a member of the lower classes and fundamentalist in belief, or personal factors. These factors reflect the fundamental psychopathology of the individual, which is not related to religion (Beit-Hallahmi & Argyle, 1997, p. 192-193). This view is supported by Stark (in Hood et al, 1996, p. 418), who found that mental disturbance is related to decreased importance of religion and participation in religious activities, and unconventional religious faith and beliefs. Many theories have been counter-proposed to that of Freud and Ellis.

Bergin (1980b) and Roberts (in Lea, 1982, p. 342) proposed that the various levels of religion, from sociological to psychological, are conducive to both positive and negative effects or results. Bergin and Roberts concluded that as there are conflicting results, the evidence supporting a particular biased view could be selected by the researcher in support of an argument, but found that the overwhelming amount of evidence supports the thesis that religion is associated with psychological health. Religious faith may lead both constructively and destructively to:

- Emotional disturbance, anxiety and guilt,
- Use of defence mechanisms such as denial, suppression, rationalisation and reaction formation,
- Dependence, infantile escapism,
- Rigid and infallible orthodoxy,
- Self-righteous separation,
- Legalism, and
- Violations of ethical and moral values.

Religious faith may also act as a haven from distress, be a source of love and compassion, facilitate acceptance of human limitations, solidarity, symbolic expression, affirmation of human potential, and understanding of contextual and universal principles.

However, the two effects depend on whether the religious beliefs are integrated, partially developed, or perfectionalistically, rigidly, inflexibly, externally imposed and internalised (Bergin, 1994, p. 85-87; Lea, 1982, p. 341-342; Malony, 1994, p. 17-18; Meadow & Kahoe, 1984, p. 379).

Sociologists have considered the study of religion in its various forms of belief, socialisation, practice and commitment as an important element in understanding the complexities of social human behaviour, group dynamics, and daily consequences (Levin & Schiller, 1987, p. 10). Theories and research have typically focused on the consequences, for both the individual and society, of the lack of religiosity. These consequences include alienation, anomie, marginalisation and secularisation. Theories and researches have also focused on the consequences of excessive religiosity, such as, lack of adaptive ability, phenomena which are of particular importance during a time of rapid social, economic and technological change (Levin & Schiller, 1987, p. 10). Psychologists have set to examining the reciprocal impact of religion on behaviour, attitudes and beliefs, and in providing conceptual definitions of religiosity, religiousness and spirituality (Levin & Schiller, 1987, p. 11). Religion plays a central part in behaviour and an important role in promoting the health of an individual, its influence capable of transforming both the individual and society (James in Batson et al, 1993, p. 231; Fuller, 1994, p. 10, 32; Wulff, 1991, p. 11).

The research literature demonstrates a complex relation between religion and psychosocial functioning (Fallot, 1998, p. 6). In their literature reviews on the relation between religion and psychological health, Becker concluded that the relationship between religion and psychological health is positive, whereas Dittes found that religion is associated with personality deficiencies, and Sanua could not draw any clear conclusion (Batson et al, 1993, p. 234-235; Gartner et al, 1991, p. 6).

When mental illness is defined as the absence of symptoms, a positive relationship has been found between psychological health and religious involvement, except among clergy (Batson et al, 1993, p. 256, 257), for all gender, age, racial and ethnic groups, socio-economic status and geographic location using both cross-sectional and longitudinal research designs, and more refined statistical controls (Ellison & Levin, 1998, p. 702-703).

Depression is a common and highly prevalent illness. Depending on the diagnostic criteria used, depression affects a high percentage of the population irrespective of age, gender and social class (Loewenthal, 2000, p. 102; Westgate, 1996, p. 26). In accordance with Beck's definition of depression, the interaction between religious orientation and depression will be discussed in terms of the view of self, others and the world.

3.1. View of self and the relation to religious orientation and depression

In the Judaeo-Christian tradition, God is depicted as personally interested and involved in creation and humans, who are created in His image, and with whom humans can form a personal relationship, influence God's actions and receive strength during adversity through prayer, which contributes towards compassion and salvation, and wholeness of being (Allport, 1968, p. 145). However, others do not believe in the existence of a divine being, or their beliefs change during the course of their development. This raises the questions of: which religious orientation is related to a positive or negative view of the self, to health or illness, and is this relationship constant or fluid.

3.1.1. Positive View of Self

The Humanist and Phenomenological schools of thought contributed most understanding to our understanding of the way in which religious orientation promotes a healthy self-conception. These theorists have emphasized the spiritual nature of human beings, their ability to change into maturity, transcend their limitations, and thereby find meaning and purpose in life.

3.1.1.1. The Spiritual Nature of Humans

Jung believed that as the human is a spiritual, religious being, whose authentic Self or spirit comprises the imago Dei or image of God, any type of healing could only occur through the development or recovery of a religious outlook on life (Bianchi, 1988, p. 23, 27; Fuller, 1994, p. 71, 79; Harding, 1988, p. 2; Ulanov, 1988, p. 44).

As he regarded healthy human nature as essentially good, Maslow regarded neurosis, unhappiness and evil as the thwarting or denial of basic human nature, and accepted the importance to humans of intrinsic values and placed the sacred at the core of his psychological theory (Fuller, 1994, p. 140, 168; Maslow, 1968, p. 82). William James distinguished between two forms of religion. The healthy-minded or saint, is characterised by a sanguine, happy, optimistic outlook that has no place for evil, in spite of hardships. The sick soul or morbid-minded, acknowledges the breadth of human experience and existence of evil within and without, and can undergo transformation and unification leading to a deeper and mystical understanding to a greater degree than the former (James, 1987, p. 78; Wulff, 1991, p. 485-488). James defined the healthy-minded religion as being involuntarily positive, sanguine, harmonious, romantic, demonstrating a high moral commitment, religious excitement, optimism and incapability to experience evil (Fuller, 1994, p. 17; James, 1987, p. 79, 86, 127; Wulff, 1991, p. 485-488).

In terms of Beck's definition of depression, William James's (1902) distinction between saint and fanatic implies that the religious orientation of the saint leads to psychological health and adaptability, a positive view of the self, others and the world, and lower levels of depression, whereas the inverse applies to the fanatic. This view was supported by the authoritarian personality project in the 1940s, which distinguished between neutralised religion versus taking religion seriously.

Adorno found that the neutralised religion, the emphasis on rigid doctrinal beliefs and the practical use of religion, was associated with ethnocentricism and authoritarianism (Batson et al, 1993, p. 159). Although Maslow regards the human being as naturally religious, striving to find truth, justice, beauty and unitive consciousness with the cosmos, he notes that there are two opposing forces within the individual: that to health and self-actualisation, and the force to illness, a tendency which can only be resolved by transcending the environment that stifles growth (Fuller, 1994, p. 168, 169, 179).

3.1.1.2. Transcendence of Limitations

Durkheim distinguished between the sacred or divine soul and profane or material body, which the sacred attempts to separate from and transcend, particularly during situations of suffering and awareness of impending death (Idler & Kasl, 1992, p. 1053). Humanistic and Phenomenological psychology emphasizes the ability of humans to grow, develop, create and transcend limitations, corresponding to Tillich's assertion that "faith as ultimate concern is an act of the total personality" (Hood et al, 1996, p. 22). Bertocci, Johnson and Gardener view religion as growth and the realisation of the self and others (Spilka et al, 1985, p. 15). Abraham Maslow stressed a holistic and self-transcendent view of the nature of the human being as comprising a combination of spiritual and sacred values of "Being" on which is inscribed the "eternal, trans-human values of the cosmos" (Fuller, 1994, p. 139).

Frankl (1986, p. 89) cites a case of endogenous depression in which the patient was encouraged to adopt a positive rather than fatalistic view of recurring depression as a challenge and task, and in this way to adopt spiritual freedom.

The need for self-actualisation is the highest, ongoing need, experience and process for health, meaning, identity, unity or integration, individuality, autonomy, excellence and growth, the need to become fully human through listening to the "inner voice", in terms of the person's unique innate talents, and is associated with spirituality and the spiritual instincts, through holistic integration of body and mind, biology and spirit, conscious and unconscious (Beit-Hallahmi & Argyle, 1997, p. 91; Fuller, 1994, p. 147, 148, 166-7; Meadow & Kahoe, 1984, p. 24).

Although not perfect, the self-actualised person is growth-motivated towards meta-needs of excellence, truth, goodness, love of the uniqueness of personhood that is not selfishness, compassion, responsibility, unity, order and beauty, to Being, which brings both happiness and fulfilment. The self-actualised also shows dismay and suffering at the violations against humanity in the Zeitgeist resulting from injustice and greed, but does not engage in self-serving attempts of self-actualisation (Fuller, 1994, p. 149, 157-8; Meadow & Kahoe, 194, p. 25, 237).

In terms of religion, the self-actualised person at various times has "peak experiences" or "transcendent" experiences that demonstrate the essence of intrinsic core-religious illumination or conversion experiences (Maslow, 1970, p. 20, 26). "Transcendence refers to the very highest and most inclusive or holistic levels of human consciousness, behaving and relating, as ends rather than as means, to oneself, to significant others, to human beings in general, to other species, to nature, and to the cosmos" (Maslow in Meadow & Kahoe, 1984, p. 24).

Human self-transcendence directs human life to choose a meaningful relation or encounter with the surrounding world and the freedom of will to rise above biological, social and psychological limitations or fall victim to them (Frankl, 1986, p. 21, 80-81, 91, 112; Fuller, 1994, p. 243, 245).

Self-transcendence and meaning is achieved and found through active engagement with external reality rather than through introspection, and accomplishing tasks in order to discover values and meanings, which are not subjective or relative, that challenge us to accept that which is good and true, and in the choice of stance or decision taken in unchangeable adversity and suffering (Andreasen, 1972, p. 162; Frankl, 1986, p. 20, 76; Fuller, 1994, p. 249, 250).

Religious experience that promotes psychological health is characterised by a freedom from fear of death, fear of life, temptation, worldly possession, social conventions and even sexual desire, as this frees the individual from existential concerns, in that religion provides a meaning structure to existence, and frees the individual from critical reflection (Batson et al 1993, p. 194-5, 198). Religion facilitates the search for identity, spirituality, self-extension, self-development and personal growth, usually in the form of the self in relation to the divine, and provides a moral code that counteracts selfishness, while at the same time providing power and status, and compensation for social deprivation (Meadow & Kahoe, 1984, p. 9, 23; Pargament, 1997, p. 51-52, 56).

3.1.1.3. Perceptions of Efficacy

Schumaker (in Schnittker, 2001, p. 395) states that “religious involvement may diminish perceptions of personal control and, instead, encourage the attribution of life outcomes to external forces such as a deity... attributing significant life outcomes to forces outside the self may increase depression ... some theodicies may undermine self-esteem by increasing guilt, which in turn may increase depression”.

Other theorists believe that religion provides a belief system, which is positive, conscientious and optimistic, and which encourages people to engage in healthy behaviours, be more able to cope with stress through positive appraisal of a situation, have their illnesses diagnosed earlier, be more compliant with treatment and improved health habits, which reduces the occurrence and increases the recovery from depression (Koenig, 2002, p. 21-23; Pargament, 194, p. 179; Plante & Sherman, 201, p. 388).

When depression is studied in terms of hopelessness theory, Murphy et al (2000, p. 1104) found that higher levels of religious belief was related to lower levels of depression and hopelessness, although the latter may be a reflection of the level of extroversion and harmful religious beliefs.

Religious involvement may reduce social stressors and isolation, enhance social resources, lower dysphoria, promote positive self-perceptions and locus of control beliefs, and provide a general sense of coherence (Ellison, 1995, p. 1570; Koenig, 2002, p. 23). Religion may satisfy the need for social affiliation and identification, friendship, warmth and affection through a sense of belonging and interdependence, and social security through provision of a haven from the stresses of life and reciprocal provision of tangible and intangible social, spiritual and emotional support, exchange and acceptance, meaningful interpretation of life events, provision of a controlled and regulated existence, which may be associated with better health (Blaine & Crocker, 1995, p. 1033; Ellison & Levin, 1998, p. 705; Meadow & Kahoe, 1984, p. 31, 323, 351; Van Uden & Pieper, 1996, p. 43-4; Woods et al, 1999, p. 172).

Religion enables people to interpret negative events in a positive way, while prayer enables people to feel more in control with "optimism, greater self-confidence, self-esteem, and sense of purpose" (Beit-Hallahmi & Argyle, 1997, p. 191), a perceived sense of control by the self or God related to physical and psychological adaptation during and after stressful events (Plante & Sherman, 2001, p. 389).

However, religion enables the ability to accept responsibility, forgiveness and accountability, but there should also be a balance between God's will and individual's responsibility. Malony (1994, p. 21) asserts that Thomas Aquinas and others believed that "a prime index of God's image in human beings is reason, so that people are never to replace their own ability to make decisions with a pseudo-pious dependence on God".

3.1.1.4. Development into Maturity

Jung believed that religion plays a positive role in human life, although it keeps humans in an infantile and submissive mental state, in that religion provides direction for maturity, facilitates integration of opposites in the psyche, gives assurance, strength and meaning, and "has allowed humankind to transcend the instinctive stage of the unconscious into the heights of the greatest moral and cultural achievements. For the masses who are unable to pursue moral autonomy, religion may continue to fulfil 'its great biological purpose'" (Wulff, 1991, p. 432). Allport maintains that as personality develops over the life-time, the mature religious sentiment is also a dynamic, changing, life-long, individual task (Fuller, 1994, p. 120), as the individual interacts intra- and extra-psychically (Batson et al, 1993, p. 233; Fuller, 1994, p. 116). In the healthy personality, which is ordered and unified, the religious sentiment, if it holds a dominant position, leads to affiliation with reality, completeness, meaning and peace (Fuller, 1994, p. 117-118).

Similarly, Fromm (in Meadow & Kahoe, 1984, p. 382) noted that use of religious ritual could be either rational or irrational, depending on whether the ritual increases anxiety when a ritual is not performed.

Whereas Freud noted the importance of the superego in moral and social development of the individual and society, Allport emphasized the importance of the conscience, which he regards as a universal phenomenon, demonstrates cultural variability and is learnt through a slow and painful process (Fuller, 1994, p. 126). However, Allport regards the conscience as a more mature form of the superego, which is focused on the "oughts" rather than the 'musts" of the superego, as individually-constructed values relative to perceived reality and corresponding to the person's level of age and experience.

In the case of the mature religious orientation, conscience is governed by love, discipline and reverence rather than fear (Fuller, 1994, p. 126-7). Allport regards the need for love and to be loved as the overall motivation in the development of religion, where the experience of love leads to affirmation and completeness, but frustration of this need leads to hostility, prejudice and misanthropy (Batson et al, 1993, p. 233; Fuller, 1994, p. 133). According to Jung, the goal of all life is achieving wholeness through reconciliation of opposites, through the individuation and actualisation of higher consciousness or spirit, the unifying and unique Self, which he defines as religion, the achievement of which leads to a life-path, a "vocation" or "calling", and failure to neurosis (Bianchi, 1988, p. 25; Fuller, 1994, p. 84, 89, 104).

3.1.1.5. Vocation: Meaning and Purpose of Life

The religious experience leads people to wholeness and meaning (Kelsey and Sanford in Wulff, 1991, p. 456). Similarly, Frankl and Jung assert that humans need ideas and convictions, imagination and intuition that give meaning to life, even during suffering (Jung, 1964, p. 76, 82). According to Fromm, meaning in life can be found when people ascribe meaning and resolve the contradictions in life through transcendence of consciousness (Fuller, 1994, p. 212, 213; Pargament, 1997, p. 51). Those who are intrinsically religious have a comprehensive worldview, sense of identity and reality, perseverance, purpose and meaning to life, which provides a positive cognitive framework to find meaning in negative existential events, including failure, alienation, chaos and disorientation in an uncertain and frightening world (Brown, 1994, p. 5; Malony, 1994, p. 19; Masters & Bergin, 1992, p. 228; Murphy et al, 2000, p. 1102).

Frankl states that freedom involves responsibility and obligation towards a positive decision regarding the individually unique life task, mission or destiny, which is based on intentional self-transcendence and which gives a meaning and purpose to life (Frankl, 1986, p. 10, 26, 54).

When it is considered that experiences of suffering, injustice and meaninglessness shape belief (Roof, 1979, p. 31), Koenig's (1997, p. 68) statement that "religious beliefs provide hope and a sense of control over one's destiny ... that something good can result from every situation if the believer puts his or her complete trust in God" outlines a positive function of religion.

Religious beliefs and practices contribute to states of well-being, optimism, positive illusions, imaginative restructuring, realistic hope that shares creative and active vision and action, the ability to set and achieve goals, give purpose and meaning to both positive and negative events, satisfaction and happiness, which has a positive effect on psychological health (Ellison & Levin, 1998, p. 708; Koenig, 2002, p. 13; Meadow & Kahoe, 1984, p. 227). Religious involvement, attendance and piety may enhance self-esteem, self-worth, and feelings of efficacy, which has positive effects on mental health, including depression (Ellison & Levin, 1998, p. 706). Of importance to psychological adjustment is the strength of the conviction, synchrony of religious values between that of the beliefs of the individual and the ideals of the religious tradition, which depends on the extent to which the individual is transcendent, transactional, fulfils their purpose in life, and gives and receives support and fellowship from the religious community (Malony, 1994, p. 18-20).

They provide meaningful answers, are personally significant, which enhances self-esteem, involves public commitment, conformity, collective belief and cognitive coherence (Batson et al, 1993, p. 203-204; Woods et al, 1999, p. 73). Festinger (in Batson et al 1993, p. 203) has provided an answer to this through the theory of cognitive dissonance, whereby people are motivated to resolve inconsistencies between elements through changing cognitions or subscribing to consonant elements. Religious beliefs, which are viewed as intrinsic and central, and which are refuted, tend to intensify.

In conclusion, many theorists believe that people experience pleasure, happiness and peak experiences when they fulfil meaning in life and transcend all types of limitations. In this, religion plays an important role, but these religious beliefs need to be authentic or intrinsic to be effective (Frankl, 1986, p. 35; Fuller, 1994, p. 251; Jackson & Coursey, 1988, p. 401). The (mainly Humanist-Existential) views discussed so far outline a positive relation between the view of self, religious orientation and depression.

However, the debate surrounding the relation between religious orientation and mental health has also examined the shadow side of religion.

3.1.2. The Negative View of Self

The Judaeo-Christian tradition emphasizes the need to acknowledge sinfulness in order to have compassion on human frailty, the guilt engendered leading to regeneration and growth (Andreasen, 1972, p. 156). However, not all guilt and anxiety has a positive outcome. A distinction needs to be drawn between pathological and healthy forms of negative self-conceptions, guilt and anxiety.

3.1.2.1. Individual Pathology, Insufficiency, Anxiety and Guilt

Religious pathology can be determined when there is cognitive distortion of beliefs, disordered affect, autism and impaired functioning relative to the standards of the religious group (Lea, 1982, p. 344). Religious beliefs may promote depression when the individual believes that he or she is being punished by God, the devil is in control, the individual has a negative image of God or attention is focused on their own sinfulness (Exline et al, 2000, p. 1482; Murphy et al, 2000, p. 1104).

William James associated psychopathology with morbid-minded religion, in particular with “pathological melancholy” or lower mysticism characterised by psychosis, pessimism and abandonment (Batson et al, 1993, p. 231; Fuller, 1994, p. 24-25; Hood, 1995, p. 58; Masters & Bergin, 1992, p. 221). The morbid-minded religion emphasizes evil, sin, inadequacy and failure, feelings of “guilt, sadness, hopelessness, and fear”(Fuller, 1994, p. 17; James, 1987, p. 79, 86, 127; Wulff, 1991, p. 485-488).

During the same epoch, Freud concluded that religion, as the shaper of the conscience, was the cause of neurotic misery, a "universal obsessional neurosis of humanity" (Batson et al, 1993, p. 232; Koenig, 1997, p. 23; Meadow & Kahoe, 1984, p. 384), the result of the "universal transference" (Belzen, 1992, p. 37) of the desires and anxieties of the Oedipal relation with the father or "dysfunctional psyche" (Belzen, 1992, p. 37). Freud described religion as an "infantile, neurotic and irrational activity" (Argyle, 2000, p. 9). Pruyser supported this position. He observed that blind faith stimulates immature denial of reality and hinders critical thinking (in Hood et al, 1996, p. 428). Freud believed this would disappear in a rational, scientific society. Maslow (1968, p. 61) noted a similar level of anxiety in religion that results in anti-intellectualism, a preference for blind faith and piety, and fear to acknowledge the god-like qualities within humans.

Freud regarded religion as a mechanism of defence against the instincts, a wish-fulfilling illusion, that is a form of escapism, denial, avoidance, a form of psychotic delusion, expressed through magical thinking, delusions and hallucinations, where the God of religion is the created and projected image of the father, who fulfils the need for tension reduction, protection and love from the uncertainties of life and nature (Batson et al, 1993, p. 232; Fuller, 1994, p. 39-41, 43, 53, 141; Godin, 1985, p. 174; Koenig, 1997, p. 23; Pargament & Park, 1995, p. 14, 19).

The defensive-protective tradition proposes that religion arises as a result of human helplessness, vulnerability and inadequacy, the need for meaning and control, in which religion forms a protective and predictive function against uncertain life events, aloneness and insignificance, which is expressed through emotion, ritual and dogma, and in which people turn to religion in order to escape doubt, fear and insecurity rather than as an act of faith (Fromm, 1950, p. 4, 13; Hood et al, 1996, p. 17-18).

Similarly, Rockeach (in Meadow & Kahoe, 1984, p. 368) regards religious beliefs as emotional defences to protect from the threatening aspects of reality, and Malinowski and Freud argue that religion arises as a result of weakness, helplessness and dependence, in order to satisfy the need to cope with a "Threatening Universe" and thereby reduce and manage tension and anxiety (Fuller, 1994, p. 38, 39; Meadow & Kahoe, 1984, p. 7; Pargament, 1997, p. 49; Spilka et al, 1985, p. 12-13).

Although Freud's theory of religion has been vigorously challenged, researchers of the psychoanalytic school have continued to build on Freud's theory. Beit-Hallahmi (1996, p. 71) believes that religion arises from infantile, paranoid psychotic ideas rather than compulsive-obsessions, whereby delusions provide functional assistance to support the depressed ego. Beit-Hallahmi (1996, p. 74-75) proposes that religious believers subscribe to bizarre beliefs within a controlled, specific, religious context and circumstance, and believe in miraculous events that provide moral inspiration and enhance functioning, and which represents an escape from reality or regression that serves the needs of the ego.

Pruyser (in Meadow & Kahoe, 1984, p. 369) explained this wishful thinking in terms of syncretism, the tendency to want a belief to be true, despite inconsistencies in the rationality. Religion can be regarded as a denial of human and social reality, which results in delusion or magical thinking, and a mechanism to prevent critical thinking and "dull consciousness and to displace responsibility" (Woodruff in Meadow & Kahoe, 1984, p. 13, 262).

Freud proposed that psychological health and wholeness could only be achieved when the individual gives up religion, which he regards as a projection of the ambiguous need-fulfilling childhood relations to the father, or Oedipal complex, and instead embraces *filios*, truth, freedom, reason and reality contained in science rather than faith (Batson et al, 1993, p. 232; Fromm, 1950, p. 13; Fuller, 1994, p. 36; Koenig, 1997, p. 24). Ellison and Levin (1998, p. 713) and Meadow and Kahoe (1984, p. 363-365, 370) pointed out that unless counteracted by beliefs in divine grace and ego-strength, the doctrines of original sin, revelation, election, theocracy, submission to a cultic leader and view of self as insignificant and sinful, erodes feelings of worth, affirmation, personal responsibility and self-esteem, hinders constructive problem-solving, and promotes excessive guilt, alienation, dependence, unreflexive acceptance of the view of religious authority, superstitious need for self-affirmation, narcissism, self-contempt and out-group hostility.

This view is supported by Wendell Watters, who proposed that Christian doctrine and teaching is incompatible with a balanced outlook that is built on healthy self-esteem, self-actualisation, individualisation, and plays an important role in the genesis of specific mental illness, including depression and schizophrenia, through occurrence of mental and emotional abuse in the form of indoctrination (Koenig, 1993, p. 27). Furthermore, religion can be abused by those who wish to gain personal power and satisfaction through rigid and inflexible application of religious precepts, which are associated with mental disturbance, depression and the extrinsic religious orientation (Hood et al, 1996, p. 426-427). However, Dittes (in Meadow & Kahoe, 1984, p. 350) points out that religious institutions attract those, who feel “frustrated, threatened, inadequate, deprived”, thus that low self-esteem is an effect rather than cause of religion, which may bring about healing in those who are extrinsically motivated, and who in time can develop an intrinsic religious orientation (Meadow & Kahoe, 1984, p. 352-353).

Extremist, strict religious sects may attract those with immature, dependable personalities and existing psychopathology, or individuals with a high need for social support, and adherence towards a rigid creed may resist movement towards self-actualisation and an autonomous, intrinsic religious orientation (Blaine & Crocker, 1995, p. 1033; Ellison & Levin, 1998, p. 705; Meadow & Kahoe, 1984, p. 31, 323, 351; Van Uden & Pieper, 1996, p. 43-4; Woods et al, 1999, p. 172). Albert Ellis equated irrationality and emotional disturbance with the inflexible, closed, absolutist, intolerant and unchanging religiosity of the devout, orthodox and dogmatic approach to religion, and noted that the emotionally-healthy person is open, flexible and tolerant, without questioning whether both orientations were aspects of pathological or healthy religiosity (Batson et al, 1993, p. 234; Koenig, 1997, p. 25).

Ellis believed that devout, orthodox religion is associated with mental and emotional illness. This is owing to the emphasis on absolutes in belief, intolerance, fanatical commitment, which results in masochistic self-sacrifice, self-damnation, dependency, intolerance, obsessive-compulsive commitment, masking of guilt and hostility, reification of beliefs, discouragement of appropriate risk-taking and self-acceptance, and encouragement of a reliance on God. This contrasts with the healthy individual, who is open, flexible, responsible, tolerant, self-accepting, independent, interpersonally competent, reasonably rational and scientific, and changing (Bergin et al, 1987, p. 198; Ellis, 1988; Koenig, 1997, p. 25-26; Masters & Bergin, 1992, p. 221).

Ellis concluded: “an irrefutable causal relationship exists between religion and emotional and mental illness” (Koenig, 1997, p. 26). This was based on the observations that religiosity is characterised by: discouragement of self-acceptance, self-interest, self-directedness, individual action to solve problems and risk-taking in order to attain personal goals; promotion of intolerance of others, excessive reliance on God and fanatical commitments; inability to deal with ambiguity and uncertainty; and ignoring reality.

Correlation studies in the United States (Lea, 1982, p. 339) found a relation between orthodox religion and higher levels of ego-defensiveness, dependency, tension and sleep-disturbance, whereas less religious individuals were related to higher self-acceptance and spontaneity, and less dependence, which were contradicted by other studies that associated religiousness with lower psychiatric impairment and higher levels of social functioning.

However, smaller religious groups, sects or cults may enable those with coping difficulties to learn coping skills in a more manageably sized group that enables them to adjust to greater society, or serve as an alternative to their own dysfunctional families (Hood et al, 1996, p. 420). These arguments suggest that religion reinforces existing psychopathology, but do they apply to individuals diagnosed with psychological illness? In the case of major depression with psychosis, the religious content of beliefs may reflect the psychotic illness and reinforce psychological health professionals' view that religious beliefs are pathological (Hilton, 2002, p. 36). However, Koenig (1997, p. 49, 120) points out that the clinical work of Freud and Ellis, who proposed this view, was mainly dependent on anecdotal reports of neurotic patients, limited clinical experience and personal bias, rather than experimental data, which contrasts with subsequent theories and research findings on the relation between religion and depression (Argyle, 2000, p. 97).

Various researchers (in Meadow & Kahoe, 1984, p. 384 – 385) have found that the majority of psychiatric patients are not concerned with religion, but that those who are, have concrete, personalised and authoritarian religious orientations, used to control hostility; that as psychological impairment increases, so religious involvement decreases; and that low religious commitment is related to "mental illness, neurotic district and psychic inadequacy" (Stark in Meadow & Kahoe, 1984, p. 385).

However, Kroll and Sheehan (in Koenig, Larson & Weaver, 1998, p. 84) found that psychiatric patients with depression and anxiety disorders showed low levels of preoccupation with sin and guilt. Meadow and Kahoe (1984, p. 383) showed that religious practices can become pathological when attempts "to overcome personal fault ... turn into excessive self-constriction; preservation and promotion of the values of one's group becomes ... fanaticism; devotional enjoyment of God ... excessive withdrawal from life ... Some personal dispositions may be mistaken for religiousness. Docility ... with obedience, insecurity and self-effacement with humility, and need to please others with charity."

In support of this view, Lea (1982, p. 342-344) highlighted the pathological religious ideation of emphasis on personal guilt and sinfulness, excessive dependency on and conformity to religious authority, gullibility, denial of critical appraisal of beliefs, ingroup-outgroup classification of saints and sinners, unhealthy repression of anxiety and anger, literalistic biblical interpretation, legalistic obsessive-compulsive adherence to moral law, masochism through flagellism, nihilism based on personal conflict and frustration, and justification of illegal and immoral acts. These processes may assist the individual to preserve psychological integration by symbolically expressing personal conflict and isolation (Oates in Lea, 1982, p. 342).

Religion can be a means by which individuals and groups express and cope with anxiety in a manner that is "abstract, metaphorical and symbolic" (Fallot, 1998, p. 6). However, Switzer (in Meadow & Kahoe, 1984, p. 384) believes that the relation between religion and mental illness can have alternative explanations, namely, the result of repressive and constrictive religious teaching, the use of repressive interpretations by marginally adjusted parents, repressive style of parenting, which leads to religious distortions and low self-esteem.

In answer to the objections raised to religion by various psychologists, Allport believes that religious preoccupation is an effect rather than cause of mental-disturbance. In addressing Freud's critique of religion as reflecting primitivism, which needs to be replaced by rational science, Allport states that members of primitive cultures are able to distinguish between empirical reality and non-empirical reality (Fuller, 1994, p. 130). Allport believes that religion includes unity and coherence (Fuller, 1994, p. 130).

The relationship between anxiety, guilt and religion is not always negative. In answer to Freud and Ellis, it can be argued that religion is associated with mental illness when it is misused in an immature manner by people to promote "blind faith", there is passive acceptance of existing conditions, Scripture is used out of context, negative attitudes are rationalised, dependency promoted, and there is loss of individual responsibility for actions (Jackson & Coursey, 1988, p. 399; Koenig, 1997, p. 105). Although Frankl (1986, p. 200-201) acknowledges the existence of a biological or endogenous cause for and symptoms of depression, he nevertheless believes that depression is a mode of existence accomplished by the spiritual person, rooted in existential and conscientious anxiety and guilt, and that the individual has the free will to choose the attitude adopted by the depressed person towards the depression, and to use the experience as an opportunity for transcendence.

Carl Jung describes the numinous as the "inexpressible", "divine" or "spiritual" source of the religious experience (Fuller, 1994, p. 86), an emotionally-charged unconscious content and experience that controls consciousness, which, depending on how it is channelled, can bring either psychosis or redemption, and a new source of psychic energy (Fuller, 1994, p. 93; Harding, 1988, p. 2).

Religion may cause, legitimise or worsen psychopathology, lead to stagnation and the inability to confront reality and change positively, as well as emphasize blind obedience, framing of behaviours as sin, thereby fostering excessive guilt or withdrawal of social support, and belief that encourages immature and unrealistic thinking, and intolerance of ambiguity of the authoritarian personality (Ellison & Levin, 1998, p. 713; Van Uden & Pieper, 1996, p. 48, 50). However, authoritarian religion has not been related to mental illness, extra- and intra-punitiveness, and further research is required (Hood et al, 1996, p. 427; Meadow & Kahoe, 1984, p. 354).

Although people may find comfort and safety in religion, these functions may also prevent people from developing a personalised religion and simplification of complex intellectual religious meanings (Hood et al, 1996, p. 427; Meadow & Kahoe, 1984, p. 13). Lloyd and Spencer (in Meadow & Kahoe, 1984, p. 379) considered religion as a coping device, which protects excessive irrational, pre-psychotic and emotionally expressive behaviour against psychological decompensation through joining synchronous religious sects. Pargament and Park (1996, p. 24; Ellison & Levin, 1998, p. 713) note a difference in religious coping and problem-solving styles, namely, deferring, counteractive and passive styles, which may have pathological consequences versus an active and collaborative style, which is related to autonomy, industry, self-efficacy and higher self-esteem, and adaptive coping. Many religious traditions have demonstrated knowledge of the importance of certain practices to the health of adherents through proscribing risky, deviant and illegal behaviours, and prescribing moderate, moral, health-enhancing behaviours, which decrease stress, anxiety and depression, and provides a supportive environment (Ellison & Levin, 1998, p. 704; Koenig, Larson, & Weaver, 1998, p. 86-87; Woods et al, 1999, p. 73). For example, the Mosaic avoidance of pork reduces the risk of trichinosis, and the Latter-Day Saints and Jesuit abstention from stimulants increases longevity (Levin & Schiller, 1987, p. 12).

Religion has been shown to play a positive role in the promotion of physical health through providing guidelines that decrease smoking, suicide, drug use, delinquency, divorce rates and increasing well-being, however, findings suggest an increase of alcohol use among more conservative denominations (Gartner, Larson, & Allen, 1991, p. 7-10; Koenig et al, 1998, p. 86-87; Woods et al, 1999, p. 73).

Koenig (1997, p. 67-69) believes that religion promotes psychological health through three mechanisms, namely, through a system of beliefs and attitudes or cognitive framework that gives hope and sense of control; increased social support and interaction, which is associated with lower levels of depression; and emphasis on focus on and love for others and a power higher than the self, whereas Ellison and Levin (1998, p. 711) outlined the mechanisms of: prevention of illness, response to stress, interactive and counterbalancing effects.

The feeling of insufficiency in the depressed person arises from the exaggerated tension and disparity between the ideal and real self, or the need and possibility of fulfilment, which leads to a sense of an inability to fulfil the life task, and a loss of meaning and purpose for life (Frankl, 1986, p. 202-203). Recent developments in the psychoanalytic tradition proposes that far from being immature, pathological or defensive, religion can play an important role in reinforcing ego strengths of trust, hope, intimacy and care; regression can contribute to reinforcing the ego and mature character strengths (Wallwork & Wallwork, 1990, p. 161-162). Allport notes that it is the immature religious sentiment, a form of egocentricity, that is the neurosis that protects the individual against anxiety, provides personal gain and social needs (Fuller, 1994, p. 131).

This egocentric, materialistic, magical, unreflective, wish-fulfilling orientation to religion arises as the religion in childhood is found to be comforting and as a result religious development is arrested, reinforced by the lack of social expectation in the development of religious maturity, resulting in a form of religion that is "unquestioning, irrational, and authoritarian" (Fuller, 1994, p. 133).

It is this immature orientation to religion that most critics focus on. Furthermore, Andreasen (1972, p. 155) points out that depression can be expressed in religious terms through feelings of guilt, intense sinfulness and worthlessness, isolation from God and meaninglessness. However, most religions restrict impulses not for psychosocial reasons, but because the human impulses separate the individual from God (Pargament, 1997, p. 50).

3.1.2.2. Socially Acceptable Paranoia

Mythology, magical thinking, compulsive rituals, minor delusional systems of belief, paranoid and delusional symptoms are universal conditions that point to concern for the human condition in all cultures, and which is reflected in art, music, faith, regression and psychosis (Beit-Hallahmi, 1996, p. 76). La Barre proposed that religion is a paranoid defence built on ideas of reference and influence, and Pruyser that it results from concrete rather than threatening symbolic thinking, which results in delusions of persecution. Arieti proposed that religion is a form of "collective schizophrenia, and in some of its practices a form of obsessive-compulsive psychoneurosis, different from the psychiatric syndromes because it is socially acceptable", but acknowledges that hallucinations and delusions are inherent in mysticism and do not necessarily reflect psychiatric paranoia (Beit-Hallahmi, 1996, p. 72; Meadow & Kahoe, 1984, p. 369).

The assumption that religion is an expression of the denial of reality and the promotion of beliefs that suffering and death are illusions can be challenged by the role that institutional religion plays in the rite of passage, which gives meaning to each stage of development, suffering and crisis (Pargament & Park, 1996, p. 20). Furthermore, Meadow & Kahoe, (1984, p. 377-378) point out that mentally ill people are usually dealing with issues that are of fundamental importance to them, and communicate their intense experiences using religious language that is distorted, magical and fragmented, or reflects a projection of anxiety and external relationships.

3.1.2.3. Violation of Basic Human Nature

Fromm regards depression as resulting from the inner emptiness and insecurity arising from the inability to integrate energy in the direction of the higher self, an inability to love, an "inner sterility and unproductiveness" (Fuller, 1994, p. 30), through the working of the conscience. The concept of conscience is the inner voice, based on knowledge and affect, which is oriented towards growth and life rather than submission to internalised authoritarian moral ethics. Consequently, Fromm regards sin and mental disturbance as the violation against our own human nature, rather than as against an external God, and guilt as an invitation to future improvement rather than self-hatred and feelings of inferiority (Fromm, 1950, p. 75, 87-90; Fuller, 1994, p. 229-230). Similarly, Mowrer (in Meadow & Kahoe, 1984, p. 385, 387) regards neurosis and depression as the result of sin, isolation and estrangement from the self and others, rather than anxiety, that is, the result of real, regretted and not imagined guilt and actions, which the healthily developed conscience would not engage in, and which can be resolved through adopting a religious outlook, finding meaning to existence and adopting transcendent values.

Psychotherapy thus involves healing the split within the self, and between the self and others, "to gain the faculty to see the truth, to love, to become free and responsible, and to be sensitive to the voice of ... conscience" (Fromm, 1950, p. 93), through replacing repressions and rationalisations with integration. Psychological health can be attained when people surrender all attachments (Fromm, 1950, p. 28, 97; Fuller, 1994, p. 233, 236). One could argue that this goal of psychotherapy fulfils the function of religious conversion.

3.1.2.4. The Need for Conversion

Although religious conversion has been extensively studied, the relation of conversion to depression was described effectively by William James. According to James, the need to be "twice-born" by the morbid-minded religion, a process of conversion from ordinary to mystical states of consciousness, originates in the subconscious. The process of conversion is characterised by unification of the personality in which the individual experiences sadness, melancholia or anhedonia, wrongness, incompleteness, sense of isolation from the divine, a religiously-based type of temporary exhaustion, helplessness and depression that plays an important role in the genuine religious life. When the process is resolved, conversion leads to a profound and momentous change, an excited and faith-filled happiness, stability and peacefulness, in which religious experience becomes the "*habitual centre of his personal energy*", but at the same time James acknowledges that this can lead to excesses (Fuller, 1994, p. 18-19; James, 1987, p. 79, 135-137, 142, 163, 183, 197, 309; Wulff, 1991, p. 493). This process of conversion has been described many centuries before by mystics, such as, St. John of the Cross, who referred to the "dark night of the soul" (Kavanaugh & Rodriguez, 1991) and St. Ignatius of Loyola, who described the cycles of consolation and desolation (Hughes, 1985, p. 96). This view suggests that religious orientation is not static, but changes during the lifetime.

3.1.3. The Changing Nature of Religious Orientation and View of Self, Others and the World

There are variables in social research that are fluid or changeable. These are human development, socio-economic status, income, education, religious affiliation, frequency of religious attendance, level of stress and language preference. Therefore one could ask whether there are cohort differences in religious orientations and their relation to depression.

Zunzunegui et al (1999, p. 367) noted that increased risk of depression is observed with increasing age, where the greater presence of chronic medical conditions are related to more depressive symptoms. Subjects with fewer functional limitations show lower prevalence of depression. Current findings generally indicate that the incidence of depression is highest among young adults and declines with increasing age, but that the educational attainment of the elderly is generally lower than the younger adults (Schieman, Van Gundy & Taylor, 2002, p. 261, 271).

3.1.3.1. Adolescence and Young Adulthood

In her review of literature on adolescence and religiosity Donelsen (1999, p. 192) noted that attention was paid to conversion, coping and defences, abortion, sexuality, eating disorders and alcohol abuse, non-traditional religions, identity development, science, secularisation, death and suicide. No mention was made in research literature of adolescence, depression and religious orientation. Factors that contribute to depression in adolescents have included drug usage, family interactions, religious beliefs, lower perceptions of control, meaning in life, well-being, ability to adjust, religious participation, levels of social support, and higher levels of self-aggression and anxiety (Wright et al, 1993, p. 560).

High scores on the Beck Depression Inventory in adolescence is related to a weak sense of purpose in life, high anxiety, self-aggression and adjustment difficulties, which serves as an early-warning signal for a suicide attempt (Wright et al, 1993, p. 560). Ross (in Donelsen, 1999, p. 198) found a curvilinear relation between strength of religious involvement and psychological health in that those with high or low levels of religious commitment experienced lower levels of distress and the highest levels of distress was felt by those adolescents who were indifferently involved in religion, thus indicating that psychological health is associated with active identification by choice.

Adolescence and young adulthood is characterised by greater abstract thinking, questioning of existential issues, complexity of differential and integrative thought, and decreased religiousness, as well as religious questioning in which many undergo conversions and confirmation. These variables are highly correlated with the quest orientation and have a low correlation with orthodox religion (Hood et al, 1996, p. 89-92). Several texts have been published on the topic of adolescent religiosity and depression (Donelson, 1999, p. 189; Spilka et al, 2003, p. 122; Wright et al, 1993, p. 560), the reason for the omission of this population from the study. Adolescent religious involvement is related to increased academic and social competence, and use of prayer as a coping mechanism, and lower suicidal ideation, delinquency, and drug and alcohol use (Donelsen, 1999, p. 197; Wright et al, 1993, p. 560).

Recent studies using more refined measures of religiosity have found that an intrinsic rather than extrinsic orientation is associated with:

- Mental and physical well-being,
- Openness to change,
- Lower levels of depression (Donelsen, 1999, p. 197),
- Personality functioning and lower anxiety (Bergin in Wright et al, 1993, p. 561),
- Sociability,
- Sense of well-being,
- Responsibility,
- Self-control that was unrelated to anxiety,
- Tolerance,
- Achievement by conformance and
- Intellectual efficiency (Bergin et al in Bergin, 1991, p. 400).

Religiosity in adolescents is related to less problem behaviour, in which prayer is regarded as an effective coping strategy to deal with any unhappiness, decreased anxiety and depression, and increased prosocial behaviour, self-esteem, tolerance and self-control (Jessor and Jessor in Wright et al, 1993, p. 560; Spilka et al, 2003, p. 124). Wright et al (1993, p. 565) found, in agreement with the theories of Carl Jung and Viktor Frankl, that adolescents with higher levels of church attendance and spiritual meaning in life, that is, intrinsic orientation, demonstrate lower levels of depression, a finding significant for females, but not for males. Bergin et al (in Bergin, 1991, p. 400) found that devout religiosity as measured by the Religious Orientation Scale was not related to psychopathology.

Bergin et al (1987, p. 200) concluded that religion was not a psychological defect, but that negative effects do occur and can be differentiated from pathological religious forms and altered to more positive religious forms during counselling. Given that research has focused on the interrelationships of the intrinsic and extrinsic religious orientations, this raises the question of whether the Quest religious orientation is related to higher or lower levels of depression in adolescence, given that existential questioning is a characteristic of adolescence, and religious doubt is related to: tension, distress, depression, conflict, lack of ego-integration, adjustment, optimism, positive self-esteem, interpersonal relationships and faith, openness, cognitive complexity, lower prejudice, altruism and various aspects of mental health (Spilka et al, 2003, p. 129-130).

3.1.3.2. Middle Age

Lower rates of depression for this age group are related to employment, identity formation and self-esteem (Schieman et al, 2002, p. 264). Research on the relation between depression and religious orientation will be seen to have used convenient samples of college students in early adulthood, with the result that the population over the age of 21 has been neglected, and the subsequent decision to focus on this population in this study.

3.1.3.3. The Elderly

A considerable amount of research has been conducted on the relation between religion and depression in the elderly population. The elderly increasingly turn to religion to cope with existential issues, deterioration of health, and alleviation of death anxiety, hostility and aggression. Religious involvement has a protective effect in conditions of stress in that the elderly who turn to religion have lower risk of psychological distress in the form of depression than those not involved in religion (Braam et al, 1996, p. 284; Zunzunegui et al, 1999, p. 364, 367).

Variables associated with lower levels of depression among the (increasingly functionally disabled) elderly include,

- High self-esteem and intrinsic religious orientation (Nelson, 1990, p. 34; Park et al in Beit-Hallahmi & Argyle, 1997, p. 190),
- Higher church attendance and membership (Cutler in Koenig, 2002, p. 15; Nelson, 1990, p. 30; Idler in Beit-Hallahmi & Argyle, 1997, p. 190),
- Contact with church-related friends (Ortega in Koenig, 2002, p. 16),
- Participation in work-related rather than social and community service groups (Palinkas, Wingard and Barrett-Connor, 1990, p. 443),
- Successful review of past life that leads to satisfaction rather than despair (Baum and Baum in Nelson, 1990, p. 34).

Religion provides future hope, coherence and meaning for life, death and suffering, protection against depression by abiding to the secular and spiritual norms of the religious group (Braam et al, 1996, p. 284; Hood et al, 1996, p. 432; Musick et al, 2000, p. 92), social interaction and coping resources, emotional support, and continual growth in faith (Baetz, Larson, Marcoux, Bowen & Griffin, 2002, p. 163; Nelson, 1990, p. 30). Religion plays an important and stable role in the self-esteem of the elderly, which also enables them to cope with the stress and depression resulting from the losses associated with increasing age (Nelson, 1990, p. 29). These losses include loss of income, financial and social status, work roles, significant others, social and religious activity, lower living standards and physical impairment, which diminishes goal-attainment, damages interpersonal relationships and erodes self-esteem (Braam et al, 1996, p. 284; Nelson, 1989, p. 199; Schieman et al, 2002, p. 262). However, these losses are counteracted through the knowledge, coping skills, positive interpersonal relationships, emotional intelligence and resources acquired over the lifetime, and fewer responsibilities towards dependents (Schieman et al, 2002, p. 262).

The Intrinsic scale correlates positively to increased age for women, whereas the Extrinsic and Quest scales show a decline with age (Spilka et al, 2003, p. 131; Wulff, 1991, p. 239). These effects of the interaction between religion and depression are particularly significant for Black elderly in the Baptist South of America (Rosen in Nelson, 1989, p. 200). Nelson (1990) found no significant correlation between extrinsic religious orientation and depression. High intrinsic religiousness enhances the ability of the elderly in the Netherlands to cope with the stress of physical illness and the rate of recovery from major depression (Braam et al in Hilton, 2002, p. 34; Koenig in Baetz et al, 2002, p. 160). The research suggests that these results are of particular relevance to elderly members of the population where lower intrinsic religion and religious activity are correlated with greater anxiety and depression. It would appear that the greater amount of existential questioning occurs in adolescence and old age.

3.1.3.4. Socio-Economic Status, Religious Affiliation and Education

In the United States, socio-economic status (SES) and level of education are commonly linked, and affect religious affiliation rather than orientation, in that more active, higher educational attainment is positively correlated with orthodox church membership, formal, middle class, Protestant church members, whereas the lower SES strata and educational attainment correlates positively with fundamental, sectarian religious activity, mysticism (Batson et al, 1993, p. 39, 40) and the extrinsic religious orientation (Meadow & Kahoe, 1984, p. 353). Freden (in Frost 1985, p. 184-185) outlined social class differences in the occurrence of depression in that depression in the lower social classes is associated with routine repetition that indicates a restricted action range, lower self-esteem, social and economic conditions, and the higher classes experience depression as a result of psychological and cultural conditions. Zunzunegui et al (1999, p. 367) noted that higher income in Spain is associated with lower depression.

The benefits of religious involvement on health have been found to be higher for members of the lower SES (Ellison & Levin, 1998, p. 714). Surveys have shown that higher educational and occupational achievements are related to lower levels of adherence to conventional religion and high privatisation (Fallot, 1998, p. 7) of religion.

Religious affiliation "reflects a discrete set of beliefs on which a person's view of the world is based" (Meador, Koenig, Hughes, Blazer, Turnbull, & George, 1992, p. 1204), which in turn effects attitudes and behaviour towards religion and health, depending on whether the affiliation is traditional or not. Despite the wide variety of experiences within the traditional religious affiliations, differences can be noted in terms of religious emphasis, Catholics focusing on tradition and participation in the Mass, Protestants on faith and the word of God, and Pentecostals on the work of the spirit (Park, Cohen, & Herb, 1990, p. 567).

Frankl noted a trend away from universal, institutional and interdenominational religion that limits growth, and is preoccupied with differences and self-justification, and towards a personal, private religiousness (Fuller, 1994, p. 267). There is thus a diverse group of spiritually-orientated people for whom organised religion and current measures of religious orientation may not apply, and inclusion of members of this group will effect the significance of the results (Wulff, 1991, p. 248), but as yet no norms exist for their exclusion, all completed responses in the study have been included.

3.1.3.5. Chronic Illness

Religion contributes towards health by providing people with coping mechanisms. Coping can be defined as "efforts, both action-oriented and intra psychic, to manage ... environmental and internal demands, and conflicts among them, which tax or exceed a person's resources" (Lazarus & Launier in Ellison & Levin, 1998, p. 707). Ellison (in Schnittker, 2001, p. 394) states "through spiritual help-seeking, whether in prayer or religious counsel, individuals may find personalized support and guidance in ways independent of service attendance alone".

According to Mirola (1999, p. 421) religion plays a stress-buffering role in that perceptions and meanings of stresses of daily life stressors are altered so that stressors do not seem so stressful, and are more manageable. Through redefinition of a situation into positive terms, those who suffer can regard difficulties as opportunities to grow in character and thereby gain eternal life or as reflection of God assessing the capacity to take on a special mission (Grzymala-Moszczynska & Beit-Hallahmi, 1996, p. 10; Hood et al, 1996, p. 382; Pargament & Park, 1995, p. 20-21). It is particularly the intrinsic religious orientation acts as a buffer against stress due to uncontrollable life events that usually produce depression as this orientation gains emotional support and finds meaning in these events (Argyle, 2000, p. 159).

3.1.3.6. Frequency of Religious Attendance

Frequency of church attendance promotes positive perceptions of social support, acts as a coping mechanism or buffer against the stressors that contribute to depression, as well as provides similarities of values and beliefs, compliance to the reciprocity norm, a daily and collective philosophy of life (Schnittker, 2001, p. 394; Strawbridge, Shema, Cohen, Roberts and Kaplan, 1998, p. S118-119).

The samples examined included younger people with a mean age of 27 (Koenig et al, 1997, p. 58-59, 61), elderly Black women in the United States (Strawbridge et al, 1998, p. S118), and those with poor health (Idler in Stack, 1992, p. 94). However, Ellison (1995, p. 1570) found that public religious involvement measured as frequency of church attendance has a beneficial relation to depression among whites only, and in contrast to most findings, found no clear association between religious activity and depression among southern African Americans, which may be due to the semi-involuntary institution of the southern black church, which provides personal legitimacy.

When religion is defined in terms of church attendance rather than orientation, higher levels of church attendance are associated with greater emotional well-being, affective status and functional ability, such as ease in social and immune functioning and coping with stress, and lower rates of depression, which is not mediated by active coping or self-efficacy (Murphy et al, 2000, p. 1102; Woods et al, 1999, p. 166, 171). The positive relation between church attendance and health is reduced when functional capacity is measured (Sloan et al, 1999, p. 665).

Baetz et al (2002, p. 160) report that regular worship attendance is associated with:

- Longer life expectancy,
- Decreased effects of stressful life events on psychological well-being,
- Enhanced psychosocial well-being,
- Positive psychological health,
- Increased social relationships, and
- More stable marital relationships.

In their meta-analysis of 200 studies, Gartner et al (1991, p. 11, 15) found that religiosity is associated with lower levels of depression, where religion is associated with psychological health problems involving over-control, such as rigidity, and lack of religiosity is associated with problems of under-control. Furthermore, Bergin et al (1988, p. 96) found that continuous religious development with a religiosity that was disciplined, loyal to traditional religious ideas and emotionally interdependent, and which gave stability and a comprehensive worldview, was related to better psychological health. It has been found that those who do not affiliate themselves with a particular religious tradition have been found to oppose prejudice, be less likely to yield to authority, more likely to have mystical experiences, and have a religious sentiment that is personal, internalised, based on higher values that have been discerned and integrated from religious-philosophical principles (Wulff, 1991, p. 247).

3.1.3.7. Perceived Levels of Stress

Anxiety and stress can also be aroused as a result of excessive investment in religious involvement, irritation, gossip, unrealistic and idealised expectations and congregational conflict (Ellison & Levin, 1998, p. 713). Jung and Boisen (in Meadow & Kahoe, 1984, p. 380) believed that psychological disturbance may in certain cases be a reflection of religious problems, where there is a need to change religious orientation, or be an invitation to personal growth, whereas Miller and William James pointed out that "sufficient sensitivity to values and inner discord makes one capable of both deep religiousness and neurotic suffering" (Meadow & Kahoe, 1984, p. 381).

3.1.3. The Static Nature of View of Self and Religious Orientation

Gender and race are ociocultural variables that remain stable over the individual's lifespan. The question is whether there are differences in the relation between religious experience and depression between different gender and racial groupings.

3.1.3.1. Gender

There is a predominance of women sufferers of depression in all age groups worldwide. This group also has high levels of untreated depression. According to the "artefact" hypothesis, this may be due to a tendency of women to express affective symptoms and seek medical help, the result of biological susceptibility or social causes (Weissman & Klerman, 1977, p. 98, 100,101), a hypothesis that has been challenged (Holmes & Rahe in Weissman & Klerman, 1977, p. 101; Paykel et al in Weissman & Klerman, 1977, p. 102). Clancy and Gove (in Weissman & Klerman, 1977, p. 102) found that the reporting of symptoms reflected actual differences, that is, that women experience more symptoms. Women tend to seek treatment, whereas men tend not to seek medical help, and tend to commit suicide (Weissman & Klerman, 1977, p. 102).

There is a wide range of causes of depression in women. Social pressures include dependency, submission and risk aversion, gender roles that lead to lower social status and power. Women in the middle-age, who are predisposed towards depression, tend to be conventional, conscientious, duty bound, perhaps prudish about sex, who "depends less on herself and more on her husband... is less self-directed and depends on others for support of self-esteem, has unfulfilled need for love and gratification leading to aggression turned in on the self" (Crocket, 1977, p. 51-52).

Donelson (1999, p. 196) points out that religious experiences, beliefs and behaviours among girls and women have been consistently higher than boys and men as religion is a source of identity, competence and power that is not based on the concrete world. Socialisation practices inhibit the expression of anger; promote internalisation of role expectations, different learning histories, which result in different strategies in dealing with stress. Cultural variables include higher exposure to stress and social discrimination, low social status, legal and economic discrimination, narrow action ranges experienced particularly by the homebound woman (Freden in Frost 1985, p. 185).

These variables have been gradually changed in the past forty years through the development of responsibility, self-direction, critique of traditional religious structures and theology, and greater leadership roles of women in churches (Bromberger & Matthews, 1996, p. 591-596; Spilka et al, 2003, p. 154-155). Further contributing ociocultural variables to depression in women include membership of the lower class, experience of marital problems, unemployment, having children and fulfilling unsatisfactory gender roles (Goldman & Ravid, 1980, p. 35; Klerman & Weissman, 1980, p. 57, 72, 73, 82; Radloff, 1980, p. 98, 102; Rothblum, 1983, p. 85, 91, 97; Weissman & Klerman, 1977, p. 106). An exception is unmarried men and married, unemployed men, who experience higher levels of depression than their female equivalents (Rothblum, 1983, p. 92).

In terms of the relation between gender and religious orientation, research has shown that women are consistently more religious than men and are also more likely to experience a form of depression (Batson et al, 1993, p. 33; Bromberger & Matthews, 1996, p. 591; Palinkas et al, 1990, p. 443; Spilka et al, 2003, p. 153).

3.1.3.2. Race

Ellison (1995, p. 1569) outlined race differences between religion and psychological well-being in that church attendance shows an inverse relationship among whites, but positive relationship among blacks; church affiliation shows lower levels of depression among blacks than blacks with no religious affiliation; and frequency of devotional activities is positively related to the number of depressive symptoms, which may be the effect of prior life stress and personal characteristics that predispose the individual to depression and the result of cross-sectional study. In the United States, African Americans are more likely to participate in religious activities, hold more central, traditional beliefs than white Americans, which may be due to differences in social norms and functions (Batson et al, 1993, p. 38).

3.2. Role of religion and psychological well being in inter-group and inter-individual relationships

3.2.1. Social Functions of Religion

Humans are essentially social beings who exist in relationships and interdependence (Spilka et al, 2003, p. 18). Emile Durkheim provided a theoretical framework for the importance of religion, whereby religion serves a life-preserving function, provides a social support system that prevents alienation and isolation, unites individuals into groups, where religion and society are synonymous (in Idler & Kasl, 1992, p. 1053 – 1055; Pargament, 1997, p. 55; Pargament & Park, 1995, p. 17).

Religion provides a moral code defining relations to others that maintains a stable social order and cultural conformity when internalised (Meadow & Kahoe, 1984, p. 29-30). By means of socialisation, people internalise the normative beliefs and behaviours of society (Hood et al, 1996, p. 73).

Active participation in a religious community's worship, study and service involves mutual interaction and responsibility, awareness of social justice, acceptance of grace and love, caring and self-sacrifice, forgiveness, lowers judgment and suspiciousness. This social support is related to lower rates of depression and appears to be more resilient than secular support (Koenig, 2002, p. 15; Malony, 1994, p. 25).

Many critics of religion argue that religion serves to reinforce the status quo rather than actively shape social life into a spiritual form or to work for social justice, an attitude reinforced by theological positions that work on individual salvation as possible and social reform as impossible (Pargament & Park, 1996, p. 25-26). These critics argue that religion functions to maintain society and moral identity (Durkheim in Meadow & Kahoe, 1984, p. 8), pacifies and compensates the average person for deprivations of living in society through imposition of codes and the promise of eternal reward (Radin in Meadow & Kahoe, 1984, p. 8), promotes submission, obedience, humility, dependence in interpersonal relations, reflected in the need to appear virtuous, proper and correct (Meadow & Kahoe, 1984, p. 355-356). Closed communities, such as the Amish, Hutterites and holy orders, have been found to have high levels of psychosis, guilt, anxiety and depression, the result of not being able to meet the expectations of the community, strict and inflexible orthodoxy of belief and behaviour applied to everyday life, or the result of pre-existing disturbance (Hood et al, 1996, p. 422-423). However, these views represent an overgeneralisation as many church denominations are actively involved not only in personal salvation, but also in addressing the socio-political and economic conditions that threaten the spiritual welfare of their neighbouring communities (Pargament & Park, 1996, p. 27).

3.2.1. Negative View of Others

Exline, Yali and Sanderson (2000, p. 1483) and Hood et al (1996, p. 432) proposed that strain in religion in the form of disagreement, rejection or fundamentalism, as well as alienation from God, fear and guilt, may be associated with or the source of psychological distress manifested through anger, frustration and depression. This is of particular relevance to the experience of women, whose inferior and secondary role in a patriarchal religion is continuously legitimated by religious tradition, which regards the woman as the source of sin and all human defects, related to the need to increase self-esteem in men.

This also leads to sex-role stereotyping, persecution, prescribed meanings of existence, inability to exert control, and internalisation of negative characteristics. These variables are related to the intrinsic religious orientation in women, intrapunitativeness, higher passivity, unassertiveness, helplessness, anxiety and guilt, lower self-esteem, social and personality characteristics that lead to existential questioning and anomie (Batson et al, 1993, p. 37; Bridges & Spilka, 1992, p. 44-48; Hood et al, 1996, p. 431; Meadow & Kahoe, 1984, p. 358-359, 366-367).

Bridges and Spilka (1992, p. 45) propose that patriarchal precepts of religion provide a risk factor for the development of psychological illness in women, but acknowledge that the current feminist movement in theology is changing this perception, through emphasis on the support for personal and social problems, the increased importance placed on truth and justice.

3.3. Positive view of the world and future

An important function of religion is to provide meaning to the incomprehensible and complex natural and social events, in order to satisfy the human need to understand and know, and to provide a meaning structure to the religious feelings and actions (Meadow & Kahoe, 1984, p. 25-26; Spilka et al, 2003, p. 16). Religion serves various psychological functions, which include:

- Explanation of the unknown, mysterious, injustices, incongruencies and tragedies;
- Protection against the terror of death;
- Reassurance that life is purposeful, orderly and meaningful;
- Ability to overcome adversity; intimacy and family substitution;
- The illusion of personal mastery and control, and
- Provision of a shared system of meanings to explain illness and suffering (Ellison & Levin, 1998, p. 707, 708; Godin, 1985, p. 48; Idler & Kasl, 1992, p. 1054; Malony, 1994, p. 19; Pargament, 1997, p. 56; Plante & Sherman, 2001, p. 389; Ryan et al, 1993, p. 586; Spilka et al, 2003, p. 17).

3.3.1. The Universal Human Condition

Paul Tillich (in Fromm, 1950, p. 94) and Margaret Mead (in Spilka et al, 2003, p. 58) regard the basic and ultimate concern of all human existence as finding the meaning of life. According to Royce and Tillich (in Meadow & Kahoe, 1984, p. 4) religions arose in response to existential questions, such as, the awareness that there is something fundamentally wrong with the human condition, anxiety about uncontrollable events, such as death and natural disasters, fear of meaninglessness and purposelessness, and concern over undesirable behaviour and unwanted feelings. The various religions of the world outline different concepts, yet agree on the difficulty of the pathways to the search for meaning or significance.

The religious experience is imbued and transmitted in all aspects of the sociocultural reality, and encompasses achieving connectedness with the sacred, becomes a way of life, expressing an active or passive path of searching for meaning, and formation of a mental representation of the world (Pargament, 1997, p. 39-40). In studying the various religions of the world, Fromm discovered that there are certain universal principles associated with religion, namely, truth, conscience, values, autonomy, responsibility, release from suffering, love, reason, productive existence and development of the soul. However, like so many other theorists, humans currently live in an age where there is separation between daily existence and spirituality (Brink in Westgate, 1996, p. 27; Fromm, 1950).

Modern society is characterised by an "existential vacuum", a "mass neurosis" or "noogenic neurosis" (Frankl in Fuller, 1994, p. 251, 253), which is demonstrated through depersonalisation, dehumanisation and emptiness, emphasis on hedonism, materialism and power, loss of spirituality and faith, and its associated "existential depression" (Andreasen, 1972, p. 158, 161), aggression, violence and addiction (Andreasen, 1972, p. 159).

The current characteristic of the nature of humans is the wish to abandon responsibility and conscience, the essence of human life, through idolatry, which includes submission to state, religion, mother, science, success, statues, popular opinion, materialism and consumerism, the worship of success and power, disguised as the worship of God (Fromm, 1950, p. 29-32, 81, 102; Fuller, 1994, p. 214, 219, 235, 237). Humans are unhappy, unloving, discontented, and no longer use reason to examine morality, factors which he regards as the basis for psychological disturbances (Fuller, 1994, p. 212-213). Similarly, Maslow regards neurosis as a "spiritual disorder" (Fuller, 1994, p. 169) characterised by loss of meaning, despair and the inability to realise one's full humanity.

Religious traditions, creeds, rituals and codes, provide a framework of beliefs, which provides meaning to unexplainable, uncontrollable or negative life events, or facilitates the reframing of these events (Blaine & Crocker, 1995, p. 1032; Meadow & Kahoe, 1984, p. 5). However, Fromm believes that the current human impulses can be overcome through active solidarity with nature and humanity, by productive acting in spontaneous love and work (Fuller, 1994, p. 215). Furthermore, Fromm regards the universal element of religion, namely love, as an art based on knowledge, effort and action rather than emotional feeling, which is expressed through giving, aliveness, joy, understanding, concern and respect, from the basis of strength rather than weakness (Fuller, 1994, p. 226). Humanistic religions teach that love of others without submission or greed is the essence of human reality, lack of which leads to unhappiness and psychological disturbance (Fuller, 1994, p. 226).

3.3.2. Worldview

Many people believe that being religious implies following institutional rules of behaviour, attitudes and feelings that lead to a authoritarian, controlling and compulsive worldview (Batson et al, 1993, p. 197). Research findings that conservative, fundamentalist or orthodox religion is related to authoritarianism, dogmatism, intolerance of ambiguity, suggestibility, low intelligence and educational attainment, constricted personality defences, conventional socialization, reliance in internal and external structure, submission and dependence, high levels of anxiety, guilt and low self-esteem, appear to bear this out (Gartner et al, 1991, p. 13-14; Hood et al, 1996, p. 427; Meadow & Kahoe, 1984, p. 351, 353, 359).

3.3.3. The Historico-Cultural Context

The psychology of religion in the last few decades of the twentieth century has increasingly focused on man as a historically- and culturally-oriented being, who is born into a historical and cultural milieu. In this view mental illness arises when a person is "psychically mutilated and disturbed" (Belzen, 1996, p. 30) to the extent that they are no longer integrated into the culture and religion of their time. The religious and cultural representatives determine whether an attitude or behaviour is appropriate or normal for the culture and a historical perspective of the roots of the psychological behaviour are examined.

The approach posits that humans can become either religious or irreligious, and that the psychology of religion needs to be examined within the specific cultural framework (Belzen, 1996, p. 30-31).

3.4. Summary of Literature Review: Intrinsic, Extrinsic and Quest Religious Orientations and Their Relation to Depression

3.4.1. Correlation Studies of Religiosity with Depression

Current researchers are still measuring religion in terms of frequency and salience, as well as in terms of religious orientation. These research studies have been concentrated on the European and American context, with only one study found for Iran (Roshdich, Templer, Cannon, & Canfield, 1998-1999), and one in South Africa. Of particular note is their use of convenient samples as well as a wide variety of operational definitions for religiosity.

In terms of convenience sampling, the most favoured have been specific populations, namely:

- Participants in medical studies or medical patients (Pressman, Lyons, Larson & Strain, 1990; Sherkat & Reed, 1991; Koenig et al, 1992; Berg et al, 1995; Kennedy et al, 1996; Miller et al, 1997; Musick et al, 1998; Woods et al, 1999; Murphy et al, 2000; Nelson et al, 2002),
- Caregivers (Zunzunegui et al, 1999),
- Life in the Spirit seminars (Lovekin & Malony, 1977), and
- Studies on ageing, such as, the Longitudinal Aging Study of Amsterdam (Braam et al 1997), Connecticut (Idler & Kasl, 1992) and Tennessee (Husaini et al, 1999),
- University or college students (Mayo, Puryear, & Richek, 1969; Roshdich et al, 1998; Loewenthal et al, 2001), and
- Workers on strike in South Africa (Edwards & Besseling, 2001).

However, there have been studies that have used random sampling of subjects, which include, data surveys of adults in Chicago (Ross, 1990), Indianapolis (Mirola, 1999), EPESE survey in the Duke catchment area (Ellison, 1995; Musick et al, 2000; Miller & Gur, 2002), and Americans' Changing Lives panel survey (Schnittker, 2001).

The depression scales favoured for use in these correlation studies have been the Beck Depression Inventory (Hintikka et al, 1998; Woods et al, 1999; Murphy et al, 2000; Edwards & Besseling, 2001), Geriatric Depression Scale (Pressman et al, 1990), Hamilton Depression Scale (Koenig et al 1992; Nelson et al, 2002), items from the DSM-IIIR (Strawbridge et al, 1998) or DSM-IV classification (Branco, 1000), and the Centre for Epidemiologic Studies Depression Scale (Sherkat & Reed, 1991; Idler & Kasl, 1992; Kennedy et al, 1995; Musick et al, 1997; Husaini et al 1999; Zunzunegui et al, 1999; Musick et al, 2000; Schnittker, 2001).

Religiosity has variously been defined in terms of self-reports of strength or salience of religious belief (Mayo et al, 1969; Ross, 1990; Idler & Kasl, 1992; Braam et al, 1995; Strawbridge, 1998; Roshdich et al, 1998; Branco, 2000; Schnittker, 2001), Index of Religiousness (Pressman et al, 1990), preference or affiliation (Ross, 1990; Idler & Kasl, 1992; Koenig et al 1992; Kennedy et al, 1995; Strawbridge et al, 1998; Meador et al, 2002), content of belief (Ross, 1990), frequency of attendance (Sherkat & Reed, 1991; Idler & Kasl, 1992; Ellison, 1995; Braam et al, 1995; Musick et al, 1997, 2000; Hintikka et al, 1998; Roshdich et al, 1998; Husaini et al, 1999; Schnittker, 2001), use of religious coping resources (Woods et al, 1999; Schnittker, 2001), and frequency of private devotion (Musick et al, 1997, 2000), self-reports on religious involvement (Mirola, 1999; Zunzunegui et al, 1999; Branco, 2000; Murphy et al, 2000; Loewenthal et al, 2001; Miller & Gur, 2002), religious well-being (Murphy et al, 2000; Nelson et al, 2002), religious practice (Edwards & Besseling, 2001).

These studies have found that the relation between religiosity and depression are either:

- Positive in general (Murphy et al, 2000) or for a specific population (Idler & Kasl, 1992), including, males (Mayo et al, 1969), moderate Protestants (Koenig et al, 1992), Pentecostals (Meador et al, 2002), Jewish respondents (Kennedy et al, 1996); or specific ociocultural variable(s), such as, high levels of social support (Sherkat & Reed, 1991), lack of religious salience (Braam et al, 1997), religious coping measures (Woods et al, 1999; Loewenthal et al, 2001; Schnittker, 2001), or maternal religiosity (Miller et al, 1997), hopelessness (Murphy et al, 2000), and low religious attendance (Ellison, 1995; Goal in Plante & Sharma, 2000);

- Negative in general (Roshdieh et al, 1998; Branco, 2000; Edwards & Besseling, 2001) or for a particular population, such, black Protestants (Koenig et al, 1992), undergraduate students (Rife & Lester, 1997), adult caregivers (Zunzunegui et al, 1999), Black cancer patients (Musick et al, 1998); or a specific ociocultural variable (s), such as, as rejection of or very strong belief (Ross, 1990; Pressman et al, 1990), religious attendance (Koenig et al, 1997; Hintikka et al, 1998; Musick et al, 2000), religious participation (Edwards & Besseling, 2001), personal devotion (Miller & Gur, 2002), religious involvement (Braam et al, 1997; Husaini et al, 1999; Catipovic et al in Plante & Sharman, 2000; Mirola, 1999; Miller & Gur, 2002), health care costs (Berg et al, 1995), spiritual well-being (Nelson et al, 2002), and non-family stressors (Strawbridge et al, 1998); or that
- There is no relation for a specific population or for ociocultural variables (Mayo et al, 1969; Lovekin & Malony, 1977).

However, a meta-analysis of research findings on the relation between religiosity and depression by Gartner, Larson, and Allen (1991) indicates that religiosity is correlated with lower levels of depression.

3.4.2. Correlations of Religious Orientations with Depression and Psychosocial Variables

Allport's Religious Orientation Scale was used for 70 published studies by 1985, but despite its usefulness has come under criticism, particularly the uncertain factor structure, value judgments about 'good' and 'bad' religiousness, responses based on social desirability, liberal versus conservative religious beliefs, and inapplicability to non-religious persons (Kirkpatrick & Hood, 1990, p. 443; Sherman & Simonton, 2000, p. 145). The E-I distinction was challenged by research findings that indicated that some individuals score high on both dimensions. Allport and Ross (in Watson, Morris & Hood, 1989, p. 46; Paloutzian, 1996, p. 204; Van Wicklin, 1990, p. 32) ascribed the latter finding to being indiscriminately proreligious, which indicates a response set to evaluate religious material positively and uncritically.

This finding undermines the theoretical distinction between the two orientations, and indiscriminately antireligious, which is ascribed to sensitivity or the suppression or repression of religious attitude and experience. This has been borne out by research (Hunt & King, 1971, p. 348, 354; Paloutzian, 1996, p. 203) that indicates that the E-I distinction does not represent poles on a continuum, but rather represents separate, yet related, variables, and that the Intrinsic dimension is a multifaceted and complex concept. Pargament (1997, p. 62, 66) notes that every spiritual journey involves both means- and ends-orientations in order to reach spiritual goals, and that a polarized conception of religious orientation does not reflect the richness of the religious experience that includes both the self and God. Furthermore, Hunt and King (1971, p. 354) point out that the E/I distinction can be applied to other facets of social and work life, not just to religion, which gives meaning to all aspects of life.

3.4.3. The Intrinsic and Extrinsic Orientations

The intrinsic orientation provides a framework for a faith life where the individual turns to religion during times of crisis, which provides a sense of mastery and self-esteem through a relationship with a mighty and benevolent God (Park et al, 1990, p. 563). There is a strong inverse relation between the Intrinsic – Extrinsic relationship, where the intrinsic religious orientation is negatively correlated with depression (Bergin et al, 1987), and is a protective factor in the course and remission of a depressive disorder whereas extrinsic religious orientation was positively correlated with depression (Bergin et al, 1987; Beit-Hallahmi & Argyle, 1990, p. 175; Koenig et al and Miller et al, 1999, p. 808; Maltby & Day, 2000, p. 384; Masters & Bergin, 1992, p. 223; Park et al, 1998, p. 315; Watson et al, 1989). To put the findings in another way, psychological health and adaptation, as well as sin-related beliefs, emotional empathy, beliefs in grace, and positive outlooks towards oneself and external reality, has been found to be positively correlated to the intrinsic orientation, and negatively correlated to the extrinsic orientation (Batson et al in Argyle, 2000, p. 159; Hood et al, 1996, p. 384; Watson et al, 1989, p. 49).

Various psychosocial variables have been correlated with the intrinsic religious orientation. These include lower levels of anger, hostility, social isolation and depressive symptoms (Hood et al, 1996, p. 388; Plante & Sharman, 2000, p. 244), and higher levels of responsibility, internal locus of control, belief in authority, emotional empathy, religious orthodoxy, close-minded conventionalism, purpose in life, intrinsic motivational traits and higher grade-point average. The intrinsic religious orientation has been found to correlate negatively with manipulativeness, depression, hopelessness and individualism (Kahoe in Bergin, 1991, p. 400; Meadow & Kahoe, 1984, p. 295-297; Van Wicklin, 1990, p. 28-29).

The intrinsic religious orientation buffers the effect of uncontrollable life events on depression (Park et al in Beit-Hallahmi, 1990, p. 190). Maltby and Day (2000, p. 385) found that the mediating factors of positivism, anxiety, neuroticism, avoidance coping, attribution and self-esteem explain this relation between depression and religious orientation. Increased religious activity in elderly people has been variously correlated to higher levels of depression (Hood et al, 1996, p. 388; Plante & Sharman, 2000, p. 244) or lower levels of depression (Idler in Beit-Hallahmi, 1990, p. 190).

Spiritual integration and meaning of the intrinsic orientation has been positively correlated with desirable personal and social characteristics, personality adequacy, mental well-being, sense of control over life, greater coping skills, self-actualisation, open-mindedness, and social adjustment, higher levels of interpersonal trust, greater superego strength and emotional sensitivity (Spilka et al, 1985, p. 314-315; Bergin et al, 1988).

The correlation between the intrinsic religious orientation and depression demonstrated that several studies found negative correlations (Bergin et al, 1987; Nelson, 1989; Nelson, 1990; Fehring et al, 1997; Hettler & Cohen, 1998; Park et al, 1998; Maltby & Day, 1999) and two studies could not find a reliable correlation (Park et al, 1990; Commerford & Reznikoff, 1996).

The extrinsic scores are positively correlated with dogmaticism, prejudice, authoritarianism and fear of death, and negatively correlated with responsibility, internal locus of control, intrinsic motivational traits, academic aptitude and educational level (Kahoe in Bergin, 1991, p. 400; Meadow & Kahoe, 1984, p. 295-297; Van Wicklin, 1990, p. 28-29), feelings of powerlessness and helplessness, greater level of mental illness, use of a shallow and confused religion (Spilka et al, 1985, p. 314-315). Batson et al (1993, p. 258-260) believe that the extrinsic orientation to religion may not lead to an increase in symptoms, whereas the intrinsic orientation as an orientation characterised by religious devotion or fanaticism, does not have a clear association with psychological health.

Most studies that measured the correlation between the extrinsic orientation and depression found a positive correlation (Watson et al, 1988; Watson et al, 1989b; Rosik, 1999; Batson et al, 1993; Genia & Shaw, 1991; Park et al, 1998; Maltby & Day, 1999; Watson et al, 2002). However, Park, Cohen and Herb (1990) found a negative correlation between the extrinsic religious orientation and depression, but a positive correlation for Catholic subjects. Findings in the differences between intrinsic and extrinsic religiosity suggests that the conflicting results prior to this conception were due to a failure to refine the measurement of the religious experience (Bergin, 1991, p. 400).

Similar to the studies that examine the relation between religiosity and depression, the studies that examine the relation between religious orientation and depression have favoured certain scales and samples. Of the studies found, most used convenient samples of university students (Bergin et al, 1987; Bergin et al, 1988, Watson et al, 1988; Nelson, 1989; Park et al, 1990; Genia & Shaw, 1991; Maltby & Day, 1999; Exline et al, 2000; Watson et al, 2002), a support group for widows (Rosik, 1999), elderly day care program (Nelson, 1989), residents of a New York nursing home (Commerford & Reznikoff, 1996), medical patients (Fehring et al, 1997; Koenig et al, 1998). Others examined public school students (in Texas, Wright et al, 1992), Protestant churchgoers in Delaware and Pennsylvania (Hettler & Cohen, 1998), and Korean Americans (Park, Murgatroy, Raynock & Spillett, 1998).

The religious orientation measurement scales used in more than three studies were: Allport and Ross Religious Orientation Scale (ROS), Age-Universal Scale of Gorsuch and Venable, and the Intrinsic/Extrinsic Religiosity Scale of Gorsuch and McPherson. The scales used in the measurement of depression were primarily the Beck Depression Inventory, Costello and Comfrey Depression Scale, Geriatric Depression Scale and Centre for Epidemiologic Studies Depression Scale.

3.4.3.1. At-Risk Populations

Park et al (1990, p. 567, 572) found that the inverse I-E pattern is more discernible between Protestant rather than Catholic subjects, but that the reverse was found in the different denominational use of religious coping, with Catholics more able to expiate distress through use of confession. Meador et al (1992, p. 1207) found that members of the Pentecostal denominations had a greater risk of experiencing major depression, when sociodemographic and psychosocial risk factors were controlled for.

These results are supported by MacDonald and Luckett, who found a similar pattern with non-mainline Protestants, and Koenig et al (1998), who found that mainline Protestants experienced lower rates of depression. These researchers point out that this may be the result of depressed persons affiliating with denominations that use charismatic healing or that they express their feelings more openly, or that these denominations foster social isolation and powerlessness, factors implicated in the aetiology of depression. However, these studies did not take religious orientation into account.

It can be suggested that it is not the religious affiliation, but rather the religious orientation within the affiliations that are related to the occurrence of depression. Meadow and Kahoe (1984, p. 359-360) proposed that nonconformist faith is related to the intrinsic religious orientation, whereas the authoritarian, conventional or conservative religion is related to the extrinsic religious orientation.

3.4.3. The Quest Orientation

Batson and Ventis theorized that the Quest dimension would produce the strongest relation to psychological health (Batson et al, 1993, p. 166, 169, 188; Donahue, 1985, p. 412; Grzymala-Moszczynska, 1996, p. 191; Masters & Bergin, 1992, p. 227; Pargament, 1997, p. 64; Wulff, 1991, p. 236). Have subsequent research studies supported this theory? Beit-Hallahmi and Argyle (1997, p. 190) found that no clear relationship was found between the Quest dimension and depression. Only one study found a low but significant positive correlation between the Quest orientation and depression as measured by the Beck Depression Inventory (Levick & Delany 1987).

Several researchers have found a negative correlation with psychological health indices, and argued that the Quest dimension was a reflection of trait anxiety, agnosticism, religious conflict, or a developmental phase in adolescence and young adulthood leading to the Intrinsic Orientation, and that the Means dimension may be a complex rather than rigid end result of existential questioning (Donahue in Masters & Bergin, 1992, p. 228; Kojetin et al, 1987, p. 111; Wulff, 1991, p. 238).

There is strong evidence to support the validity of the Quest orientation. The Quest orientation has positive correlations to values, such as, moral judgment, equality, racial tolerance, liberal attitudes, openness to experience, beauty, cognitive complexity, non-discrimination, true friendship, social recognition, world mindedness, altruism, social activism, ego identity development and principled moral reasoning, and negative correlations with social desirability, authoritarianism, fundamentalism and prejudice (Batson & Schoenrade, 1991a; Spilka et al, 2003, p. 132; Van Wicklin, 1990, p. 31; Wulff, 1991, p. 241).

Burris et al (1996, p. 1070 – 1073) found that the Quest dimension was a temporary orientation in response to difficult or tragic life events, conflict, and characteristic of individuals outside established religious institutions, individuation from and critique of social groups, trauma, motivation to maintain a sense of personal freedom and avoidance of cognitively simple situations. However, Hood et al (1996, p. 25) believe that individuals, who score high on both the intrinsic and quest dimensions are true intrinsics, whereas those who score high only the intrinsic dimension may adhere to a simplistic and orthodox religious orientation. Furthermore, Paloutzian (1996, p. 227) proposes that the liberal-conservative qualities of religious distinctions be included and outlined a classification of: intrinsic liberal, intrinsic conservative, extrinsic liberal, extrinsic conservative.

Consequently, Gartner, Larson and Allen (1991, p. 6) have stated that the consistent patterns in the complexity of the relation between religion and psychological health can only be discerned when specific aspects of religion are studied in relation to specific forms of mental illness. No studies could be found that examined the relation between *religious* orientation and depression in a designated Third World country. The South African study by Edward and Besseling (2001) used the Beck Depression Inventory, but defined religious practice in terms of church membership, attendance, activities, Bible reading and financial contributions. No studies could be found that examine the relative strength of importance of various religious orientations to depression. The following Chapter 4 outlines aspects of the relationship between religious orientation and depression that require further research, with emphasis on the complex nature of the relationship.

6. Towards further research in the relation between religious orientation and depression

As outlined in the previous chapter, a considerable body of literature exists on the nature of the relationship between religion and mental health. However, studies that examine the relationship between religious orientation and depression need to consider the complexities of this relationship. Chapter 4 discusses the complexities between religion and depression, and proposes the research hypotheses, which are the focus of this study, against the background of these complexities.

4.1. Complex nature of relation between religion and depression

The views and theories on whether religion has positive or negative effects on psychological health lie along a continuum ranging from cause of pathology to cause of health. Bergin (Bergin et al, 1987, p. 198; Bergin et al 1988, p. 91) proposed that religion has a variety of positive consequences, but is a complex phenomena that has both positive and pathogenic consequences for psychological health and functioning, depending on how it operates in the individual's life. Spilka, Hood, and Gorsuch (in Van Uden & Pieper, 1996, p. 52) state: "a faith which provides an open-minded, competent guide for everyday living is found in conjunction with good adjustment and effective coping behaviour. A shallow, externalised religion that is needed when things aren't what one desires is more likely to be a correlate of shortcoming in personality and social interaction." Religion has been demonstrated to be a multidimensional phenomenon that interacts and relates to health and illness in a number of ways.

Research into the relation between religious orientation and psychological health is inconclusive, mainly the result of a lack of distinction, consensus, operationalisation and differentiation between the various types of religious orientation, the wide range of theories, and methodological problems leading to results that are inconclusive and ambiguous (Bergin et al, 1988, p. 91; Chirban, 2001, p. 269; Ellison & Levin, 1998, p. 702; Hood et al, 1996, p. 8; Meadow & Kahoe, 1984, p. 313).

Gartner et al (1991, p. 15) have pointed out that findings supporting a positive role of religion in health have used empirically observable measures of behaviour, whereas findings supporting a negative influence of religion on health have used value-laden "intrapsychic" testing instruments. Bergin (1994, p. 85) points out that research into the correlation between the same religious orientation, namely, orthodoxy, and psychological test scores was found to be positive by Ellis and negative by Bergin. Similarly, Freud and Ellis positively correlated Eysenck's neuroticism scale, which incorporates depression, with religion as an expression of instability, whereas Jung and Allport showed a negative correlation (Francis, 1994, p. 97). Studies show that there is an inverse correlation between depression and religious orientation, that greater religiousness at the baseline of a study correlates with a lower level or quicker recovery from depression, and that those patients receiving religious intervention recovered faster than those receiving secular or no intervention (Koenig, 2002, p. 14; Murphy et al, 2000, p. 1104).

It would appear that when examining the relation one has to discover "what *this* particular religious form means with *this* particular person having *this* particular disorder" (Belzen, 1992, p. 33). Subsequently, Wright et al (1993, p. 561)

regard religion as a “complex, multidimensional phenomenon that may interact with health along a number of dimensions”.

For example, Paloutzian (in Van Uden & Pieper, 1996, p. 37) distinguishes between the relation between religion and mental illness as: functioning to control mental illness, that it makes originally healthy people unhealthy, may be pathogenic or healing, or has no connection whatsoever. Similarly, Spilka et al (in Van Uden & Pieper, 1996, p. 37) found the relation to be characterised by: being able to cure pathology, repression of pathological and deviant behaviour through religious socialization, being a haven from the pathological, and cause of pathology.

According to Stack (1992, p. 93) there are three simultaneously-operating hypotheses, which present ways in which religion effects depression, namely, the social cohesiveness hypothesis, in which religion offers religion-based social support as congregations promote social cohesiveness and interaction among people with common values, altruistic behaviour and the reciprocity norm; the coherence hypothesis, in which religion fosters a sense of optimism and reduces the sense of fatalism; and the theodicy hypothesis, which argues that negative perceptions of suffering are altered. Depression has an effect on religious belief and orientation in that the deepest phase of depression is associated with a loss of faith, characterised by a lost sense of contact and presence with God, which Stahlberg (1994, p. 269) proposes arises from the loss of the parental representation, or may precede conversion (Beit-Hallahmi & Argyle, 1990, p. 118).

Thoresen et al (in Plante & Sherman, 2001, p. 23) acknowledge that there are aspects of religion and spirituality that are beyond the scope of scientific study, but nevertheless that scientists and non-scientists can collaborate to discover more about the relationship between religion and all aspects of health.

Many testing instruments have been developed by scholars of religion that provide an often-ignored resource to health professionals to assess the role, importance, and nature of religion in their patients' lives (Sherman & Simonton, 2000, p. 139). Using these instruments, psychologists would be able to answer the following questions: Is the relationship positive/ negative/ ambiguous? Are the contents of religious beliefs expressed by the client pathological? Do they reflect the beliefs of their religious community? Do they contribute towards mental illness or health? Which religious populations are most 'at-risk'? These questions need to be posed to avoid oversimplified categorisation of the relation between religion and depression being placed on the ends of a functional-dysfunctional bipolar model.

6.80 Delineating the research problem

Given that the relationship between depression and religious orientation is multidimensional and complex, the shortcomings in the current knowledge needs to be outlined, the research study needs to be clearly defined and research problems clearly delineated in order to avoid becoming enmeshed in the complexities.

Shortcomings of Current Research

Socio-cultural Context

The social constructionist school of thought proposes that the concepts of religious orientation and religion are formed through historical and cultural interaction that is unique to a specific group (Creswell, 2003, p. 8). The Western Cape region of South Africa is a unique cultural melting pot, an area in which Africans, Asians and Europeans have intermingled in terms of marriage and culture for over three centuries, in both positive and negative ways and with similar effects.

The current study is based on the assumption that the unique history of the Afrikaans- and English-speaking populations of the Western Cape has led to differences in terms of identity and culture, which includes responses to and expressions of religion. In the Western Cape context, use of the mother-tongue language can be closely related to differences in cultural meanings and traditions, including religious affiliation.

The socio-cultural variable of religious affiliation in the Western Cape is congruent with the religious traditions of Western nations (see Table 4.1). In terms of Christian religious culture, the "Coloured" population has been primarily allied to the Western religious traditions taught by European missionaries, and not been strongly influenced by the liberation theology of the African and South American continents. Similar to the Black population in the United States, the "Coloured" population experiences high level of ociocultural and –economic discrimination that has consistently been directed towards it over the centuries.

The Afrikaans-speaking population has over the past three and more centuries, been primarily influenced by the Calvinistic religious tradition. Despite the presence of the French Huguenots, the Calvinistic religious tradition was the official religion of the Cape of Good Hope settlement from the 16th century, until the Lutheran church was permitted to conduct services in 1780, and the Church of England was introduced by the First and Second British occupations of the Cape Colony in 1795 and 1805.

During the 19th century, the Afrikaans-speaking population continued with the Calvinistic religious tradition, while the English-speaking population primarily attended British church traditions, such as, the Anglican, Presbyterian and Methodist churches, and Church of England. A language-oriented difference in ascription to religious tradition continues to exist, but this difference is not as distinct as in previous centuries.

Despite the occurrence of various religious systems in the Western Cape region, the researcher decided to focus on the relation between religious orientation and depression in the Christian community, Christianity based on the precepts of the unity of the Trinitarian godhead, redemption through belief in Christ, human sinfulness, mysticism and the application of the Ten Commandments and the Golden Rule (Loewenthal, 2000, p. 19-20). Current Christian religious experience in the Western Cape region encompasses a wide range from Pentecostal, a variety of Protestant doctrines, and Catholicism. In terms of the present study, the frequency distribution of religious affiliation can be seen to be divided in terms of language tradition, as is given in Table 4.1, where the Reformed subjects ascribing to the Calvinistic and Lutheran theology are Afrikaans-speaking, and subjects ascribing to the Wesleyan, Anglican, Baptist and Roman Catholic theologies are primarily English-speaking.

Table 4.1. Frequency Distribution of Language Tradition and Religious Affiliation

Theological Tradition		N of English	N of Afrikaans
Pentecostal		14	10
Protestant		7	9
	Reformed	0	10
	Wesleyan	5	2
	Anglican	8	2
	Baptist	4	0
	Lutheran	0	2
Apostolic		6	5
Roman Catholic		6	2
None Specified		8	3

This distribution suggests that religious affiliation and language tradition plays a role in personal and social identity formation in the Western Cape socio-cultural context.

As an expression of identification, language tradition and religious affiliation reflects the need for:

- Reciprocal social support, love and belonging (Allport, 1968; Andreasen, 1972; Bickel et al, 1998; Bergin, 1991; Commerford & Reznikoff, 1996; Ellison, 1991; Frankl, 1986; Hintikka et al, 1998; Mirola, 1999; Sherkat & Reed, 1991, p. 261),
- Personal and group survival (Ellis, 1988, p. 28; Koenig et al, 1992), through cooperation and helpfulness;
- Positive in-group attributions (Blaine & Crocker, 1995, p. 1032);
- Social integration (Bergin et al, 1988, p. 96);
- Normative frame of reference (Bergin, 1991, p. 398; Ellison & Levin, 1998, p. 704; Meador et al, 1992);
- An existential response to find meaning and identity in an uncertain world (Andreasen, 1972, p. 162; Bickel et al, 1998; Elkins et al, 1988, p. 11; Miller & Gur, 2002, p. 211).

Social identification processes that involve self-esteem, levels of anxiety and cohesion, mediate the relation between depression and religious orientation (Bergin, 1991, p. 401; Bergin et al, 1987, p. 201; Blaine & Crocker, 1995, p. 1033; Braam et al, 1998, p. 485; Donahue, 1985, p. 405; Ellison & Levin, 1998, p. 706; Nelson, 1990; Pfeifer & Waelty, 1999). It is thus proposed that language tradition is a variable that forms a basis of social identification and fulfils psychosocial functions, which mediate the relationship between depression and religious orientation in the Western Cape region.

No research has been conducted on how language tradition mediates the relationship between religious orientation and depression. In order to research the manner in which the language traditions of English and Afrikaans mediate the relationship between religious orientation and depression in the Western Cape socio-cultural context, a valid and reliable translation of all measuring instruments are required.

Knowledge of the Relationship between Depression and Religious Orientation

There is acknowledgement that the relation between depression and religious orientation is under researched (Schnittker, 2001, p. 393). Depression is one of the psychological scourges of the century (Koenig, 1999, p. 131). When studies that examine the specific relation between religious *orientation*, as opposed to religious attendance, involvement, well-being, participation, salience and affiliation, and depression are examined, Koenig et al (1997) controlled for sociodemographic variables in terms of remission of depression amongst medically-ill, older patients, while Maltby and Day (1998) controlled for correlates to depression, Park et al (1998) controlled for sociodemographic variables among Korean American students.

These studies concentrated on specific sub-populations and the I-E religious orientation distinction, but no studies were found which examined the relation between religious orientation, which includes the *Quest* orientation, and depression while controlling for sociodemographic variables, such as, differences in gender, age, socio-economic status, educational attainment, and levels of stress. The relationship between depression and religious orientation may be affected by the influence of confounding variables. Various ociocultural variables, such as, socio-economic status variables, age, gender, religious affiliation and attendance, chronic illness, recent bereavement, language tradition and marital status, are also under researched (Sloan, Bagiella and Powell, 1999, p. 665), and will be controlled. These control variables were chosen on the basis of a literature review, which indicated that these confounding sociodemographic variables have an influence on the occurrence, aetiology and recovery from depression. They were also chosen on the basis that they influence the nature and strength of religious orientation.

Questions Addressed by the Current Study

This study will attempt to answer the following questions:

- *Do the language traditions of Afrikaans and English mediate the relationship between religious orientation and depression within the context of Afrikaans- and English-speaking Western Cape culture?*
- *Do ociocultural and –demographic variables influence the manner in which language tradition mediates the relationship?*

6. Research study and results

6.80 General introduction

On the basis of the general hypotheses outlined in chapter 4, an empirical study was undertaken to examine the nature and direction of the relationship between depression and religious orientation in the Western Cape region of South Africa. In chapter 5, a description will be given of the research design and characteristics of the selected measuring instruments. Chapter 5 states the research questions and describes the study that was conducted to address these questions. The results are provided in Chapter 6.

6.80 Research questions and hypothesis

This present study centred on the question: ***How does language tradition mediate the relationship between religious orientation and depression in the Western Cape region of South Africa, while controlling for the effects of confounding sociodemographic variables on the relationship.***

In order to answer these questions the following hypotheses were tested:

1. There is a relation between depression and religious orientation;
2. There is a relation between depression and the dimensions of Intrinsic, Extrinsic and Quest religious orientation;
3. There is a difference between the cultural groups of Afrikaans- and English-speaking subpopulations in the relation between depression and the dimensions of religious orientation,
4. There is a difference in the relation between depression and the Intrinsic RO scores when sociodemographic variables are controlled between Afrikaans- and English-speaking individuals;
5. There is a difference in the relation between depression and the Extrinsic RO scores when sociodemographic variables are controlled between Afrikaans- and English-speaking individuals;

6. There is a difference in the relation between depression and the Quest RO scores when sociodemographic variables are controlled between Afrikaans- and English-speaking individuals;
7. There is a difference in the relation between depression and religious orientation when sociodemographic variables are controlled.

6.80 Design of the current study

The design of the current study needed to take the various research questions and hypotheses, outlined in chapter 5.2, into account. The study measured the systematic variance between two variables, namely depression and religious orientation. In order to examine the *relation* between the two constructs of religious orientation and depression, as given in hypotheses 1 to 3, a one-group cross-sectional correlation design was used. The design included the influence that various sociodemographic variables have on the relation, outlined in hypotheses 4 to 7, through the examination of the influence of these covariates. The potential for response bias through provision of socially acceptable responses was addressed, but not completely ensured, through ensuring the anonymity of the respondents.

6.80 Data collection

Unlike the Beck Depression Inventory (BDI), the Religious Life Inventory (RLI) had not been translated into Afrikaans. The Religious Life Inventory by Batson, Schoenrade and Ventis (1993) was given to a professional translator, Professor J.D. Kies, to translate into Afrikaans. The reliability and validity of the Afrikaans translation was measured in terms of internal consistency, item-total correlations and cross-correlation matrices. These tests were conducted on the Afrikaans and English-speaking respondents in order to ascertain the reliability and validity of the use of these tests for a Western Cape population.

The Measuring Instruments

The choice of measuring instruments to measure religious orientation and depression was based on both theory and prior research regarding the reliability and validity of the instruments. The measuring instruments were compiled into a questionnaire format, and included a section in which the respondents were requested to provide information on their ociocultural and demographic characteristics. The questionnaire comprised both an English version and the Afrikaans translation. The use of the questionnaire method was based on the assertion by Gorsuch (1984, p. 230) that questionnaires have been found to be particularly valuable and adequately reliable, and various scaling methods produce similar results in the study of the psychology of religion. The variables measured in the study were: depression, dimensions of religious orientation, and the confounding variables of age, gender, educational attainment, language use, race, level of income, marital status, perceived levels of stress, chronic illness, recent bereavement, religious affiliation and level of religious attendance.

Description of the BDI

The Beck Depression Inventory (BDI) was initially designed to measure depressive severity of those already diagnosed as depressed, but has been used in both clinical and nonclinical populations to estimate the prevalence of depression (Santor et al, 1995, p. 131). The BDI is widely used as a screening instrument to detect depression in practice and research in both clinical and the general population irrespective of age and gender (Canals et al, 2001, p. 63; Lasa et al, 2000, p. 264). Based on a cognitive conception of depression, the 21-item self-evaluation inventory provides finer discrimination in scores between patients and the intensity of depressive symptoms, and comparison with other quantitative measurements and has become widely used in assessing depression in both psychiatric and non-psychiatric patients (Beck, 1967, p. 169, 176, 187; Beck et al, 1988, p. 78, 90).

The items chosen reflect overt cognitive, behavioural, affective and somatic symptoms of depression rather than a theoretical viewpoint in that the instrument was compiled from clinical observations of attitudes and symptoms of depressed and non-depressed patients (Beck, 1967, p. 189; Beck et al, 1988, p. 79; Wright et al, 1993, p. 562). The scoring of the scale items ranges from 0 to 3 so that the overall scores range from 0 to 63 (Ambrosini et al, 1991, p. 51; Robinson & Kelley, 1996, p. 929). Robinson and Kelley (1996, p. 929) found significant intercorrelations between the BDI and scores on generalised anxiety (0.69), locus of control (0.49), and self-concept (0.35). The respondents were requested to provide scores on the basis of their experience over the previous 3 days prior to answering it, thus depression scores as mood rather than trait were collected (Beck et al, 1988, p. 82).

5.4.1.2. *Psychometric Properties of the BDI*

Construct validity has been confirmed through significant correlations between BDI scores and scores on a hostility-inward scale, masochistic dreams, suicidal behaviour, alcohol consumption, student and marital maladjustment, diabetes, loneliness, stress, various medical symptoms and depressive thoughts, tendency to identify with the "loser" in pictorial stimuli, the tendency to make pessimistic predictions after inferior task performance, and underestimate actual performance, and negative correlations with social desirability and generalized anxiety, often a concomitant to depression (Beck et al, 1986, p. 477; Beck et al, 1988, p. 91; Gottschalk et al in Beck, 1967, p. 203).

Content validity of the BDI through comparison with the DSMIII has been confirmed in that the BDI reflects 6 of the 9 criteria stipulated (Beck et al, 1988, p. 85; Richter et al, 1998, p. 161). Various factor analyses (in Beck et al, 1988, p. 92) have demonstrated 3-7 identifiable factors, dependent on the type of sample and extraction procedure.

Principle-components factor analysis conducted by Endler et al (1999, p. 1309) indicate cognitive-affective or psychological and physiological symptoms or somatic factors for the BDI with high reliability for both factors.

Beck points out (1967, p. 177) that variance in scores is partly due to patients' response sets and that the partitioning of depression into separate scorable units may provide a distorted measure of depression. In terms of reliability, the BDI has shown high positive correlations in tests of internal consistency despite differences in sampling, modes of administration and time frames (Beck and Steer, 1984, p. 1367). Test-retest was found to be high (Hatzenbuehler, Parpal and Matthews in Burkhardt et al, 1984, p. 1368, Ambrosini et al, 1991, p. 54; Yin & Fan, 2000, p. 213). Research indicates that the Beck Depression Inventory has high reliability as measured by internal consistency and test-retest reliability, and that concurrent, construct and discriminant validity is high between the BDI and scores measuring various behavioural, physiological and attitudinal dimensions of depression (Beck et al, 1988, p. 89, 95). Concurrent validity has been confirmed by positive correlation with clinical judgment, psychiatrist's rating, the D Scale of the MMPI, MMPI-D, Hamilton Rating Scales and Zung Self-Reported Depression Scale (Beck, 1967, p. 198; Beck et al, 1988, p. 89).

Description of the Religious Life Inventory

Batson et al (1993, p. 169) developed the Religious Life Inventory to empirically measure the difference between the External, Internal and Quest dimensions of religious orientation, in order to determine how these dimensions facilitate or hinder psychological adjustment and health. The Religious Life Inventory (RLI) does not distinguish between various distinct types of being religious, but rather regards religion as a continuous dimension where the various dimensions are uncorrelated with each other and regarded as independent, not interchangeable, orthogonal dimensions (Batson et al, 1993, p. 189; Batson & Schoenrade, 1991a, p. 418).

The External Scale is a dimension, which defines religion as an external means to serve self-interests, to gain social approval, and emphasizes the importance of authority figures and social institutions in shaping religious experience.

The Internal scale correlates with the intrinsic dimension suggesting that the scale measures the need for certainty, strength and direction. However, Batson noted that the correlation between the Intrinsic and Orthodoxy scales suggests that the Internal represents rigid, devout adherence to orthodox beliefs (Fuller, 1994, p. 286).

The Quest scale measures the extent to which religion is open-ended, self-critical, reflexive dialogue with existential questions and perception of religious doubts as positive, openness to change and non-dogmatic approach to religion, and measures the dimensions absent from Allport's measurement of mature religion (Masters & Bergin, 1992, p. 227; Ryan et al, 1993, p. 588). The Quest dimension correlates positively with the variables of psychological health, tolerance and sensitivity to others' needs by Batson, Schoenrade, and Ventis (Fuller, 1994, p. 286). Watson, Howard, Hood and Morris (in Fuller, 1994, p. 287) found that scores on the Internal Scale increase with age, whereas the scores on the Quest scale decrease with age, which suggests a developmental change in the religious orientation.

Psychometric Properties of the Religious Life Inventory

The initial validation study was completed with a small sample of 22 individuals and significantly yielded the expected results (Batson et al, 1993, p. 176). Batson and Schoenrade (1991a) addressed concerns by various researchers that the RLI measures:

- Agnosticism, uncritical orthodoxy, sophomoric religious doubt (Ryan et al, 1993, p. 588) or
- Religious conflict (Batson et al, 1993, p. 177; Spilka, Kojetin, & McIntosh in Fuller, 1994, p. 287),
- The Extrinsic scale comprises more than one dimension and the Quest scale measures "doubt and questioning rather than commitment to a religious life" (Argyle, 2000, p. 31; Ryan et al, 1993, p. 588),
- Methodology of validating the scale through the use of college students, which raises the question of lack of generalizability to the general population and of using samples with a moderate interest in religion, which skewed the sample towards the intrinsic group (Donahue, 1985, p. 414).

In defence of the validity of the Quest dimension, and concluding that the Quest Scale does closely measure what it intended to measure, Batson and Schoenrade (1991a) demonstrated that:

(1) Low correlations have been found between the Quest scale and the Extrinsic and Intrinsic scales;

(2) Princeton Theological Seminary students could be regarded as religious, and were correlated with undergraduate students who were moderately religious, the former scoring significantly higher on the Quest and Intrinsic scales and lower on the Orthodoxy scales, which meets the requirements for validity;

(3) There is a weak correlation between the Quest and orthodoxy scales among the general population of adults as well as sophomores indicating a low level of agnosticism in the scale; and

(4) Kojetin included no Quest items in a Doubt and Confusion Scale and 3 Quest items in an Active Questioning Scale on the basis of factor analysis. Doubt has been found to correlate weakly, but significantly, with depression (Hood et al, 1996, p. 94).

For the purpose of the current study, a 5-point Likert scale, where responses read: "High Disagree, Agree, Neutral, Agree, Highly Disagree", is used for the RLI with scoring ranging from 1-5. All items left unanswered are scored "neutral", that is, 3.

The Sample

Van Belle (2002, p. 18-19) states: "the width of a confidence interval, involving estimation of variability and sample size, decreases rapidly until 12 observations are reached and then decreases less rapidly." Therefore, in order to obtain a confidence level of 95%, a minimum of 12 subjects is needed for each level of each variable. To obtain a confidence level of 90%, a minimum of 8 subjects was required for each level. As the suitability for the use of the Religious Life Inventory was required, subjects, who speak Afrikaans as a first language, which in the Western Cape refers to the White and Coloured population, were selected. Subsequently, the sample selected from the responses included English- and Afrikaans-speaking White and Coloured respondents residing in the Western Cape region of South Africa. The minimal number of subjects required for the study is summarised in Table 5.1.

Table 5.1. Minimal Number of Subjects Required For All Variables			
Variable	Level of Variable	Number Per Level	Total
Depression	High	8	24
	Moderate	8	
	Low	8	
Religious Orientation	Intrinsic	8	24
	Extrinsic	8	
	Quest	8	
Gender	Male	8	16
	Female	8	
Age	Below 41	8	24
	41-60	8	
	Above 61	8	
Language Tradition	English	8	16
	Afrikaans	8	
Education	Primary	8	24
	Secondary	8	
	Tertiary	8	
Income	Low	8	24
	Moderate	8	
	High	8	
Race	White	8	16
	Coloured	8	
Marital Status	Married	8	16
	Unmarried	8	
PLS	Low	8	24
	Moderate	8	
	High	8	
Variable	Level of Variable	Number Per Level	Total
Illness	Present	8	16
	Not present	8	
RB	Yes	8	16
	No	8	
Denomination	None	8	32
	Pentecostal	8	
	Protestant	8	
	Conservative	8	
FRA	Low / Never	8	16
	Weekly	8	

With the use of tables, random sampling was used in all stages of selection of respondents in order to ensure greater representativeness of the population of Christians in the Western Cape. The sources for selection of the population

were: church membership lists, municipal account records and computerised random selection of telephone numbers.

This was done in order to include respondents, who are not members of a formal church, or listed as residing in the Cape Town metropole, or had unregistered telephone numbers and addresses. Subjects were drawn from various sources. A list was drawn up of 788 individual church congregations in the Western Cape, which represented Christian congregations from all socio-economic areas and included Catholic, Protestant and Pentecostal orientations. From this list 12 congregations were chosen using random tables. The congregations were then approached and a request was made to gain access to the membership lists.

Of the 12 churches only 4 sent their membership lists: Church of England, New Apostolic, Old Apostolic and Assembly of God. Random sampling was used to select 150 respondents from these membership lists. All Catholic, Full Gospel, Baptist and Methodist parishes approached, were unresponsive.

The questionnaire, comprising both the English and Afrikaans versions of ociocultural characteristics, the BDI and RLI, together with a SASE, was sent by mail and subjects requested to respond anonymously.

In order to gain a more representative sample of religious tradition, a second sample was selected at random from the Cape Town Metropolitan municipal area list of ratepayers and the same procedure used. This questionnaire was adjusted to contain 4 pages with more detailed instructions and the scores of the BDI removed.

Thirdly, telephone numbers were generated at random by the computer. Respondents at these phone numbers were contacted and requested to fill in a

questionnaire. The adjusted 4-page questionnaire and SASE were posted and returned anonymously. All the responses from these various methods are included in the study. The questionnaires were issued over a six-month period, starting in May 2004.

5.5. Method of data analysis

The characteristics of the sample were described with use of frequency distributions. These characteristics included: sociodemographic variables, levels of depression and classification of religious orientation. The independence of the levels of these characteristics was tested through use of Pearson's Chi-squared tests.

Once the reliability and validity of the data set(s) were established, the hypotheses were tested. The internal-consistency of the BDI and Religious Orientation scores were tested with Cronbach's coefficient Alpha. The validity of the data sets were tested with use of cross-correlations between the various scales of the RLI, cross-correlations between all the items of the RLI, and an item-reliability index of the BDI and RLI scores.

In order to examine hypothesis 1, covariance was calculated. Hypotheses 2 and 3 were tested through use of Pearson's correlation coefficient. As bi-directional correlations may give an incomplete picture, and in order to ensure greater internal validity, partial correlations to establish the strength of the association between religious orientation and depression, while controlling sociodemographic variables, were calculated for hypotheses 4 to 6. Finally, in order to examine hypothesis 7, the three dimensions of religious orientation were regressed onto depression, while removing the influence of the covariates, that is, significant correlations with sociodemographic variables.

The results of these analyses are given in chapter 6.

6. Data analysis

The raw data collected, was converted to standard scores. All subjects with standardized scores 3 standard deviations above or below the mean were eliminated from the Religious Life Inventory and Beck Depression Inventory, as the presence of these outliers could have an unduly large effect on the correlation results (Tabachnik and Fidell, 1983, p. 74).

6.80 Sample characteristics

The sample characteristics were described in terms of the frequency distributions of socio-cultural characteristics; low, moderate and high BDI scores; and classification of religious orientation.

Socio-cultural characteristics

Although 700 research participants were selected at random and questionnaires posted to each, the response rate was affected by natural selection, in that only 117 (17%) were returned. The sample comprised of 103 subjects after the outliers were removed. Chi-squared tests were performed in order to ascertain whether any of these ociocultural and demographic variables had an undue influence on the test results. Table 6.1 indicates the frequency distribution of the sociodemographic or control variables.

Table 6.1. Sociocultural and Demographic Characteristics of the Sample					
Language Tradition		Afr	Eng	Total	Chi^2
Gender	Male	20	19	39	0.34
	Female	29	35	64	
Age	21-40	22	15	37	3.39
	41-60	19	29	48	
	61+	8	10	18	
Education	Primary	12	9	21	4.02
	Secondary	22	18	40	
	Tertiary	15	27	42	
Income	- R40000	16	23	39	2.31
	Moderate	25	20	45	
	+R150000	8	11	19	
Race	"White"	34	41	75	0.56
	"Coloured"	15	13	28	
PLS	Low	14	14	28	1.28
	Moderate	26	25	51	
	High	9	15	24	
MS	Married	30	35	65	0.15
	Unmarried	19	19	38	
CI	Yes	15	20	35	0.47
	No	34	34	68	
RB	Yes	12	11	23	0.25
	No	37	43	80	
DNM	None	3	8	11	2.68
	Pentecostal	10	14	24	
	Protestant	25	24	49	
	Conservative	7	12	19	
FRA	Weekly	33	26	59	3.87*
	Seldom	16	28	44	

*Note: Levels of Significance, p. $\alpha > 0.05$ * $\alpha > 0.01$ ** $\alpha > 0.001$ *** All other values are not significant*

The following statistical hypothesis were tested:

$H_{0:}$ χ^2 is not significant

$H_{1:}$ χ^2 is significant, where χ^2 is the measure of independence between the levels of the sociodemographic variables.

Pearson Chi-square results of the differences between the demographic variable of language tradition and the other sociodemographic variables of the sample

indicated that they are independent from each other, and did not have an influence on each other.

However, the exception was the variable Frequency of Religious Attendance (χ^2 = 3.870, $p<0.05$), which indicated that Language Tradition (LT) correlated with the frequency of religious attendance. Thus, the null hypothesis was rejected for the variable frequency of religious attendance. A Chi-squared test conducted on the data given in Table 4.1 (χ^2 = 26.732, $p<0.01$), indicated that religious denomination was dependent on language tradition, and that language could be used as an indicator of religious / cultural differences.

Several variables did not have the required number of subjects to meet the requirement of a 95% confidence level, namely those who:

- Have no or conservative religious affiliations, conservative defined as Old Apostolic or Roman Catholic,
- Are Afrikaans-speaking Pentecostals,
- Are recently bereaved in the case of the English-speaking sample
- Have a high level of income,
- Have high levels of stress in the Afrikaans-speaking sample,
- Have not matriculated in the case of the English sample,
- Are over the age of 61.

These variables met the 90% level of confidence, except the levels of the religious denomination, no and conservative religious affiliation. This implied that the null hypothesis could be falsely rejected, for results that involved these levels of the religious denomination variable for the Afrikaans LT, as there was a 56% probability of making an erroneous decision (Shelley, 1984, p. 429, 659). There were sufficient total numbers of subjects for all variables, except for those with no religious affiliation.

Levels of Religious Orientation

Five levels of religious orientation (RO) were extracted, which included respondents, who were indiscriminately pro-religious, that is, score high (more than 1 standard deviation above the mean) on both the Intrinsic and Extrinsic religious orientations, and those who were indiscriminately anti-religious, that is, score low (less than 1 standard deviation below the mean) on both the Intrinsic and Extrinsic religious orientations. Subjects were classified as True Intrinsic RO when both the IRO and QRO scores were 1 standard deviation above the mean score (Hood et al, 1996, p. 25).

It needs to be noted that the subjects, who unambiguously fall into the Intrinsic category, also score high on orthodoxy (Watson et al, 1989, p. 46). The presence of indiscriminately proreligious subjects could lower the possibility of obtaining theoretical predication (Watson et al, 1989, p. 46), thus it was important to ascertain whether their presence may have a strong effect on the results. The subjects were classified as indicated in the following table 6.2. A Pearson Chi-square test to assess whether there was any association between the various levels of religious orientation in the sample and language preference gave the following statistical hypothesis:

H_0: χ^2 is not significant

H_1: χ^2 is significant, where χ^2 is the measure of independence between the dimensions of the religious orientation.

The results are given in table 6.2.

Table 6.2. Number of Subjects with High Scores on the RLI (Independent Variables)

Religious Orientation	Mean	Standard Deviation	Frequency Distribution	
			Afr	Eng
Intrinsic (only score 1*s* above mean)	26.64	2.59	13	10
True Intrinsic (Intrinsic and Quest scores differ by 0.2 in their Z-scores)	30.33	2.83	1	1
Extrinsic (only score above mean / highest value in mixed values)	25.65	2.07	14	11
Quest (only score 1*s* above mean or highest score in mixed values)	26.2	2.91	14	24
Indiscriminately Pro-Religious (<+1*s* on both Intrinsic and Extrinsic Scales)	27.95	1.78	5	2
Indiscriminately Anti-Religious (> -1*s* on both Intrinsic and Extrinsic Scales)	22.24	2.47	2	5

The results ($\chi^2 = 5.806$, $\alpha < 0.05$) indicated that the sample distributions are independent, that is, they do not influence each other, and none had an undue influence on the results. The null hypothesis was rejected. Religious orientation was independent of Language Tradition.

Levels of depression

The depression scores were classified into three categories of low, moderate and high, indicated in each score's relation to the standard deviation from the mean, the results given in table 6.3. A Pearson Chi-square test to assess whether there

was any association between the various levels of religious orientation and Language Tradition gave the following statistical hypothesis:

H_0: χ^2 is not significant

H_1: χ^2 is significant, where χ^2 is the measure of independence between the levels of depression scores.

Table 6.3. Number of Subjects with Low, Moderate and High Scores on the BDI (Dependent Variable)

Mean	6.602	
Standard Deviation	5.464	
Language Tradition	Afr	Eng
Frequency of Low Scores (> -1 standard deviation)	11	6
Frequency of Moderate Scores (-1<>1)	28	39
Frequency of High Scores (< 1 standard deviation)	7	12

The data set gve χ^2= 3.457, where the critical value at $\alpha < 0.05$ is 5.99, which indicated that the sample distributions are independent. In other words, Language Tradition did not correlate with the level of depression.

6.80 Psychometric properties of the obtained data set

The reliability, and in the case of the Afrikaans translation of the RLI, the validity of the scales needed to be established in order to provide reliable data for investigating particular hypotheses. It was important to establish whether the various dimensions of the RLI scale were independent, that is, did not measure the same construct, in order to ensure greater meaning and accuracy from inferences derived from the statistical tests. The independence of the RLI scales ensures that the various motivations of religious orientation are distinct and have specific effects on behaviour (Gregory, 1996, 107-108).

Reliability of the Obtained Data Set

In order to test the reliability of the data sets, various sub-hypotheses needed to be considered. Using analysis of variance, the internal consistency of the responses to the three dimensions of the Religious Life Inventory and the Beck Depression Inventory was calculated. The results of the Afrikaans and English samples are shown in table 6.4.

Table 6.4. Measures of Internal Consistency of the Religious Life Inventory and Beck Depression Inventory Scores

	Intrinsic RO r_{io}	Extrinsic RO r_{eo}	Quest RO r_{qo}	BDI r_{yy}
Afrikaans Sample	0.548 ***	0.718 ***	0.684 ***	0.712 ***
English Sample	0.646 ***	0.844 ***	0.803 ***	0.788 ***

*Note: Levels of Significance: $\alpha > 0.05$ * $\alpha > 0.01$ ** $\alpha > 0.001$ *** All other values are not significant*

On the basis of the results in table 6.4, it can be concluded that the internal consistency of responses of the Afrikaans and English LT to both the RLI and BDI was moderate to high and significant, and could thus be used for the purpose of comparison and correlation. On the basis of the results in table 6.4, it could be concluded that the internal consistency of responses of the sample to both the RLI and BDI was moderate to high and significant, and could thus be used for purposes of comparison and correlation.

The Afrikaans-speaking sample was far more homogeneous than the English sample, as the Afrikaans sample was skewed towards Calvinist and Pentecostal doctrinal affiliations, while the English subjects had a greater likelihood of representing Pentecostal, Anglican, Roman Catholic or no doctrinal affiliation.

Validity of the Afrikaans RLI Translation

The cross-correlations of the three scales, which include all respondents, as summarised in table 6.5, showed that the various dimensions of religious orientation were independent for the Afrikaans sample.

Table 6.5. Cross-Correlations of the Intrinsic, Extrinsic and Quest Scales Using Afrikaans-Speaking Respondents of the Obtained Sample

	Intrinsic	Extrinsic	Quest
Intrinsic	1.00		
Extrinsic	0.26	1.00	
Quest	-0.011	-0.155	1.00

*Note: Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

The scale was reliable, as measured in terms of internal consistency, for the Afrikaans LT.

Table 6.6. Cross-Correlations of the Intrinsic, Extrinsic and Quest Scales Using English-Speaking Respondents of the Obtained Sample

	Intrinsic	Extrinsic	Quest
Intrinsic	1.00		
Extrinsic	0.553 ***	1.00	
Quest	-0.1263	-0.359 **	1.00

*Note: Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

Cross-correlations of the RLI showed that there is collinearity between the Intrinsic and Extrinsic Scales in the English sample, which measured the same dimension (see Table 6.6). The collinearity between the Intrinsic and Quest

Scales indicated that these dimensions measure opposite poles of the same construct.

Therefore, as the reliability of the data sets was positive, the validity of the use of the Religious Life Inventory when applied to an English-speaking Western Cape sample needed to be regarded with caution.

Item Reliability

For the purposes of further examining the validity of the test items, item analysis was conducted – that is, each item score on the scale was correlated with the total score of each subscale.

Table 6.7. Item Reliability Index of the RLI

Scale	Reliability and Homogeneity Index		
	Item	Afrikaans LT	English LT
Intrinsic	1	0.50 **	0.202
	7	0.383 *	0.753 ***
	10	0.574 ***	0.626 ***
	15	0.436 **	0.527 ***
	20	0.438 **	0.581 ***
	25	0.587 ***	0.385 **
	33	0.701 ***	0.489 **
Extrinsic	4	0.57 ***	0.437 **
	9	0.679 ***	0.755 ***
	12	0.695 ***	0.763 ***
	13	0.531 ***	0.697 ***
	18	0.61 ***	0.713 ***
	23	0.442 **	0.801 ***
	27	0.542 ***	0.841 ***
	30	0.503 ***	0.762 ***
	34	-0.011	-0.659 ***
Quest	3	-0.123	0.194
	5	0.50 **	0.839 ***
	6	0.695 ***	0.714 ***
	8	0.357 *	0.368 **
	11	0.368 **	0.654 ***
	16	0.554 ***	0.542 ***
	17	0.453 **	0.274 *
	19	0.373 **	0.579 ***
	24	0.515 ***	0.711 ***
	26	0.552 ***	0.668 ***
	29	0.466 **	0.31 *
	32	0.628 ***	0.565 ***

*Note: Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

The responses to items 3 for both language traditions were not internally consistent, whereas item 34 was not internally consistent for the Afrikaans sample.

Afrikaans Language Tradition

The extent of homogeneity of the test items was additionally measured in order to determine whether the scales measured a single construct, through a correlation matrix between all the items of the Religious Life Inventory Scales, as outlined in Tables 6.8 to 6.13. Significant positive correlations indicated that the items of the scales measured the same construct, while significant negative correlations indicated that the items measured opposite poles of the same dimension. These significant correlations together with item reliability scores indicated questionable construct validity of the items. The results for the inter-correlations of the Intrinsic RO Scale are given in table 6.8.

Table 6.8. Correlation Matrix of Intrinsic Religious Correlation Items for the Afrikaans Language Tradition

IO	1	7	10	15	20	25	33
1	1.00						
7	0.65 ***	1.00					
10	0.04	0.00	1.00				
15	-0.02	-0.3	0.46 **	1.00			
20	-0.08	-0.1	0.24	0.41 **	1.00		
25	0.06	0.2	0.17	0.2	0.12	1.00	
33	0.45 **	0.1	0.36 **	0.2	0.13	0.29 *	1.0

*Note: Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

The cross-correlations of the items of the Intrinsic Scale were mainly positive or orthogonal, which confirmed the construct validity of the scale for the Afrikaans sample. The results of the test for discriminant validity between the Intrinsic and Extrinsic RO scales are given in table 6.9.

Table 6.9. Correlation Matrix between Items of Intrinsic and Extrinsic Religious Orientations for the Afrikaans Language Tradition

IO EO	1	7	1 0	15	20	2 5	3 3
4	0.31 *	0.26	-0.09	-0.13	0.06	0.17	-0.09
9	0.00	-0.05	0.11	0.06	0.51 *	0.18	0.21
12	0.15	0.00	0.02	0.07	0.27	0.12	0.16
13	0.08	-0.04	-0.18	-0.28 *	0.16	-0.01	-0.03
18	0.3 *	0.22	-0.02	-0.24	0.02	0.12	0.34 *
23	0.01	0.02	0.16	0.09	0.14	0.2	0.08
27	0.21	0.09	0.07	-0.06	0.31 *	0.04	0.19
30	0.13	-0.04	-0.2	-0.21	-0.02	0.02	0.07
34	0.21	0.37 **	-0.14	-0.03	-0.32 *	-0.04	-0.07

*Note: Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

When the cross-correlations between the items of the Intrinsic and Extrinsic scales were considered, most of the correlations were orthogonal, which indicated independence in terms of these items. The following items measured the same construct:

- Item 1 of the Intrinsic Scale (IRO) and items 18 (r=0.312, *α > 0.05)* and 4 (r=0.3, *α > 0.05)* of the Extrinsic Scale (ERO);
- Item 7 of the IRO and item 34 (r=0.37, *α > 0.01)* of the ERO;
- Item 20 of the IRO and items 9 (r=0.51, *α > 0.001)* and 27 (r=0.31, *α > 0.05)* of the ERO;
- Item 33 of the IRO and item 18 (r=0.34, *α > 0.05)* of the ERO.

Significant negative correlations, correlations between constructs that measure the opposite poles on the same dimension, were found between:

- Item 15 of the IRO and item 13 of the ERO (r=-0.28, *α > 0.05);*
- Item 20 of the IRO and item 34 (r=-0.32, *α > 0.05)* of the ERO.

The results for the test for discriminant validity between the Intrinsic and Quest RO scales are given in table 6.10.

Table 6.10. Correlation Matrix between Items of Intrinsic and Quest Religious Orientation Scales for the Afrikaans Language Tradition

Items	1	7	10	15	20	25	33
3	0.19	0.12	-0.03	-0.01	0.41 **	0.19	0.15
5	0.11	0.03	0.06	0.03	0.03	-0.13	0.15
6	0.24	0.2	-0.2	-0.18	-0.1	0.24	0.07
8	-0.02	-0.08	0.12	-0.15	-0.31 *	-0.06	-0.17
11	0.15	0.18	0.03	-0.1	0.02	0.08	0.07
16	0.12	0.08	-0.11	-0.13	-0.11	-0.16	-0.05
17	0.26	0.11	0.14	-0.17	-0.12	-0.22	0.23
19	-0.07	-0.06	-0.02	-0.07	-0.09	0.02	-0.1
24	-0.06	0.01	-0.07	-0.17	-0.32 *	-0.11	-0.36 *
26	0.12	0.17	-0.12	-0.32 *	-0.35 *	0.06	-0.12
29	0.19	0.2	-0.03	-0.19	-0.2	0.2	0.01
32	0.13	0.21	-0.05	-0.05	-0.04	0.11	0.01

*Note: Levels of Significance:$\alpha > 0.05$ * $\alpha > 0.01$ ** $\alpha > 0.001$ *** All other values are not significant*

The cross-correlations between the items of the IRO and items of the Quest Scale (QRO) indicated that there is no relation between the items, which means that they measured different, not the same construct. There was a low positive correlation between items 20 of the IRO and item 3 of the QRO (r=0.41, $\alpha > 0.05$). Low, but significant, negative correlations were found between:

- Item 15 of the IRO and item 26 (r=-0.32, $\alpha > 0.05$) of the QRO;

- Item 20 of the IRO and items 8 (r=-0.31, $\alpha > 0.05$) and 24 (r=-0.35, $\alpha > 0.05$) of the QRO;
- Item 33 of the IRO and item 24 (r=-0.36, $\alpha > 0.05$) of the QRO.

The results to examine the internal consistency of the Extrinsic RO scale are given in table 6.11.

Table 6.11. Correlation Matrix of Items of the Extrinsic Scale for the Afrikaans Language Tradition

Items	4	9	12	13	18	23	27	30	34
4	1.00								
9	0.11	1.00							
12	0.37 **	0.53 ***	1.00						
13	0.33 *	0.45 ***	0.50 ***	1.00					
18	0.15	0.18	0.26	0.00	1.00				
23	0.16	0.32 *	0.35 *	0.08	0.23	1.00			
27	0.22	0.44 **	0.4 **	0.11	0.33 *	0.15	1.00		
30	0.11	0.22	0.2	0.04	0.58 ***	-0.002	0.07	1.00	
34	-0.17	-0.24	-0.27	-0.15	-0.12	-0.31 *	-0.21	-0.03	1.00

*Note: Levels of Significance:$\alpha > 0.05$ * $\alpha > 0.01$ ** $\alpha > 0.001$ *** All other values are not significant*

The cross-correlations between the items of the ERO confirmed the construct validity of the scale for the Afrikaans sample, as most cross-correlations were positive or orthogonal. The exception is item 34, which had primarily negative correlations, significant with item 23 (r=-0.31, $\alpha > 0.05$).

The results of the test for discriminant validity between the Extrinsic and Quest RO scales are given in table 6.12.

Table 6.12. Correlation Matrix between the Items of the Extrinsic and Quest Scales for the Afrikaans Language Tradition

Item	4	9	12	13	18	23	27	30	34
3	0.24	0.23	0.18	0.04	0.5 **	0.1	0.13	0.49 **	-0.24
5	0.04	-0.03	-0.25	-0.22	-0.16	-0.09	-0.07	-0.25	0.101
6	0.1	-0.1	-0.21	-0.01	-0.05	-0.01	-0.03	-0.16	0.1
8	0.09	-0.3 *	-0.08	0.05	-0.15	-0.14	0.04	-0.05	0.07
11	0.06	-0.07	-0.25	-0.08	0.09	0.05	0.06	0.02	0.23
16	0.03	-0.28 *	-0.18	-0.14	-0.09	-0.31 *	-0.02	-0.21	-0.11
17	0.01	-0.12	-0.23	-0.06	0.11	-0.17	0.08	-0.02	0.1
19	0.09	0.08	0.14	0.05	0.01	0.2	0.14	-0.03	-0.46 **
24	0.11	-0.24	-0.2	0.00	-0.24	-0.01	-0.04	-0.3 *	-0.04
26	-0.1	-0.26	-0.35 *	-0.23	0.18	-0.16	-0.02	-0.21	0.18
29	0.1	-0.23	-0.15	0.04	0.01	-0.11	0.04	0.06	0.13
32	-0.13	-0.21	-0.27	-0.06	-0.13	-0.21	-0.09	-0.14	-0.02

*Note: Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

The cross-correlations between the ERO and QRO were primarily orthogonal, which indicated independence of the items.

Exceptions, which pointed to collinearity between the two scales, were the positive correlations between:

- Item 3 of the QRO and items 18 (r=0.5, $\alpha > 0.05$) and 30 (r=0.49, $\alpha > 0.05$) of the ERO.

Significant negative correlations were found between:

- Item 9 of the ERO and items 8 (r=-0.3, $\alpha > 0.05$) and 16 (r=-0.28, $\alpha > 0.05$) of the QRO;
- Item 12 of the ERO and item 26 (r=-0.35, $\alpha > 0.01$) of the QRO;
- Item 23 of the ERO and item 16 (r=-0.31, $\alpha > 0.05$) of the QRO;
- Item 30 of the ERO and item 24 (r=-0.3, $\alpha > 0.05$) of the QRO;
- Item 34 of the ERO and item 19 (r=-0.46, $\alpha > 0.01$) of the QRO.

The results to examine the internal consistency of the Quest scale are given in table 6.13.

Table 6.13. Correlation Matrix between the Items of the Quest Scale for the Afrikaans Language Tradition

Items	3	5	6	8	11	16	17	19	24	28	29	32
3	1.00											
5	-0.03	1.00										
6	-0.08	0.53 ***	1.00									
8	-0.3 *	-0.15	-0.11	1.00								
11	0.09	0.22	0.45 **	0.05	1.00							
16	-0.17	0.41**	0.26	-0.02	-0.17	1.00						
17	-0.2	0.33 *	0.2	0.15	0.28 *	0.29 *	1.00					
19	-0.13	-0.02	0.17	0.32 *	-0.22	0.19	-0.01	1.00				
24	-0.46 **	0.08	0.21	0.3 *	-0.01	0.32 *	0.1	0.22	1.00			
26	-0.1	0.05	0.22	0.2	0.09	0.19	0.06	0.06	0.48 **	1.00		

Items	3	5	6	8	11	16	17	19	24	28	29	32
29	-0.05	0.03	0.24	0.27	-0.04	0.27	-0.18	0.09	0.14	0.28 *	1.00	
32	-0.18	0.16	0.48 **	0.02	0.06	0.41 **	0.23	0.21	0.27	0.38 **	0.25	1.00

*Note: Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

The cross-correlations in table 6.13 confirmed the construct validity of the Quest RO scale. There were only significant positive correlations, with the exception of the items 3-24 interaction (r=-0.46, α > 0.01). All other correlations were orthogonal.

On the basis of these results and the reliability coefficients of Tables 6.8 to 13, items 3 and 34 appeared to be of questionable validity to the scales when used in the Afrikaans-speaking Western Cape context. The decision was made to omit these items from subsequent correlations to test the relations between religious orientation and depression.

English Language Tradition

The results to examine the internal consistency of the Intrinsic RO scale are given in table 6.14

Table 6.14. Correlation Matrix of Intrinsic Religious Correlation Items for the English Language Tradition

IO	1	7	10	15	20	25	33
1	1.00						
7	0.47 **	1.00					
10	0.32 *	0.31 *	1.00				
15	0.07	0.37 **	0.25	1.00			
20	0.3 *	0.33 *	0.25	0.1	1.00		
25	-0.05	0.08	0.16	0.24	0.19	1.00	
33	0.2	0.36 **	0.35 **	0.03	0.06	-0.03	1.00

*Note: Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

The cross-correlations between the various items within the IRO scale confirmed the construct validity, as there were only significant positive.

The results for the test for discriminant validity between the Intrinsic and Extrinsic RO scales are given in table 6.15.

Table 6.15. Correlation Matrix between Items of Intrinsic and Extrinsic Religious Orientations for the English Language Tradition

IO EO	1	7	10	15	20	25	33
4	0.31 *	0.26	-0.09	-0.13	0.06	0.17	-0.09
9	0.00	-0.05	0.11	0.06	0.51 *	0.18	0.21
12	0.15	0.00	0.02	0.07	0.27	0.12	0.16
13	0.08	-0.04	-0.18	-0.28 *	0.16	-0.01	-0.03
18	0.3 *	0.22	-0.02	-0.24	0.02	0.12	0.34 *
23	0.01	0.02	0.16	0.09	0.14	0.2	0.08
27	0.21	0.09	0.07	-0.06	0.31 *	0.04	0.19
30	0.13	-0.04	-0.2	-0.21	-0.02	0.02	0.07
34	0.21	0.37 **	-0.14	-0.03	-0.32 *	-0.04	-0.07

*Note: Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

High levels of cross-correlations were found between items 1,7 and 20 of the IRO and items 4, 9, 18, 27 and 34 of the ERO. Item 34 of the ERO indicated that the item measured different dimensions of religious orientation. The significant correlations confirmed the collinearity of the two scales and indicated questionable validity.

The results for the test for discriminant validity between the Intrinsic and Quest RO scales are given in table 6.16.

Table 6.16. Correlation Matrix between Items of Intrinsic and Quest Religious Orientation Scales for the English Language Tradition

Items	1	7	10	15	20	25	33
3	0.16	0.29 *	0.16	0.19	0.04	0.29 *	0.23
5	-0.259	-0.05	0.04	0.13	-0.38 **	-0.1	0.002
6	-0.308 *	-0.13	-0.12	0.05	-0.39 **	-0.02	-0.12
8	-0.13	0.261 *	0.09	-0.28 *	-0.19	0.005	0.255
11	-0.256	-0.09	-0.09	-0.05	-0.36 **	0.05	-0.105
16	-0.44 **	-0.098	0.23	0.16	-0.49 **	-0.05	-0.22
17	-0.34 **	-0.331 **	0.267 *	-0.24	-0.37 **	-0.15	-0.14
19	-0.15	0.04	-0.16	0.05	-0.02	-0.11	-0.03
24	-0.21	0.02	0.02	0.12	-0.36 *	0.09	0.09
26	-0.18	-0.07	-0.01	-0.04	-0.348 **	-0.03	0.09
29	0.11	0.25	0.09	-0.18	0.23	0.04	0.058
32	-0.35 **	0.031	0.001	-0.02	-0.15	0.11	-0.03

*Note: Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

The high number of significant cross-correlations between the IRO and QRO pointed to collinearity between these two scales, where the items measured opposite ends of the same dimension.

The results to examine the internal consistency of the Extrinsic RO scale are given in table 6.17.

Table 6.17. Correlation Matrix of Items of the Extrinsic Scale for the English Language Tradition

Item	4	9	12	13	18	23	27	30	34
4	1.00								
9	0.41 **	1.00							
12	0.29 *	0.59 ***	1.00						
13	-0.02	0.32 *	0.54 ***	1.00					
18	0.11	0.45 **	0.4 **	0.59 ***	1.00				
23	0.23	0.55 ***	0.54 ***	0.603 ***	0.55 ***	1.00			
27	0.23	0.75 ***	0.56 ***	0.59 ***	0.56 ***	0.66 ***	1.00		
30	0.35 *	0.602 ***	0.46 **	0.37 **	0.54 ***	0.597 ***	0.65 ***	1.00	
34	-0.29 *	-0.68 ***	-0.499 **	-0.47 **	-0.59 ***	-0.59 ***	-0.66 ***	-0.67 ***	1.00

*Note: Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

The cross-correlations between the items of the ERO confirmed the validity of the scale for the English LT, as most cross-correlations were positive or orthogonal. The exception was item 34, which correlated negatively and significantly with all other ERO items, and thus measured the opposite dimension of both the IRO and ERO.

The results to test for discriminant validity between the Extrinsic and Quest RO scales are given in table 6.18.

Table 6.18. Correlation Matrix between the Items of the Extrinsic and Quest Scales for the English Language Tradition

Items	4	9	12	13	18	23	27	30	34
3	0.256	0.12	0.15	0.097	-0.04	0.17	0.06	0.24	-0.00
5	0.05	-0.36**	0.15	-0.21	-0.34**	-0.27*	-0.38**	-0.23	0.25
6	0.07	-0.3*	-0.25	-0.28*	-0.19	-0.26	-0.37*	-0.13	0.3 *
8	-0.04	0.07	0.07	-0.03	0.05	0.03	0.13	0.04	-0.003
11	-0.08	-0.39*	-0.28*	-0.27*	-0.42**	-0.31*	-0.33*	-0.33*	0.42**
16	-0.06	-0.3*	-0.05	-0.17	-0.23	-0.21	-0.27*	-0.25	0.12
17	-0.24	-0.32*	-0.35**	-0.29*	-0.27*	-0.25	-0.39**	-0.24	0.36**
19	0.27*	-0.12	-0.11	-0.19	-0.28*	-0.06	-0.13	-0.07	0.03
24	-0.001	-0.3*	-0.13	-0.12	-0.35**	-0.19	-0.26	-0.26	0.3 *
26	0.08	-0.24	-0.22	-0.2	-0.32*	-0.23	-0.34*	-0.14	0.21
29	0.22	0.06	0.02	-0.06	-0.07	0.08	0.11	0.16	0.05
32	-0.11	-0.25	-0.09	0.01	-0.07	-0.21	-0.19	-0.17	0.29 *

*Note: Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

According to Table 6.18, there were several significant positive correlations between the items of the two scales, which indicated collinearity between the ERO and QRO scales.

The results to examine the internal consistency of the Quest scale are given in table 6.19.

Table 6.19. Correlation Matrix between the Items of the Quest Scale

Items	3	5	6	8	11	16	17	19	24	28	29	32
3	1.00											
5	0.21	1.00										
6	0.15	0.72 ***	1.00									
8	0.19	0.13	0.1	1.00								
11	0.002	0.57 ***	0.54 ***	-0.04	1.00							
16	-0.11	0.49 ***	0.4 **	-0.08	0.39 **	1.00						
17	-0.22	0.09	0.18	0.003	0.18	0.15	1.00					
19	0.01	0.49 ***	0.28 *	0.14	0.22	0.27 *	-0.02	1.00				
24	0.08	0.62 ***	0.34 **	0.07	0.48 **	0.38 **	0.05	0.49 **	1.00			
26	0.35 **	0.52 ***	0.39 **	0.26 *	0.25	0.22	0.22	0.46 **	0.48 **	1.00		
29	0.32 *	0.15	0.13	0.46 **	0.13	-0.16	-0.16	0.19	0.11	0.09	1.00	
32	0.25	0.46 **	0.39 **	0.21	0.4 **	0.35 **	0.35 **	0.01	0.34 **	0.34 **	-0.03	1.00

*Note: Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

The positive cross-correlations in table 6.19 confirmed the construct validity of the Quest RO scale.

On the basis of these results and the reliability coefficients of Table 6.14 to 19, items 1, 3 and 34 appeared to be of questionable validity to the scales when used in the English-speaking Western Cape context. The decision was made to omit these items from subsequent correlations to test the relations between religious orientation and depression.

Reliability of the Revised RLI for use with the Afrikaans and English Language Traditions

Table 6.20 summarises the measures of internal consistency for these scales, once the items 3 and 34 were removed from the Afrikaans LT, and items 1, 3 and 34 were removed from the English LT.

Table 6.20. Measures of Internal Consistency of the Revised Religious Life Inventory

Religious Orientation	Internal-Consistency Correlation Coefficients	
	Afrikaans LT	English LT
Intrinsic	0.757 ***	0.602 ***
Extrinsic	0.459 **	0.837 ***
Quest	0.801 ***	0.786 ***

*Note:Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

As all measures of internal consistency were significant and moderately high, the adjusted RLI could be used for purposes of correlation and comparison.

6.2.5. Independence of The Dimensions of Religious Orientation of the Afrikaans LT

In order to test the discriminant validity of the adjusted test, cross-correlations were calculated between the items of the RLI scale. The results for the Afrikaans LT are given in table 6.21.

Table 6.21. Cross-Correlations of the RLI for the Afrikaans Sample

	IO	EO	QO
IO	1.00		
EO	0.244	1.00	
QO	-0.051	-0.221	1.00

*Note: Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

The cross-correlations of the dimensions of religious orientation indicated that the dimensions were independent for the Afrikaans sample.

Independence of The Dimensions of Religious Orientation of the English LT

The positive cross-correlations of the IRO-ERO and ERO-QRO dimensions, as given in Table 6.22, indicated collinearity between these dimensions. However as the cross-correlations are less than 0.80, the dimensions of religious orientation were kept separate rather than combined (Stevens, 1996, p. 76-77).

Table 6.22. Cross-Correlations of the RLI for the English Sample

	IO	EO	QO
IO	1.00		
EO	0.576 ***	1.00	
QO	-0.19	-0.38 **	1.00

*Note: Levels of Significance:α > 0.05 * α > 0.01 ** α > 0.001 *** All other values are not significant*

In addition, the reliability and discriminant validity of the BDI for the particular sample data sets was also tested.

The Reliability of the BDI Data Set

The item reliability of the BDI, with use of analysis of variance, as given in Table 6.17, was high and significant for both the Afrikaans and English language traditions. Item analysis was conducted in that each item on the BDI scale was correlated with the total score for item-reliability (Gregory, 1996, p. 140-142), as given in table 6.23.

Table 6.23. Item Reliability for the BDI

Item	Item Reliability Index	
	Afrikaans LT	English LT
A	0.477 **	0.403 **
B	0.368 **	0.664 ***
C	0.255	0.73 ***
D	0.433 **	0.653 ***
E	0.254	0.303 *
F	0.346 **	0.584 ***
G	0.126	0.517 ***
H	0.337 *	0.324 *
I	0.00	0.486 **
J	0.448 **	0.411 **
K	0.602 ***	0.448 **
L	0.221	0.296 *
M	0.386 **	0.465 **
N	0.531 ***	0.382 **
O	0.518 ***	0.314 **
P	0.535 ***	0.635 ***
Q	0.695 ***	0.537 ***
R	0.155	0.442 **
S	0.367 **	0.16
T	0.611 ***	0.337 **
U	0.38 *	0.406 **
ANOVA R	0.711 **	0.792 ***

*Note: Levels of Significance: * $\alpha > 0.05$ ** $\alpha > 0.01$ *** $\alpha > 0.001$ All other values are not significant*

The results confirmed the reliability of the BDI for use with the present study.

6.80 Relation between religious orientation and depression: tests of hypotheses

Each of the hypotheses outlined in chapter 5.2, will be tested individually. Collinearity between the dimensions of religious orientation rendered analysis of the English sample problematic (Tabachnik & Fidell, 1983, p. 82).

"There is a relation between depression and religious orientation scores"

A suitable means of analysing the relation between depression and the dimensions of religious orientation when analysis is problematic is the analysis of covariance, where the question posed was: are the changes in depression scores associated with religious orientation, the result of religious orientation or nuisance variables (Tabachnik, 1983, p. 176). Thus, the following null hypothesis was tested: religious orientation has no systematic effect on depression scores, that is:

H_0: $CoV_{yx} = 0$

H_1: $CoV_{yx} \neq 0$, where CoV_{yx} is the covariance calculated between depression scores (y) and religious orientation scores (x).

Table 6.24. Analysis of Covariance between Religious Orientation and Depression Scores

F	0.172	η^2	0.054

*Note: Levels of Significance: * $\alpha > 0.05$ ** $\alpha > 0.01$ *** $\alpha > 0.001$ All other values are not significant*

Thus the null hypothesis was not rejected, as the covariance between depression and religious orientation was not significant and only 5% of the variance of the depression scores was explained by variation in religious orientation scores.

"There is a relation between depression and the dimensions of Intrinsic, Extrinsic and Quest religious orientation in the Western Cape"

As a first step, the Pearson's Product Moment Coefficient was calculated between the three forms of religious orientation and depression, as measured by the BDI, without controlling for covariance with other sociodemographic variables. The following statistical hypotheses were tested:

H_0: $r_{id} = 0$

H_1:$r_{id} \neq 0$, where r_{id} is the correlation between the Intrinsic RO scores and the BDI scores

H_0: $r_{ed} = 0$

H_1: $r_{ed} \neq 0$, where r_{ed} is the correlation between the Extrinsic RO scores and the BDI scores

H_0: $r_{qd} = 0$

H_1: $r_{qd} \neq 0$, where r_{qd} is the correlation between the Quest RO scores and the BDI scores

The results are summarised in the following table 6.25:

Table 6.25. Correlations between the Dependent and Independent Variables: Depression and Religious Orientation

Correlation Measured	Pearson's R
RIO: BDI	0.015
REO: BDI	-0.138
RQO: BDI	0.169

*Levels of Significance: * $\alpha > 0.05$ ** $\alpha > 0.01$ *** $\alpha > 0.001$ All other values are not significant*

The null hypotheses were all supported. There was no relation between the depression scores and any dimension of religious orientation.

6.3.3. "There is a difference between the cultural groups of Afrikaans- and English-speaking subpopulations in the relation between depression and the dimensions of religious orientation in the Western Cape"

As a first step, the Pearson's Product Moment Coefficient was calculated between the three forms of religious orientation and depression, as measured by the BDI, without controlling for covariance with other sociodemographic variables. The following hypotheses were tested for both language traditions:

H_0: $r_{id} = 0$

H_1: $r_{id} \neq 0$, where r_{id} is the correlation between the Intrinsic RO scores and the BDI scores

H_0: $r_{ed} = 0$

H_1: $r_{ed} \neq 0$, where r_{ed} is the correlation between the Extrinsic RO scores and the BDI scores

H_0: $r_{qd} = 0$

H_1: $r_{qd} \neq 0$, where r_{id} is the correlation between the Quest RO scores and the BDI scores

The results are summarised in the following table 6.26.

Table 6.26. Correlations between the Dependent and Independent Variables: Depression and Religious Orientation

Sample Group	Correlation Measured	Pearson's R
Afrikaans LT	rIO: BDI	0.005
	REO: BDI	-0.196
	RQO: BDI	0.068
English LT	rIO: BDI	0.08
	REO: BDI	-0.035
	rQO: BDI	0.234

*Note: Levels of Significance: * $\alpha > 0.05$ ** $\alpha > 0.01$ *** $\alpha > 0.001$ All other values are not significant*

As there were no significant correlations between the depression and dimensions of religious orientation scores, no differences between the means needed to be calculated. The null hypotheses were supported: there is no relation between the depression scores and dimensions of religious orientation for both language traditions.

"There is a difference in the relation between depression and the Intrinsic RO scores when sociodemographic variables are controlled"

The following formula was used for Hypotheses 5, 6 and 7 to measure the effect that the various sociodemographic variables have on the relation between the religious orientation and depression:

$$R_{xy|z} = \frac{r_{xy} - r_{yz}\, r_{xz}}{\sqrt{(1 - r^2_{yz})(1 - r^2_{xy})}}$$

Where Y is the dependent variable, depression, X is the independent variable and Z is the control variable. The question was given: do any of the control variables influence the relation between depression and the dimensions of religious orientation. The following hypothesis was tested: the relation between variable X and variable Y is influenced by variable Z, or given as a statistical hypothesis:

H_0: $R_{xy|z} = 0$

H_1: $R_{xy|z} \neq 0$, where $R_{xy|z}$ is the partial correlation between the Intrinsic RO scores, BDI scores and sociodemographic variables. The results are summarised in table 6.27.

Table 6.27. Partial Correlations Between Intrinsic RO – Depression Relation Controlling for Sociodemographic Variables

Control Variable	Afrikaans LT	English LT
Gender	-0.076	0.0917
Age	0.175	0.068
Education LOE	0.151	0.03
Income LOI	0.268	0.073
Race	0.228	0.086
Stress PLS	-0.326 *	0.047
Marital Status MS	0.175	0.117
Chronic Illness CI	-0.210	0.096
Recent Bereavement RB	-0.227	0.124
Denomination DNM	*0.194*	0.113
Frequency of Religious Attendance FRA	0.455 *	0.213

*Note: Levels of Significance: * $\alpha > 0.05$ ** $\alpha > 0.01$ *** $\alpha > 0.001$ All other values are not significant*

According to the results in Table 6.27, there were significant influences of $R_{xy/z}$ in the Afrikaans LT. Perceived levels of stress (r=-0.326, $\alpha > 0.05$) and frequency of religious attendance (r=0.455, $\alpha > 0.01$) influenced the relation between depression and the Intrinsic RO. The null hypothesis was rejected for the variables PLS and FRA for the Afrikaans LT. The null hypothesis was supported for the English LT and the remaining control variables of the Afrikaans LT. The exception was the variable religious denomination, which may be a spurious support for the null hypothesis. The research for this variable needs to be repeated with a far large sample.

Partial correlation coefficients did not indicate if a particular level of the control variable significantly influenced the relation between depression and the Intrinsic RO.

Subsequently, the covariance between the Intrinsic RO and depression scores was examined in terms of the particular level of the control variables, that is, the following hypothesis was tested:

H_0: $CoV_{yx/z} = 0$

H_1: $CoV_{yx/z} \neq 0$, where $CoV_{yx/z}$ is the covariance between depression scores (y) and Intrinsic RO scores (x) for a particular level of sociodemographic variable (z). The results are given in table 6.28.

Table 6.28. Covariance Between Intrinsic RO –Depression Relation For Levels of Control Variables

Correlation between IRO and BDI		Afrikaans LT	English LT
Gender	Male	0.073	0.164
	Female	-0.194	0.033
Age	Below 41	-0.169	0.101
	Middle	-0.183	-0.002
	Above 61	0.924 **	0.089
LOE	Primary	0.027	0.217
	Secondary	0.11	0.285
	Tertiary	0.004	-0.309
LOI	Low	0.207	0.191
	Middle	-0.102	0.435
	High	0.638	-0.908 **
Race	"Coloured"	0.648 **	0.245
	"White"	0.319	0.002
PLS	Low	-0.194	-0.029
	Moderate	0.245	-0.151
	High	-0.561	0.372
MS	No	-0.457	0.318
	Yes	-0.457 *	-0.082
CI	No	-0.233	-0.042
	Yes	0.4997	0.277
RB	No	0.126	0.158
	Yes	-0.059	-0.201
DNM	None	*-0.265*	0.391
	Pentecostal	-0.026	0.022
	Protestant	0.197	0.07
	Conservative	*0.025*	0.082
FRA	Low	0.012	0.108
	High	0.134	0.105

*Note: Levels of Significance: * $\alpha > 0.05$ ** $\alpha > 0.01$ *** $\alpha > 0.001$ All other values are not significant*

For the Afrikaans sample, the relation between the Intrinsic RO and depression was influenced by:

- Age group over 61 (r=0.924, n = 8, $\alpha > 0.05$),
- Being of the 'Coloured' race (r=0.648, n = 15, $\alpha > 0.05$) and
- Of unmarried status (r=-0.457, n = 30, $\alpha > 0.05$).

Within the English sample, a lower correlation between depression and Intrinsic RO is related to the levels of sociodemographic variables:

- High level of income (r=-0.908, n = 11, $\alpha > 0.05$).

The null hypothesis could only be rejected for the variables Frequency of Religious Attendance, Perceived Levels of Stress, high Level of Income and the age group over 61, and presence of Chronic Illness in the case of the Afrikaans sample, and high Level of Income and low frequency of religious attendance in the case of the English sample. For all other relations the null hypothesis was supported.

6.3.5. "There is a difference in the relation between depression and the Extrinsic RO scores when sociodemographic variables are controlled"

The following statistical hypothesis was tested:

H_0: $R_{xy|z} = 0$

H_1: $R_{xy|z} \neq 0$, where $R_{xy|z}$ is the partial correlation between the Extrinsic RO scores, BDI scores and sociodemographic variables

The results are given in Table 6.29.

Table 6.29. Partial Correlations between Depression, Extrinsic RO and Control Variables

Control Variables	Afrikaans LT	English LT
Gender	-0.209	-0.046
Age	-0.216	-0.028
LOE	-0.2	-0.055
LOI	-0.199	-0.044
Race	-0.21	-0.047
PLS	-0.214	-0.053
MS	-0.208	-0.024
CI	-0.216	-0.083
RB	-0.207	0.019
DNM	*-0.201*	-0.033
FRA	-0.192	0.122

*Note: Levels of Significance: * $\alpha > 0.05$ ** $\alpha > 0.01$ *** $\alpha > 0.001$ All other values are not significant*

No significant partial correlations were found to be significant for either language tradition. Covariance between the Extrinsic RO and depression is examined in terms of the particular level of the control variables. The null hypotheses for all variables and language traditions were supported. The exception was the variable religious denomination, which may be a spurious support for the null hypothesis. The research for this variable needs to be repeated with a far larger sample.

The covariance between the Extrinsic RO and depression scores was examined in terms of the particular level of the control variables.

H_0: $CoV_{yx/z} = 0$

H_1: $CoV_{yx/z} \neq 0$, where $CoV_{yx/z}$ is the covariance between depression scores (y) and Extrinsic RO scores (x) for a particular level of sociodemographic variable (z). The results are given in table 6.30.

Table 6.30. Covariance Between the Extrinsic RO –Depression Relation For Levels of Control Variables

Correlation between ERO and BDI		Afrikaans LT	English LT
Gender	Male	- 0.379	0.118
	Female	- 0.091	-0.03
Age	Below 41	-0.337	0.124
	Middle	-0.566 **	-0.168
	Above 61	0.712	0.029
LOE	Primary	-0.347	0.412
	Secondary	-0.22	-0.138
	Tertiary	-0.067	-0.148
LOI	Low	-0.07	-0.076
	Middle	-0.317	0.073
	High	0.098	-0.51
Race	"Coloured"	-0.178	-0.064
	"White"	-0.218	-0.204
PLS	Low	-0.22	-0.162
	Moderate	-0.175	-0.089
	High	-0.119	0.042
MS	No	-0.147	0.294
	Yes	-0.253	-0.266
CI	No	-0.201	-0.06
	Yes	-0.216	-0.131
RB	No	-0.181	0.056
	Yes	-0.263	-0.111
DNM	None	*-0.788*	0.699
	Pentecostal	-0.006	-0.376
	Protestant	-0.307	-0.137
	Conservative	*-0.25*	0.169
FRA	Low	-0.575 *	0.108
	High	0.048	0.101

*Note: Levels of Significance: * $\alpha > 0.05$ ** $\alpha > 0.01$ *** $\alpha > 0.001$ All other values are not significant*

The relation between depression scores and the Extrinsic RO for the Afrikaans LT was found to be low for the variable:

- Age between 40 and 61 (r= -0.566, n = 19, $\alpha > 0.05$) and
- Low FRA (r= -0.575, n = 16, $\alpha > 0.05$).

The null hypothesis could only be rejected for the variables low FRA and middle age for the Afrikaans sample. For all other relations, and for all covariance of the English LT, the null hypothesis was confirmed.

6.3.6. "There is a difference in the relation between depression and the Quest RO scores when sociodemographic variables are controlled"

The following statistical hypothesis was tested:

H_0: $R_{xy|z} = 0$

H_1: $R_{xy|z} \neq 0$, where $R_{xy|z}$ is the partial correlation between the Quest RO scores, BDI scores and sociodemographic variables. The results are given in Table 6.31.

Table 6.31. Partial Correlations between Depression, Quest RO and Control Variables

Control Variables	Afrikaans LT	English LT
Gender	0.104	0.09
Age	0.066	0.076
Education	0.079	0.0387
Income	0.075	0.075
Race	0.074	0.089
PLS	0.091	0.041
MS	0.069	0.118
CI	0.097	0.098
RB	0.073	0.119
DNM	*0.044*	0.126
FRA	0.086	0.206

*Note: Levels of Significance: * $\alpha > 0.05$ ** $\alpha > 0.01$ *** $\alpha > 0.001$ All other values are not significant*

No significant partial correlations were found to be significant for either language tradition. The null hypothesis was supported. The exception was the variable religious denomination, which may be a spurious support for the null hypothesis. The research for this variable needs to be repeated with a far larger sample.

The covariance between the Quest RO and depression scores were examined in terms of the particular level of the control variables.

H_0: $CoV_{yx/z} = 0$

H_1: $CoV_{yx/z} \neq 0$, where $CoV_{yx/z}$ is the covariance between depression scores (y) and Extrinsic RO scores (x) for a particular level of sociodemographic variable (z). The results are given in table 6.32.

Table 6.32. Covariance Between Quest RO –Depression Relation For Levels of Control Variables

Correlation between QRO and BDI		Afrikaans LT	English LT
Gender	Male	0.049	0.267
	Female	0.143	0.235
Age	Below 41	-0.117	0.5278 *
	Middle	0.297	-0.027
	Above 61	0.004	0.111
LOE	Primary	-0.211	0.6974 **
	Secondary	0.336	0.4205
	Tertiary	-0.238	-0.262
LOI	Low	-0.142	-0.188
	Middle	0.333	-0.161
	High	-0.468	-0.231
Race	“Coloured”	-0.231	0.647 **
	“White”	0.216	0.134

Correlation between QRO and BDI		Afrikaans LT	English LT
PLS	Low	-0.124	0.219
	Moderate	0.432 *	0.069
	High	-0.191	0.403
MS	No	0.194	0.3803
	Yes	-0.069	0.124
CI	No	0.07	0.165
	Yes	0.05	0.256
RB	No	0.054	0.136
	Yes	-0.041	0.541
DNM	Pentecostal	-0.02	0.80 **
	Protestant	-0.023	0.061
	Conservative	*-0.079*	-0.11
	None	*-0.217*	0.364
FRA	Low	0.028	0.253
	High	0.075	0.022

*Note: Levels of Significance: * $\alpha > 0.05$ ** $\alpha > 0.01$ *** $\alpha > 0.001$ All other values are not significant*

For the Afrikaans LT, only one significant level of sociodemographic variable was found to influence the relation between depression and the Quest RO, namely, moderate levels of perceived stress (r=0.431, n = 26, $\alpha > 0.05$).

For the English sample, the high correlation between depression and the Quest RO was influenced by the variables:

- Below age 40 (r=0.528, n = 19, $\alpha > 0.01$),
- Being "Coloured (r=0.647, n = 13, $\alpha > 0.01$),
- Having a primary level of education (r=0.697, n = 9, $\alpha > 0.01$), and
- Pentecostal affiliation (r=0.8, n = 12, $\alpha > 0.001$).

The null hypothesis could only be rejected for the variable moderate PLS for the Afrikaans sample, and the variables low level of income, being 'Coloured', primary level of education and Pentecostal affiliation for the English LT. For all other relations the null hypothesis was confirmed.

6.3.7. "There is a relation between depression and religious orientation once sociodemographic variables are controlled"

A multiple regression procedure was used in which the sociodemographic variables were used as covariates, using the following formula:

$$F = \frac{(R^2_{y,\,full} - R^2_{y,\,cv})/(k_1 - k_2)}{(1-R^2_{y,\,full})/(N - k_1 - 1)}$$

Where $R^2_{y,full}$ was the regression of BDI scores onto all the independent and sociodemographic variables, $R^2_{y,cx}$ was the regression of BDI scores onto the sociodemographic variables, k_1 was the number of variables regressed onto the dependent variable and k_2 was the number of sociodemographic variables regressed onto the dependent variable. The sociodemographic variables that were previously found to not influence the relation between depression and any of the dimensions of religious orientation were omitted, namely, Gender and Recent Bereavement.

Thus, the variables regressed onto depression in the equation $R^2_{y,full}$ were: QRO, ERO, IRO, Chronic Illness, Marital Status, Frequency of Religious Attendance, Perceived Level of Stress, Level of Education, Language Tradition, Religious Denomination, Race, Level of Income, and Age. Thus, the following statistical hypothesis was tested:

H_0: F = 0

H_1: F ≠ 0, where F is the variance between depression scores and religious orientation scores when the influence of sociodemographic variables was excluded. The result of F = 1.1188 < 1.75 (critical value for F), indicated that the null hypothesis could be rejected. There was no relation between depression and religious orientation, when sociodemographic variables were controlled.

The results of these data analyses will be discussed in greater depth in chapter 7.

7. Discussion

It has previously been mentioned in Chapter 4 that the objective of the study was to establish whether there is a relation between depression and religious orientation in and between the English- and Afrikaans-speaking populations of the Western Cape region. The descriptive and correlational results derived from the various stages of the research process will be discussed.

7.1. Sampling and sample characteristics

7.1.1. Sociocultural Characteristics

The low response rate of 17% negatively affects the external validity and therefore generalisability of the results. Despite the anonymous nature of the responses, the low response rate to all requests made to religious institutions and the general population supports the observation among the social science researchers of the sociocultural resistance, and anti-intellectualism and antipathy to any empirical study in the field of religion (Beit-Hallahmi, 1989, p. 57; Maslow, 1968, p. 61).

The Pearson Chi-square tests conducted on the sample indicate that when examined in terms of language preference, most of the sociocultural variables examined in the study would not have an undue influence on each other. As outlined in Chapter 6.1.1, the sociocultural variables are independent of each other, with the exception of frequency of religious attendance. This result indicates that Language Tradition plays a role in determining the frequency of formal religious attendance, where Afrikaans-speaking respondents tend to attend religious services on a weekly basis, but English-speaking respondents show low levels of regular religious attendance**.**

7.1.2. Religious Life Inventory

The majority of respondents fell into the frequency distributions of the main types of religious orientation, namely, Intrinsic RO (22%), Extrinsic RO (24%) and the Quest RO (35%). The Chi-Square test that examined whether these levels of religious orientation, as well as the levels of True Intrinsic (0.02%), Indiscriminately Proreligious (0.07%) and Indiscriminately Anti-Religious (0.07%), would influence each other in terms of language preference, indicate that the various levels are independent. Gorsuch (1984, p. 232) has noted that the classification into which individuals fall is dependent on the particular sample, thus the results can only be applied to the particular sample of the current study.

The low frequency of subjects, who are not affiliated to any formal religious institution (11%) as opposed to those who are affiliated to a formal religious institution (89%), may indicate that the low response rate could be the result of apathy or antipathy towards formal religion, and strongly suggests a process of self-selection, which negatively affects the external validity of the results. This distribution suggests that the results should be interpreted as applicable to members affiliated to formal religious institutions, who are motivated to attend church. A separate study needs to be conducted that examines the motivations for lack of attendance of and affiliation to formal religious institutions; whether this population should rather be studied in terms of spirituality rather than religious orientation, and the psychosocial characteristics of these individuals attracted to the various spiritual paths, such as the via negativa or via positiva, or to no path at all.

7.1.3. Beck Depression Inventory

The characteristics of the frequency distribution of low, moderate and high depression scores indicate a normal distribution, where 65% of the sample has moderate levels of depression scores, 17% have low scores and 18% have high scores. The Pearson Chi-square indicates that the various levels of depression are independent of each other, and can thus be used for purposes of comparison.

7.2. Reliability and validity of the measurement scales

Statistical studies were undertaken to establish whether the obtained scores of the measurement scales of the RLI and BDI were reliable and valid for use in establishing whether there is a relation between depression and religious orientation in the obtained Western Cape sample.

7.2.1. Reliability of the Measurement Scales

The results of reliability as measured in the form of internal-consistency, as given in Table 5.4, demonstrate that the internal consistencies of the English-speaking and Afrikaans-speaking samples, are moderate to high for all measurement scales, and can thus be used for purposes of comparison.

7.2.2. Validity of Measurement Scales To A Western Cape Population

Internal validity of the tests has been addressed through the use of multivariate tests of covariance (Shelley, 1984, p. 445) in order to reduce error variance. There are differences relating to language tradition when the discriminant validity of the RLI is assessed. There is a significant relation between the Intrinsic and Extrinsic Scales ($r = 0.553$, $\alpha < 0.001$), and between the Extrinsic and Quest Scales ($r = -0.359$, $\alpha < 0.01$) for the English sample. This indicates that these scales tend to measure the same construct in the case of the former, and opposite poles of the same dimensions in the case of the latter for the English LT. However, the cross-correlations between the scales of the RLI in the Afrikaans LT indicate that these scales are independent dimensions.

In terms of frequency distribution, language tradition is independent of religious orientation, and religious orientation measures, irrespective of sampling, have been shown to be reliable.

Although no measures of religious orthodoxy were taken for the study, it is proposed that it may be this particular theological aspect of religious belief that has influenced the validity of the Extrinsic Scale (Watson et al, 1989). Furthermore, the Intrinsic and Extrinsic scales are significantly related to security and self-esteem, in terms of religious orthodoxy for the Intrinsic RO and social support and status in the case of the Extrinsic RO (Batson et al, 1993, p. 203-204). Further research is required to examine the reason for the disparity in terms of Language Tradition, Genia (1993), similarly having noticed disparities in terms of religious affiliation. These scales need to be assessed in terms of social desirability, religious orthodoxy and doctrinal differences, cultural values and psychological variables, such as, cognitive complexity or self-concept. It is beyond the scope of the study to examine these variables, but simply to note that the lack of discriminant validity in the English sample will affect the interpretation of the results of the main hypothesis, namely, that there is a relation between religious orientation and depression, once sociodemographic variables are controlled.

7.2.3. Item Analyses, Discriminant and Construct Validity of the Measurement Scales

7.2.3.1. Intrinsic Religious Orientation Scale

The item reliability index of the IRO as given in tables 6.7, indicates that all items on the scale, for both language traditions, are moderately or highly reliable. However, when the items are correlated with each other, as given in table 6.8 for the Afrikaans sample and table 6.14 for the English language tradition, the cross-correlations within the IRO items confirm the construct validity of the scale.

When the correlations of items on the IRO are compared to correlations with items on the ERO, as outlined in tables 6.9 for the Afrikaans sample and table 6.15 for the English sample, it can be seen that there are 6 positive item cross-correlations, and 2 negative cross-correlations for the Afrikaans language tradition, and 8 positive item cross-correlations for the English language tradition. This confirms the earlier observation that the Intrinsic and Extrinsic scales are not independent, that is they do not measure different constructs. When the item correlations of the Intrinsic and Quest scales are compared, the Afrikaans language tradition demonstrates that there is collinearity with item 20 of the IRO and 4 items of the QRO, but that the other items are independent. The item correlations of the English language tradition, demonstrates a high degree of collinearity between several items of both the IRO and QRO.

The measurement of the Intrinsic RO may not reflect a true religious orientation, the strength of the Christian religious belief system and extent to which these beliefs have been integrated into personal value systems (Malony, 1994, p. 18-20), or extent to which they are authentic beliefs (Frankl, 1986), bearing in mind that there is a significant, positive correlation between these variables (Batson et al, 1993).

7.2.3.2. Extrinsic Religious Orientation Scale

The item reliability index of the Extrinsic RO, as given in table 6.7, indicates that all items on the scale are highly reliable (all $\alpha < 0.001$), with the exception of Item 34, which was removed from subsequent calculations. When both language traditions are compared, with the except of item 34 for the English language tradition, all the other items on the Extrinsic RO scale correlate positively and significantly with each other, which indicates that the items are related to each other. Item 34, however, correlates negatively and significantly with all the other items on the Extrinsic RO scale, and positively with the items on the Quest scale for the English language tradition.

This suggests that item 34 should rather be included into the Quest scale and removed from the Extrinsic RO scale. The items on the Quest scale, as given in table 6.12 for the Afrikaans language tradition and table 5.12 for the English language tradition, correlate negatively with the items on the Extrinsic Scale, indicates that the items measure opposite poles of the same construct. The cross-correlations with items of the Intrinsic RO have been discussed in the previous section, that is, there is collinearity within the English language tradition, but not the Afrikaans language tradition.

7.2.3.3. Quest Religious Orientation Scale

The item reliability index of the Quest RO, as given in table 6.7, indicates that all items on the scale are highly reliable (all $\alpha < 0.001$), with the exception of item 3. When the cross-correlations, as given in table 6.19, are examined, the cross-correlations between confirm the construct validity of the scale. When the Afrikaans language tradition is considered, the Intrinsic and Quest scales, and Extrinsic and Quest scales are independent. The inverse occurs for the English language tradition.

7.2.3.4. Beck Depression Inventory

The item reliability index of the BDI, as summarised in table 6.15, indicates that item I (r=0.07, *ns*) has an orthogonal correlation to the total test and has a smaller item mean and standard deviation to the other correlations. This item, therefore, is of questionable validity to this particular sample.

7.2.3.5. The Revised Religious Orientation Inventory

When items 3 and 34 are removed from subsequent correlations, the internal consistencies of the various scales are significant and high, as given in table 6.20. The cross-correlations of the Afrikaans language tradition given in table 6.21 and of the English language tradition in table 6.22 indicate that there is no difference to the validity of the RLI scale if items 3 and 34 are removed.

In conclusion, the Intrinsic, Extrinsic and Quest Scales of the Religious Life Inventory and the Beck Depression Inventory meet the requirements for internal consistency. Item analysis of these scales led to the decision to omit items 3 and 34, in order to improve the construct validity of the RLI in administration to a Western Cape sample. However, the validity of the English data set is questionable. The collinearity of the Intrinsic and Extrinsic scales may suggest a tendency of being closed to experience and tendency to engage in self-deception (Burris et al, 1994). The collinearity of the Extrinsic and Quest scales may suggest the provision of socially acceptable responses (Bergin et al, 1987, p. 202). This latter collinearity may also be a reflection of greater homogeneity in terms of religious denomination and doctrinal adherence within the Afrikaans sample, whereas the English sample shows greater heterogeneity in terms of religious affiliation. The RLI needs further examination regarding various aspects of internal and external validity, as well as a form of scoring, which is not dependent on within-group comparisons of scores.

7.3. Examination of Hypotheses

As outlined in Chapter 5, the following questions were to be addressed by the study:

- *What is the relation between religious orientation and depression within the context of different language traditions in the Western Cape culture?*
- *Is there a significant difference in the relation between religious orientation scores and depression scores, between English- and Afrikaans-speaking populations, once sociocultural and –demographic variables have been controlled?*

In order to answer these questions the following hypotheses were tested:

1. There is no relation between depression and religious orientation in the Western Cape;
2. There is no relation between depression and the dimensions of Intrinsic, Extrinsic and Quest religious orientation in the Western Cape;
3. There is no difference between the cultural groups of Afrikaans- and English-speaking subpopulations in the relation between depression and the dimensions of religious orientation in the Western Cape,
4. There is no difference in the relation between depression and the Intrinsic RO scores when sociodemographic variables are controlled between the Afrikaans- and English-speaking populations in the Western Cape;
5. There is no difference in the relation between depression and the Extrinsic RO scores when sociodemographic variables are controlled between the Afrikaans- and English-speaking populations in the Western Cape;
6. There is no difference in the relation between depression and the Quest RO scores when sociodemographic variables are controlled between the Afrikaans- and English-speaking populations in the Western Cape.

7.3.1. The Significant Relations between Religious Orientation, Depression and Sociocultural Control Variables

The English- and Afrikaans-speaking subgroups of the sample's respondents were found to follow the different patterns in terms of reliability and validity measures, as well as in the relation between depression and religious orientation. The Afrikaans-speaking sample was found to be reliable and valid. However, the validity of the English-speaking sample is questionable, despite high reliability, which limits the ability to interpret the results.

The lack of validity may reflect the inadequacy of the measuring instrument rather than the relation between the religious orientation and depression, or the lack of homogeneity in terms of doctrinal affiliation within the English group, which includes Roman Catholic respondents, and greater homogeneity within the Afrikaans language tradition as there more subjects with a Calvinist affiliation. No studies could be found that examine the influence of Language Tradition on the relation between depression and religious orientation.

Analysis of covariance, as given in table 6.24, indicates that there is no relation between depression and religious orientation, which confirms hypothesis 2. Furthermore, correlations between depression scores and the three dimensions of religious orientation, as given in table 6.25, indicate that there are no significant correlations between these variables. Tabachnik and Fidell (1983, p. 68) points out that correlations may be lower between a continuous and dichotomous variable if most of the responses to the dichotomous variable fall into one category. However, Chi-squared tests of table 6.1, 6.2 and 6.3 confirm that this is not the case.

However, this bivariate correlation method can be regarded as an oversimplistic measurement of the relation between religion and religious orientation when it is considered that cross-cultural studies indicate group differences in social expectations, the expression of depression and religious orientation (Kennedy et al, 1996, p. P305; Braam et al, 1998; Husaine et al, 1999; Park et al, 1998). The current study's assumption of cultural differences between the language traditions can be demonstrated in that significant Chi-squared differences were found between language tradition and doctrinal affiliation (table 3.1), as well as between language tradition and frequency of religious attendance (table 6.1). Differences have been shown in the cultural expression of religious denomination and commitment between the Afrikaans and English language tradition.

Although Chi-squared tests indicate that the sample is not skewed towards a particular category, except in the case of denomination, and can thus be regarded as fairly representative, the use of Intrinsic - Extrinsic scales or data sets that meet the requirements of discriminant validity for the two language traditions may yield different results.

Subsequently, partial correlation coefficients were calculated to examine which sociodemographic variables have an influence on the variables of depression and the dimensions of religious orientation for the different language traditions. Partial correlation coefficients were also examined between the levels of sociodemographic variables and the relation between religious orientation and depression. In order to examine the cultural differences in the nature of the relation, these results will be discussed in terms of the influence these sociodemographic variables have on the relationship between depression and the three dimensions of religious orientation.

7.3.1.1. The Relation Between Depression and the Intrinsic Religious Orientation

It will be recalled that the Intrinsic RO is end-orientated, growth-motivated, internalised, personally relevant and universalistic (Allport & Ross, 1967). Individuals with high intrinsic scores tend to have internalised their religious belief systems; they live their belief, which is of central importance to their self-concept, and which gives meaning and purpose to their lives and to events in the world, but at the same time increases inflexible orthodoxy (Batson et al, 1993, p. 291). In theological terms, they have a personal relationship with their concept of God. By internalising and accepting a belief system, these individuals show greater self-acceptance, -efficacy and -esteem, and believe themselves to have definitive answers, which frees them from existential questioning, anxiety and fear (Batson et al, 1993, p. 259; Park et al, 1990).

One subsequently expects this religious orientation to be an all-encompassing philosophy, and the hypothesis can be given that the Intrinsic RO correlates negatively with depression.

The results of the present study indicate that there is no relation between depression and the Intrinsic RO, irrespective of Language Tradition, as outlined in Table 6.26, which confirms hypothesis 4. Again, this is an oversimplistic measurement of the relation. Therefore, in correspondence with social constructionist theory, the following hypothesis was tested: the relation between depression and the Intrinsic RO of the Afrikaans Language Tradition is different to the relation between depression and the Intrinsic RO for the English Language Tradition in the Western Cape, when sociodemographic variables are controlled.

When partial correlations are measured, cultural differences in the nature of the relation between depression and the Intrinsic RO were found. Language Tradition regressed onto depression and the Intrinsic RO ($R^2 = 0.296$, $F = 3.14$, $\alpha < 0.05$) confirms a social constructionist view of this particular relation. No significant partial correlations between the Intrinsic RO and depression scores were found for the English language tradition. However, significant partial correlations were found within the Afrikaans language tradition for PLS ($pR = -0.326$, $\alpha < 0.05$) and for frequency of religious attendance ($pR=0.455$, $\alpha < 0.05$).

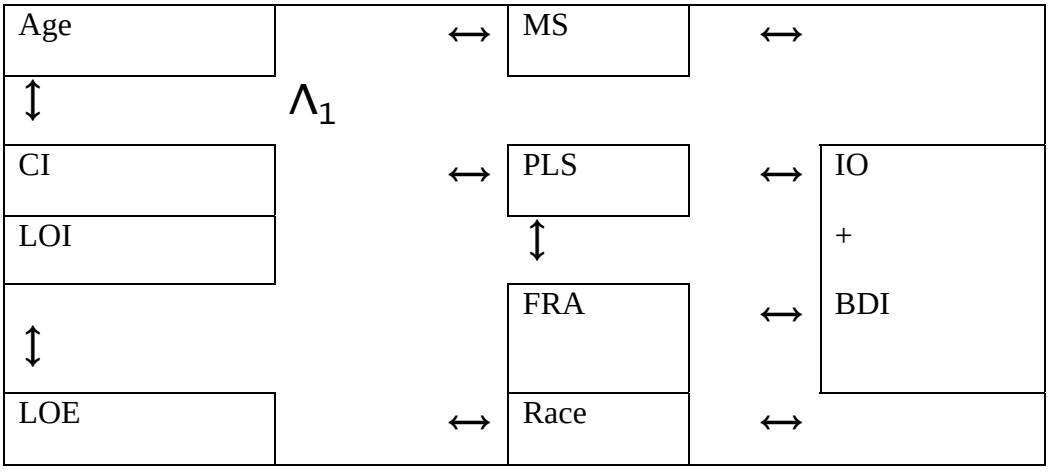
7.3.1.1.1. Afrikaans Language Tradition

When covariance between depression and IRO scores for the various *levels* of sociodemographic variables was measured, the relation between depression and the Intrinsic RO for the Afrikaans LT was influenced by being above the age of 61 ($R = 0.924$, $n = 8$, $\alpha < 0.05$), being 'Coloured' ($R = 0.648$, $n = 15$, $\alpha < 0.01$) and being married ($R = -0.457$, $n = 30$, $\alpha < 0.05$).

The Distress-Deterrent model (Branco, 2000, p. 44) suggests that religiosity is a protective factor against psychosocial stressors. The results of the present study show that PLS has a negative correlation with FRA for the Afrikaans language tradition (r=-0.322, $\alpha < 0.05$) and a positive correlation with chronic illness (r=0.391, $\alpha < 0.05$). The Intrinsic RO scores have a positive correlation with FRA (r=0.343, $\alpha < 0.05$), whereas the depression scores have no relation to any of the variables. Race was found in the present study to be related to level of education (r=0.32, $\alpha < 0.05$), whereas age is related to marital status (r=0.34, $\alpha < 0.05$) and chronic illness (r=0.43, $\alpha < 0.05$).

The following model 1 can be proposed to indicate the manner in which the *relation* between depression and the Intrinsic RO operates within the Afrikaans LT, but does not indicate causality:

Model 1. Relational Diagram of Influence of Sociodemographic Variables on the Relation Between the IRO and Depression for the Afrikaans LT



Note: Λ_1 *Regression of chronic illness and age onto PLS (R = 0.379,* $\alpha <$ *0.05)*

The sociodemographic variables of being over the age of 61, of a different race, frequent religious attendance and being of married status for women, are all variables that have been separately related to higher levels of Intrinsic RO, stress and depression, as outlined in chapter 3. The result of the current study reflects theories and research findings in western sociocultural contexts that an Intrinsic RO mediates the effects that sociocultural stressors have on depression.

The current study found that the stressors, which influence PLS for the Afrikaans LT are the presence of chronic illness and being over the age of 61. As a form of suffering, which is often characterised by loneliness, anxiety, despair and loss of faith and meaning, chronic illness and increased age effects the view of self, others and external reality (Schmidt, 1988, p. 265), with the implication that they negatively effect the relation between religion and depression. On the basis of the stress buffer model, it is expected that a higher level of chronic illness be related to a negative correlation between depression and religious orientation.

The findings of the current study confirm previous research, which has found that religion provides a supportive function and mitigates the presence of and remission from depression for the chronically ill (Fehring et al, 1997, p. 664; Idler & Kasl, 1992; Koenig et al, 1997; 1998; Musick et al, 1998). However, the current study has also found that the interaction between the Intrinsic RO and depression is indirectly also influenced by these variables. Higher age is related to increased levels of chronic illness, which increases the perceived levels of stress, where the higher the PLS, the lower the relation between the Intrinsic RO and depression. Theoretically, the Intrinsic RO provides meaning to suffering and a positive cognitive triad, which decreases the probability of depression occurring.

Watters and Ellis (in Koenig, 1993, p. 27; 1997, p. 25), Koenig (1997) and Jackson and Coursey (1988) believed that indoctrination, the internalisation of orthodox Christian doctrine, passive acceptance of teaching, dependency and "blind faith", lead to absolutist thinking and reification of beliefs, variables that play a role in the genesis of depression. It can therefore be proposed that frequency of religious attendance is related to higher depression scores.

No sociodemographic variables or BDI score were found to correlate with FRA, with the exception of PLS, where the higher the FRA the lower the PLS. Both the variables of FRA and PLS influence the relation between depression and the Intrinsic RO. However, as a correlational study no inference can be made whether higher PLS *causes* higher FRA, or vice versa. The higher frequency of religious attendance for the Afrikaans LT mediates perceptions of stress and both these variables influence the relation between depression and the Intrinsic RO.

The findings of the current study suggests that in terms of theory, greater religious attendance may enhance self-esteem and efficacy, and provide a buffer against stressful life events, which has a positive effect on depression (Argyle, 2000; Bergin et al, 1987, p. 200; Ellison and Levin, 1998, p. 706). The patterns of relations may reflect the high levels of social support within the Afrikaans community, or alternatively, reflect the role that the IRO plays in the spiritual lives of the Afrikaans LT, that is, that members of the Afrikaans LT have internalised beliefs that find meaning in adversity.

Within the Afrikaans language tradition there is a high frequency of religious attendance (see Table 6.1). It is proposed that FRA is a variable that is a socialised or learned behaviour from role models, and that within the Afrikaans LT religious attendance is the fulfilment of social expectations or a reflection of collective identity, rather than a response to PLS.

Batson et al (in Paloutzian, 1996, p. 225-226) found a positive correlation between the IRO and social desirability, whereas Bergin et al (1987, p. 202) found the inverse relation. These studies need to be taken a step further, to examine how social desirability and FRA affect the relation between depression and religious orientation within the Afrikaans LT

Similar to FRA and age variables, marital status in the study was examined in terms of the presence of social support and Beck's cognitive triad, rather than existential questioning as a result of loss of a spouse through death, or value judgments in the case of those who are divorced. As no distinction was made between subjects never married and those widowed or divorced, no definitive explanation can be given for the result in terms of loss theory, which posits that depression relates to loss and separation (Klerman & Weissman, 1980, p. 65).

An explanation cannot be given in terms of specific social support systems (Koenig et al, 1992; Pargament, 1997). Several theorists have noted that lower levels of depression are related to exchange and acceptance, experience of love, a regulated existence, and reciprocal social and emotional support (Allport in Batson et al, 1993, p. 233; Blaine & Crocker, 1995; Ellison & Levin, 1998). It is outside the scope of the study to examine how the quality of the marriage relationship and style of attachment (Bartholomew, 1990) effects the relation between religious orientation and depression. The finding that marital status influences the relation between depression and the Intrinsic RO scores for the Afrikaans LT, where the covariance is high for those who are not married, supports various existing theories. These theories include Fromm's thesis that depression results from inner emptiness and the inability to love (Fuller, 1994, p. 30), that vulnerability to depression arises from the cult of individualism, and reflects a loss of emotional attachment, hedonism and emptiness (Beck, 1967; Frost, 1985; Westgate, 1996, p. 31).

Further research is required into the interaction between the quality of the marital relationship, religious orientation and depression, in terms of psychological measures, such as, self-extension, self-transcendence, optimism, universalism, meaningful relations and commitment (James, 19876; Maslow, 1984; Frankl, 1986).

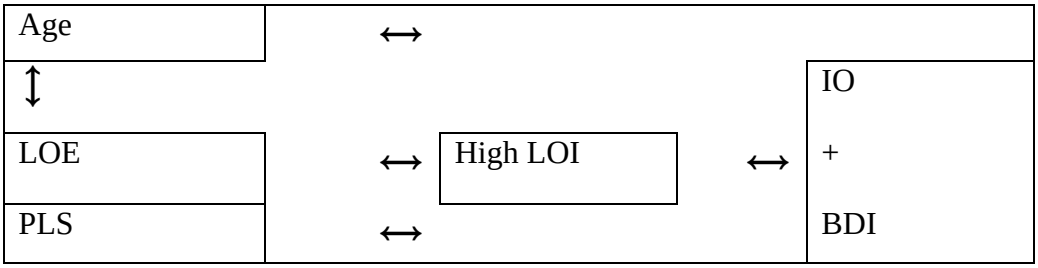
The study found that being of the Afrikaans-speaking 'Coloured' race is related to a lower level of education, which in turn is related to a lower level of income. Although no correlation was found between race and PLS (r=-0.07, *ns*), with a more refined measurement of anxiety, this pattern of relations may be explained in terms of lower levels of anxiety (Bergin et al, 1987, p. 201) related to the Intrinsic RO and to greater economic security. The result can also be explained in terms of the helplessness theory in which the intrinsic motivation to express the self through work, which is self-actualising, -fulfilling and –meaningful, is frustrated or unrealised for this group (Spence, 1985, p. 1288).

7.3.1.1.2. English Language Tradition

Similar to the Afrikaans-speaking 'Coloureds', a low correlation between depression and IRO is influenced by higher level of income (R=-0.908, n = 11, $\alpha < 0.01$) for the English LT. Furthermore, higher the level of income is related the higher age group (r=0.27, $\alpha < 0.05$), tertiary level of education (r=0.48, $\alpha < 0.05$), higher PLS (r=0.27, $\alpha < 0.05$), lower depression scores (r=-0.28, $\alpha < 0.05$), but not with IRO (r=0.03, *ns*).

Thus, the following relational model 2 is proposed to explain the relations between variables for the English language tradition:

Model 2. Relational Diagram of Influence of Sociodemographic Variables on the Relation Between the IRO and Depression for the English LT



Note: Age, LOE and PLS regressed onto LOI gave R = 0.572 (α < 0.01)

Socio-economic status in the United States and United Kingdom is related to level of income and religious denomination. The relation between depression and the Intrinsic RO for the English LT is influenced by socio-economic factors. All three variables of: age, level of education and PLS, individually or collectively, are related to the level of income, which in turn influences the relation between depression and the IRO. The results indicate that the English LT shows no relation between level of income and denomination (r = -0.08, *ns*). However, as a larger sample for the variable religious denomination may produce different results, additional research is required on the effects of religious affiliation on the relation between the Intrinsic RO and depression.

The positive correlation found between level of stress and levels of Income (r=0.27, *p>0.05),* where the higher the level of Income the higher the perceived level of stress, points to overloading, and provides support for Bickel et al's (1998, p. 34) assertion that situational factors play a role in religious phenomena. The finding also supports the stress-vulnerability model of Brown and Harris (in Braam et al, 1995, p. 285).

When frequency of religious attendance is regressed onto depression, perceived levels of stress and levels of income, $R^2 = 0.355$ ($F = 4.668$, $\alpha < 0.05$), the multiple correlation provides support for the suggestion and findings that religious attendance is a protective factor in the genesis of depression, as a coping mechanism for life stressors (Braam et al, 1995, p. 285), and to the role played by religious involvement in engendering positive emotions and illusions of contentment, love, forgiveness, hope, optimism and compassion (Ellison & Levin, 1998, p. 708).

7.3.1.1.3. Similarities and Differences of the Relation Between Depression and the Intrinsic Religious Orientation for The Language Traditions

The current study's social constructionist view regarding the relation between religious orientation and depression, gives only partial support for the theory. Both the Afrikaans and English LT results provide support for the stress-buffering model, which states that the Intrinsic RO mediates the relation between depression and stressful sociodemographic variables.

However, different pathways in the manner in which the variables influence the relation between depression and the Intrinsic RO were found between the Afrikaans and English language traditions. It will be recalled that Chi-square tests (Table 4.1.) confirm that language tradition determines the choice of religious denomination in the Western Cape, that indicate differences in cultural characteristics and identity. Cultural differences were found in that the nature of the sociodemographic variables differed for the language traditions. The relation between depression and the Intrinsic RO is influenced by perceived level of stress, frequency of religious attendance, age, race and marital status for the Afrikaans LT, and level of income for the English LT. It appears that the language traditions show differences in the relation between depression and the Intrinsic RO in terms of sociodemographic and socio-economic variables.

These results reflect different norms and functions that religion plays in various societies (Batson et al, 1993, p. 38), that is, may reflect differences in cultural meanings and values, as correlational studies in the United States (Lea, 1982) found that depression was related to high orthodoxy and lower levels of religiousness, (Meadow & Kahoe, 1984). This suggests that the relationship between the Intrinsic religious orientation and depression may be mediated by personal and social identity structures.

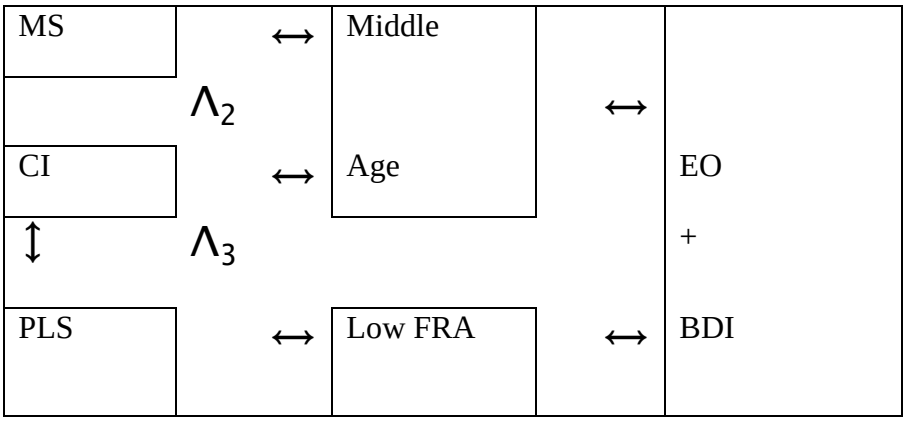
7.3.1.2. The Relation between Depression and the Extrinsic Religious Orientation

No relation was found between depression and the Extrinsic RO irrespective of language tradition, as indicated in Table 6.19, which confirms hypothesis 4. This is contrary to theory, as individuals, who have higher scores on the Extrinsic orientation use their religion for instrumental purposes, such as, social and economic advancement or social support, without having internalised the religious beliefs of the congregation to which they adhere. Consequently, they have not constructed a unified meaning basis for events in their own lives, that of others, or the world, nor does this religious orientation have a solid basis in a belief system (Allport, 1967). Batson et al (1993) suggest in terms of theory, that narcissism is beneficial to levels of depression. However, these individuals show low levels of self-acceptance, self-actualisation, appropriate social behaviour, personal competence, unified belief structure and flexibility (Batson et al, 1993, p. 286), which explain higher rather than lower levels of depression.

When the influence of sociodemographic variables was considered, no significant partial correlations were found for either language tradition. However, when the *levels* of control variables are considered, significant covariance was found in the Afrikaans language tradition with the variable low frequency of religious attendance ($R = -0.575$, $n = 16$, $\alpha < 0.05$) and middle age ($R = -0.566$, $n = 19$, $\alpha < 0.05$.

This indicates that a lower correlation is found between depression and the Extrinsic RO for low FRA and the middle age group for the Afrikaans LT. Consequently, the following relational model 3 is proposed to explain the way in which the relation between depression and ERO is influenced by sociodemographic variables:

Model 3. Relational Diagram of Influence of Sociodemographic Variables on the Relation Between the ERO and Depression for the Afrikaans LT



Note: Λ_2 denotes regression of chronic illness and marital status onto age (R = 0.448, $\alpha < 0.05$); Λ_3 denotes regression of chronic illness and PLS onto age (R = 0.401, $\alpha < 0.05$)

The variables of marital status, chronic illness, age and PLS, similarly to the Intrinsic RO, play a role in the relation between depression and the Extrinsic RO for the Afrikaans LT. However, for the Extrinsic RO the relation is influenced by: being of middle age, which is in turn influenced by being married and the presence of a chronic illness, singly and in combination. For the Extrinsic RO, when there is a higher level of perceived stress, the frequency of religious attendance is low and a chronic illness is present. In the category of middle age and when frequency of religious attendance is low, higher ERO scores are related to lower BDI scores. The findings can both be explained in terms of existing theory.

The Extrinsic RO is a pragmatic, utilitarian, self-centred and exclusionary religious orientation in which religion is used in order to satisfy various psychosocial needs (Allport & Ross, 1967). As the extrinsically religious are motivated towards gaining self-serving social status and security, frequent church attendance would serve the needs of this group. This supports the social support theory of the role that the Extrinsic RO plays. Stark (in Hood et al, 1996, p. 418) found that emotional disturbance is related to lack of participation in religious activities, however the current study has found the inverse to occur. Research indicates that religious attendance promotes perceptions of social support, is a coping mechanism, buffer against stressors, and promotes similarity of beliefs and compliance to the reciprocity norm (Braam et al, 1998, p. 485; Schnittker, 2001; Strawbridge et al, 1998). This is in turn associated with lower rates of depression (Murphy et al, 2000; Woods et al, 1999).

No significant partial correlations or levels of covariance were found for the English LT. With use of a sample or Extrinsic RO scale that has greater internal validity, a clearer picture of the nature of the relations between the variables may emerge. Therefore, in terms of hypothesis testing, the rejection of hypothesis 6 for the English LT needs to be considered with caution, and requires further research.

7.3.1.3. The Relation between Depression and the Quest Religious Orientation

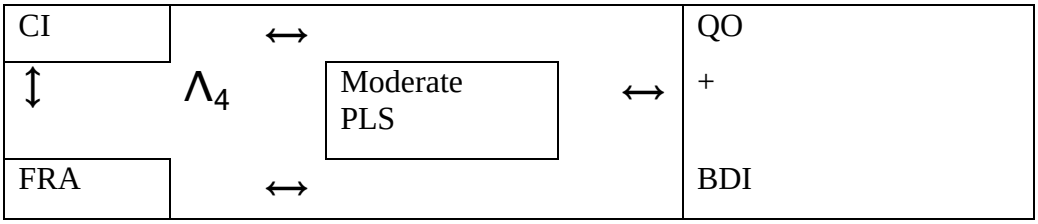
The Quest religious orientation emphasizes flexible, reflexive and critical thinking concerning religious matters. In psychosocial terms the result is tolerance, openness to change, situational sensitivity and self-reliance (Hood et al, 1996, p. 36). The Quest religious orientation as conceptualised by Batson et al (1993), a conception similar to that of Albert Ellis (1998), assumes that it is psychologically healthy to ask creative, flexible, open-ended questions about life and religion, without expecting definitive answers.

There is a greater degree of self-reliance, and confidence in self-efficacy associated with lower levels of depression. On the basis of this theoretical conception the hypothesis can be given that low depression scores are related to high Quest RO scores. However, no significant correlations were found between depression and the Quest RO for both language traditions. Partial correlations, which tested the influence that the sociodemographic variables have on the relation between depression and the Quest religious orientation, found no significant relations irrespective of language tradition. Measures of covariance between depression and QRO scores for the different levels of sociodemographic variables gave significant covariance for moderate PLS (R= 0.431, n = 22, $\alpha < 0.05$) for the Afrikaans LT, and for the 'Coloured' (R= 0.647, n = 14, $\alpha < 0.05$), low level of education (R = 0.697, n = 9, $\alpha < 0.05$), being below the age of 41 (R= 0.528, n = 15$\alpha < 0.05$) and Pentecostal denomination (R = 0.8, n = 12, $\alpha < 0.05$) for the English LT.

7.3.1.3.1. Afrikaans Language Tradition

The relation between depression and the Quest RO for the Afrikaans LT is influenced by the variable: moderate levels of perceived stress. PLS is in turn related to the presence of chronic illness and low frequency of religious attendance.

Model 4. Relational Diagram of Influence of Sociodemographic Variables on the Relation Between the QRO and Depression for the Afrikaans LT



Note: Λ_4 denotes regression of chronic illness and FRA onto PLS (R = 0.393, $\alpha < 0.05$)

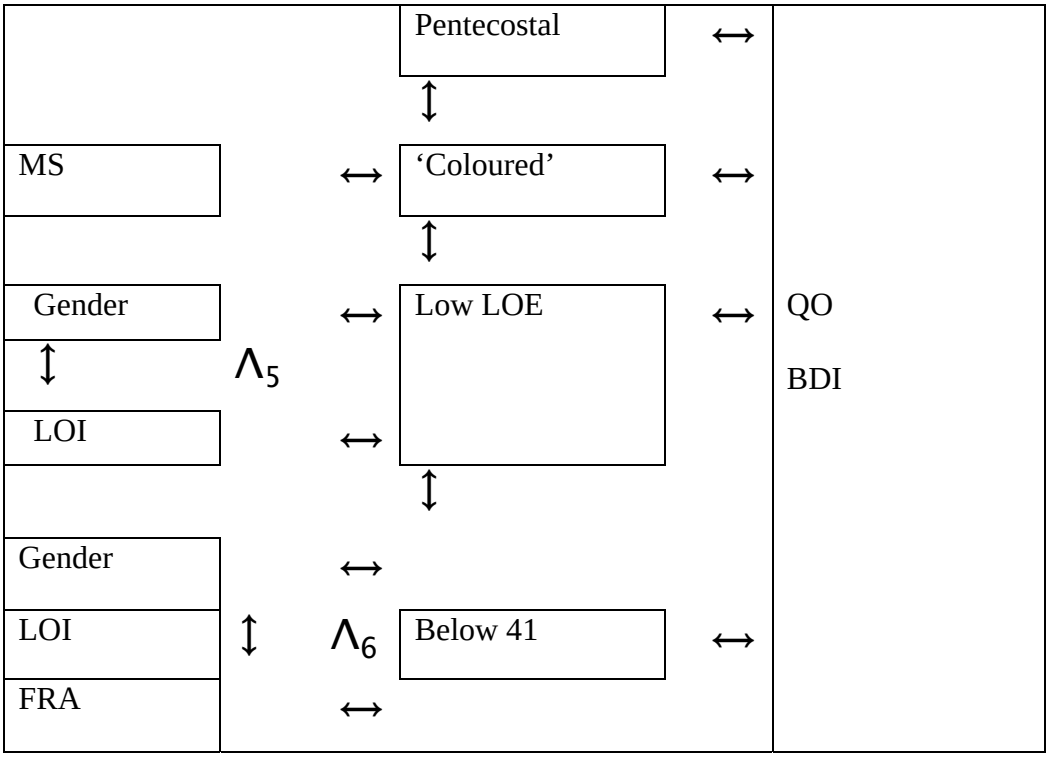
Musick et al (1998, p. S225) noted that: studies of the relation between religion and mental health need to consider the moderating effect of stress. The test of the influence of PLS on the relation between depression and the Quest RO was based on the moderator model (Branco, 2000, p. 45), where high levels of stress are related to low levels of religiosity. If the Quest RO as proposed by Batson et al (1993) regards this orientation as a healthy questioning of beliefs, the hypothesis proposed is that a high correlation between depression and the Quest RO is related to lower levels of stress.

Higher Quest RO scores are related to higher levels of perceived stress and depression scores. This provides support for the argument that the results suggest that individuals in the sample may be demonstrating religious conflict and anxiety, that is, cognitive dissonance (Donahue, 1989; Festinger, 1957; Kojetin et al, 1987; Wulff, 1991), the feeling of inadequacy, guilt and failure associated with James's (1987) conception of morbid-minded religion, rather than the competence of the Quest orientation suggested by Batson et al (1993). The results indicate that the Quest RO may be a temporary orientation to stressful life events (Burris et al, 1996), Stark's (in Hood et al, 1996, p. 418) finding that depression is related to unconventional religious beliefs, and the findings of Spilka et al (2003) that religious doubt is related to tension, depression and conflict.

7.3.1.3.2. English Language Tradition

The relation between depression and the Quest RO is higher when the individual is 'Coloured', has a low level of income, is below the age of 41 and follows a Pentecostal affiliation. The following model 5 demonstrates the relations between the variables for the English language tradition:

Model 5. Relational Diagram of Influence of Sociodemographic Variables on the Relation Between the QRO and Depression for the English LT



Note: Λ_5 *denotes regression of gender and level of income onto level of education (R = 0.493,* $\alpha < 0.01$*);* Λ_6 *denotes regression of gender, frequency of religious attendance and level of income onto age (R = 0.528,* $\alpha < 0.01$*)*

Research indicates that the relation between religion and psychological well-being is particularly relevant to Black subjects (Blaine & Crocker, 1995). This relation is mediated by the mechanisms of self-enhancing religious attributions and positive social identity associated with religious affiliation. The relation is particularly relevant to the Intrinsic RO rather than the Quest RO (Blaine & Crocker, 1995). Although in the Western Cape sociocultural context, the unique "Coloured" community has been greatly influenced by Western religious tradition, the community has also experienced high levels of gang activity, drug use, crime, discrimination and poverty.

As a result of these factors, the hypothesis can be given that the relation between depression and the Quest RO is positive for the "Coloured" subjects. The positive relation between depression and the Quest RO in the "Coloured" data set suggests that the relation may reflect a search for meaning, need for control, love and self-esteem or use of religion as a coping mechanism (Batson & Raynor-Prince, 1983; Blaine & Crocker, 1995, p. 1032; Ellison, 1995) in a tumultuous, anxious, threatening, enduring and rapidly changing sociocultural climate. Therefore, the results may be explained in terms of helplessness theory (Seligman, 1975) and attribution theory in relation to divine action and purpose.

Further support for the helplessness and hopelessness theories is provided in that this 'Coloured' sample also has a lower level of education ($r = 0.51$, $\alpha < 0.01$) and is affiliated with no or the Pentecostal denomination ($r = -0.31$, $\alpha < 0.01$). This reflects the pattern of relations found in the United States, where socio-economic status and level of education are linked, and affect religious affiliation rather than orientation. Socio-economic status is also linked to lower self-esteem and –efficacy, a restricted action range, and higher levels of anxiety and depression (Freden in Frost 1985, p. 184-185; Zunzunegui, 1999, p. 367).

Alternatively, the results confirm the relation between a "self-directed pursuit of meaning at the behest of suffering and contradiction" (Burris et al, 1996, p. 1075), which is related to a lack of in-group identification, lower frequency of religious attendance, and greater levels of individualism. Further research is required regarding the nature of the personal and cultural identity of the "Coloured" group (Blaine & Crocker, 1995), and how this relates to religious orientation and psychological variables.

When the characteristics of the Quest RO are considered, it can be expected that the relation between the depression and Quest RO scores would be highest among younger adults beginning to embark on their lives, and among the aged, who are re-evaluating their lives that were. A hypothesis can be suggested that the relation between low depression scores and high Quest RO scores would be highest for young adults and the 'aged'.

However, the study found that this was only relevant for the case of young adults. The results of the partial correlation coefficients indicate that there are cohort differences in the Quest religious orientation, where the Quest scores decline with increasing age (Spilka et al, 2003; Wulff, 1991). The variable younger age is in turn related to being male, having a lower level of income and lower frequency of religious attendance. The findings in the current study that included lower FRA and younger age support the theoretical position of Batson et al (1993) that the Quest RO is related to lower levels of depression when there is creative, flexible, open-ended questioning about life and religion, and greater of self-reliance and -efficacy. It can be assumed that there is the social expectation of a lower income for those, who are younger adults. However, the anxiety mentioned in regard to the variable Race, may be mediated by the hope and expectation of a future rise in income for this age group, which is not the case for the 'Coloured' community of the Western Cape.

Although religious orientation has been investigated in terms of human development, religious orientation as a state-trait personality characteristic is still under-researched. Results indicate that religious affiliation or denomination shows parallels with personality traits, such as, between Calvinism and the Type A personality (Ellison & Levin, 1998, p. 713). Further research is required to establish whether the relation between depression and the Quest RO scores, when controlled in terms of age, is the cause and/or effect of psychosocial, maturational, personality, developmental, and/or sociocultural variables.

Previous research results indicate that depression is higher for particular denominational groups given particular psychosocial variables (Meador et al, 1992; Park et al, 1990). This suggests that religious denomination would influence the relation between religious orientation and depression scores. The current study found that within the English LT this relation is relevant to the Pentecostal religious affiliation, where a high depression score is related to a low Quest RO score. This suggests that these specific denominations foster social isolation and powerlessness, factors that increase depression, rather than release for depression through use charismatic healing or open expression of emotion (Meador et al, 1992, p. 1207; Koenig et al, 1998). The result provides further support for the theoretical conception of the Quest RO as conceived by Batson et al (1993) as being psychologically healthy, the suppression of which is related to dysfunction.

7.3.1.3.3. Similarities and Differences Between the Language Traditions for the Relation Between the Quest Religious Orientation and Depression

The Afrikaans and English language traditions demonstrated differences concerning the sociodemographic variables that influence the relation between depression and the Quest RO. Within the Afrikaans LT the relation is influenced by the variable moderate perceived levels of stress, that is, high depression scores are related to low Quest RO scores when PLS is at a moderate level. PLS is in turn influenced by the presence of chronic illness and lower frequency of religious attendance, that is, variables related to functional ability, rather than socio-economic stressors of race, age, education and income. In contrast, these socio-economic variables influence the relation within the English LT, namely, being below the age of 41, having a primary educational level, of the 'Coloured' race and Pentecostal denomination, variables which are intercorrelated (see Table B, Appendix B).

Despite the differences for the language traditions, the influence of the sociodemographic variables on the relation between depression and the Quest RO reflects a search for meaning during times of adversity and suffering, as well as differences in the social construction of meaning. The question arises whether the inference can be made that the English LT places greater importance on socio-economic status than the Afrikaans LT, which emphasizes functional capacity, and whether adversity within these realms of psychosocial life determine the relation between depression and the Quest RO for the language traditions in the Western Cape.

7.3.2. The Null Relation Between Depression and Religious Orientation

The variables Religious Denomination, Gender and Recent Bereavement gave no significant influence on the relation between depression and any dimension of religious orientation through the calculation of partial correlations. These results contradict proven theories, such as, Seligman's hopelessness theory (1975) and the Distress-Deterrent model (Branco, 2000).

7.3.2.1. Religious Denomination

For all the relations studied, controlling for religious denomination, with the exception of the relation between depression and the Quest RO for the English LT, no significant relations were found. However, it was found that there is 56% probability that a larger sample would provide different results. It is therefore suggested that the study be repeated with a larger sample. Furthermore, the operationalisation of the variable needs greater refinement, as religious orientation differs widely within the same denominational group (Gorsuch, 1984, p. 230) with differential results on the presence of depression.

7.3.2.2. Recent Bereavement

Recent bereavement is often characterized by existential questioning on behalf of the survivors, a trauma model, which originates in the overturning of the assumption of the benevolence and meaningfulness of reality (Janoff-Bulman in Burris et al, 1996, p. 1074). It can therefore be proposed that in, there is a positive correlation between depression and the Quest RO when suddenly bereaved. As the Intrinsic RO is characterized by a well-structured religious meaning system, which provides ready answers to existential questions, and the Extrinsic RO is an instrumental orientation in which religion is used in order to gain social support, all variables that mitigate the occurrence of depression after a sudden bereavement, the hypothesis can be given that recent bereavement is related to a low correlation between depression and the Intrinsic and Extrinsic RO scores.

Unfortunately, causality cannot be inferred. It can therefore not be established whether the high correlation between depression and the Quest RO is the result of recent bereavement, a personality trait or predisposed Quest religious orientation. However, a multiple partial correlation that tests the influence of both perceived levels of stress and recent bereavement have on the relation between depression and the Quest RO gave pR = 4.967 ($p<0.05$), while PLS regressed onto Recent Bereavement, the Quest RO and depression gave (R2 = 0.408, $p<0.05$). This further suggests that high Quest scores are related to anxiety, doubt and conflict (Donahue, 1989; Kojetin et al, 1987; Wulff, 1991), and reflects a low need for closure and cognitive dissonance (Festinger, 1957).

7.3.2.3. Gender

Theory suggests that according to the stress buffer model, religion would provide the greater protection for women against depression. Mirola (1999) found gender differences in the relation between religious involvement and depression.

No gender effects with any other sociodemographic variables, except for levels of income (r=-0.264, $p<0.05$) or on the relation between depression and any of the dimensions of religious affiliation were found for the present study. This null relation may be the result of lack of refinement in operationalisation of specific religious activities rather than sample homogeneity (Mirola, 1999). The influence of gender on the relation between depression and religious orientation may only become clearer when approached as a separate study, which takes contextual, psychosocial processes, religious beliefs, values and practices into account.

7.3.3. The Relation Between Religion and Religious Orientation Once Sociodemographic Variables are Controlled

Analysis of covariance using a multiple regression technique indicates that there is no relation between depression and religious orientation, when sociodemographic variables are controlled. These included (in order placed into the regression equation): Chronic Illness, Marital Status, Frequency of Religious Attendance, Perceived Level of Stress, Level of Education, Language Tradition, Religious Denomination, Race, Level of Income, and Age.

This represents an oversimplification of the relation between depression and religious orientation. The results and discussion of the relation between depression and the *dimensions* of religious orientation have already demonstrated that the relation cannot be described in simple linear terms.

The relation has been found to be significant for specific levels of sociodemographic variables, and demonstrated differences between the Afrikaans and English language traditions. This suggests the examination of the relation between depression and religious orientation needs to be placed within a specific sociocultural context, and that the meaning of the situational factors has for the relevant population needs to be considered.

8. Conclusion

8.1. Introduction

In order to assess the influence of the research findings on the research problem, a summary will be given of the findings, shortcomings in the research discussed, and the impact of the new information gained will be assessed.

8.2. Summary of the findings and their influence on the research problem

When the relation between depression and religious orientation is studied in terms of different language traditions in the Western Cape context, a complex picture emerges. The original correlations between various dimensions of religious orientation and depression, and the ultimate examination of regression of religious orientation onto depression, while controlling for sociodemographic variables in the present study, show no relation. However, when the results are examined in terms of specific sociocultural variables, a more complex picture emerges. When the relationship between the various dimensions of religious orientation and depression are considered, the variables Level of Income, Age, Level of Education, Race, Perceived Stress, Chronic Illness and Frequency of Religious Attendance demonstrated different patterns of relation when the English and Afrikaans language traditions are compared.

Whether the relation between religious orientation and depression is positive, negative or orthogonal depends on the influence of various sociodemographic variables (Strawbridge et al, 1998). The study thus supports the hypothesis of Ellison and Levin (1998, p. 714) that religious variables have different mental health outcomes for different population groups.

8.3. Shortcomings of the research project

Based on a motivational orientation to the psychology of religion, the study does not do justice to the religious experience of individuals as unique and subjective (Pargament, 1997, p. 11). Furthermore, the study has not outlined the conditions under which religious variables contribute to or undermine psychological health, or which religious variables are important before, during or after illness (Plante & Sherman, 2001, p. 392-393; Sherkat & Reed, 1992, p. 270; Watson et al, 1989).

Religious orientation and its relation to depression may reflect underlying psychological mechanisms, dispositions, and needs that can be better explained in terms of psychological theory, rather than theology or philosophy, and this may be better researched in descriptive methods and case studies (Gorsuch, 1984, p. 235; Wulff, 1991, p. 242, 249; Watson et al, 1989). As this is not a case study, there has been no examination of the base-line mechanisms of depression or religious variables and how they relate to the development of a specific religious orientation (Braam et al, 1997; Stahlberg, 1994, p. 270). The religious orientation of Quest, as conceptualised by Batson, Schoenrade and Ventis (1993), meets the requirements of validity for the sample in question, but the Intrinsic and Extrinsic religious orientation scales need to be re-assessed. More research is required on the RLI scale, which appears to be valid for use with a homogeneous sample group in the Western Cape, but not with a more heterogeneous sample group.

Gorsuch (1984) pointed out that the measurement of religion should establish the means to study the impact of religion on health. The use of a cross-sectional, correlational design has its disadvantages in that the design cannot establish causal relationships nor can it give predictions of future advantages or disadvantages to psychological health or distinguish the effects religion has on transient as opposed to chronic depression (Braam et al, 1997; Kleinbaum, Kupper, Muller & Nizam, 1998, p. 36).

The questionable validity of the Intrinsic-Extrinsic association may reflect attempts of test developers to oversimplify what is generally acknowledged to be the complex and multidimensional phenomenon of religious orientation (Fallot, 1998). A possible solution could be conducting factor analytic studies that extract higher- or second-order factors, or use of comprehensive case studies, in order to develop more refined measures that address the reasons for the relationships (Bergin, 1991, p. 400).

Means of examining religiousness that includes non-Christian spirituality of church- and non-church-going respondents, that is, a religion-universal scale that examines core religious beliefs, values, attitudes and behaviour (Gorsuch, 1984, p. 234; Pfeifer & Waelty, 1999) specifically relevant to African cultural meanings, is required for further empirical studies in an African context. This may mean distinguishing between various aspects of intrinsic religious motivation, for example, Lenski's distinction between doctrinal orthodoxy and devotionalism (Meadow & Kahoe, 1984, p. 304), Glock's experiential and relational aspects of religiosity (Meadow & Kahoe, 1984, p. 305), and the extent to which religious beliefs have been inflexibly internalised and integrated (Bergin, 1994), as well as the dimension of spirituality (Nelson et al, 2002, p. 218). Concurring with Thoresen et al (in Plante & Sherman, 2001, p. 22-23) a model that simulates a Venn diagram may be required.

The operationalisation of the concepts religious denomination and frequency of religious attendance may not be sufficiently refined for the current study. Instead of denomination, finer discrimination may have been achieved through measurement of the presence of orthodox, conservative or liberal religious belief systems (Meador et al, 1992), religious values and level of religious salience within a denomination. Furthermore, the role that religion plays in mental health may be better measured in terms of separate personality traits, rather than in terms of motivational typologies (Donahue, 1985, p. 408; Kennedy et al, 1996, p. P307).

Frequency of religious attendance, that is public worship, was measured, but not private, personal devotion and how this impacts on the relation between depression and religious orientation (Husaini et al, 1999; Miller & Gur, 2002, p. 212).

The question also arises whether an inference can be made that both positive and negative effects of religious doctrine and participation are internalised when the frequency of religious attendance is higher, as the present study found that frequency of religious attendance correlates positively with the Intrinsic and Extrinsic religious orientations, but negatively with the Quest religious orientation within the Afrikaans LT.

It has been shown that there are differences in social identity, measured in terms of different language traditions, in the way that religious orientation and depression is manifested, as well as in the way in which depression relates to religious orientation.

Further research is required to answer the questions as to:

- How does personal and social *identity formation* mediate the relation between religion and depression?
- To what extent is religious orientation the effect of sociocultural learning through emulation of the language/religious norms of the primary caregivers?
- Can the relationship be described in terms of the social psychological processes of: attitude formation, conflict resolution, belief congruence and intergroup relations?
- Would it be more appropriate to regard the relation between religion and religious orientation as a complex, dynamic system, which can be examined through non-linear methods?

8.4. New information and the implications of these findings

The results of the current study suggest that identity formation plays a mediating role in the relationship between religious orientation and depression. This in turn has implications for clinical practice in terms of assessment and treatment.

Many studies have found a significant improvement in depression when religion is included in psychotherapy, (Plante & Sharma, 2000, p. 246; Fallot, 1998, p. 97). A considerable amount of research has emerged during the past decades outlining the benefits of religion to all aspects of health, and scientific and clinical scepticism has been to a degree replaced by acceptance so that the mind-body problem is gradually being replaced by the spirit-body or spirit-mind-body problem (Bergin, 1991, p. 298; Chirban, 2001, p. 267). While medications may help one's behaviours become more acceptable to society, they do nothing to put one's shattered soul back together (Cooper in Sullivan, 1998, p. 25). "The mentally sick person is one who regrets his past, abhors his present, and dreads his future", but "healing follows the path of redemptive love, whether human or divine" (Allport, 1968, p. 143).

The attitude towards the role of religion in healing by health care professionals encompasses a wide range from avoidance to regarding religion as irrelevant, (Fallot, 1998, p. 7; Koenig, 1997, p. 28; Hilton et al, 2002, p. 34, 36; Levin, 1994, p. 1475; Nelson & Wilson, 1984, p. 18; Pargament, 1997, p. 22), or including 'soul matters', such as the humanistic school, which emphasizes self-actualisation, flexible self-exploration, dignity of the individual and group, happiness, and an all-encompassing philosophy of life (Bergin, 1986, p. 98). Spirituality may be one means in which the balance between mental, physical and spiritual aspects of human experience can be kept, especially a spirituality that promotes love, compassion, tolerance, patience, forgiveness, contentment, sense of responsibility and harmony (Solomon, 2002, p. 39).

Religious beliefs, and the emotional reaction they provoke, provide clinicians with valuable information regarding values, personality, coping resources and relationships as well as whether religion plays a positive, healing or negative, destructive role in the patients or clients psychosocial characteristics and behaviours (Chirban, 2001, p. 268; Exline et al, 2000, p. 1490). Glueck (1988) correctly points out that as holiness and health are not synonymous, it cannot be inferred that all religious people are healthy, and disturbed people are unholy, as there are many examples of the reverse, nor can it be inferred that religion is the cure-all for disturbed people.

The role of religion in the client or patient's life should be carefully assessed, whether the religious beliefs and involvement contribute to, detract from or play a neutral role in the symptomology of any mental disturbance in order to ascertain whether the role of religion should be promoted, annihilated or corrected without imposition of the clinician's religious beliefs (Malony, 1994, p. 22-24). Plante and Sherman (2001, p. 394-395) point out that the therapeutic orientation of the religious client with a spiritual conflict needs to differ from that of clients seeking help for nonspiritual conflict.

Information regarding the sociocultural orientation, which includes religious orientation, needs to be gathered in order to gain a holistic overview of the functioning of the patient as well as the ability of the clinical team to encourage healing through participation in supportive religious activities, development of a spiritual self-concept and facilitate reintegration into the community in the case of hospitalised patients.

As an aid to clinical assessment, the Religious Orientation Scale of Batson, Schoenrade and Ventis (1993) reflects a Western theological and philosophical bias, which does not take modern African or Eastern theology and philosophy into account, nor does it reflect the differences in the healthy and pathological orientations, use and functions of religion.

A scale needs to be developed that examines religious orientation in the African context, which will be of benefit to African therapists in their use of spirituality to facilitate optimal functioning, growth and health. This implies developing a religious orientation scale that includes the 'individualism-collectivism' dimension, and a relational or attitudinal dimension to the self, others and divine.

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APPENDIX 1: DUMMY CODING

Number	0	1	2	3
Age	21-40	41-60	61+	-
Gender	Male	Female	-	-
Educational Attainment	No matric	Secondary	Tertiary	-
Income	R0 - 40 000	R 40 000 - R150 000	R 150 000 +	-
Language Tradition	Afrikaans	English	-	-
Marital Status	Unmarried / Divorced / Widowed	Married	-	-
Chronic Illness	No	Yes	-	-
Recent Bereavement	No	Yes	-	-
Race	Coloured	White	-	-
Perceived Level of Stress	Low	Moderate	High	-
Religious Preference	None	Pentecostal	Protestant	Conservative = Catholic / Apostolic
Religious Attendance	Never / Seldom	Weekly	-	-

Appendix B: Correlation Matrix Between All Variables

Table A. Correlation Matrix Between All Variables for Afrikaans Language Tradition

	BDI	IO	EO	QO	GNDR	AGE	LOE	LOI	RACE	PLS	MS	CI	RB	DNM	FRA
BDI	1.00														
IO	-0.04	1.00													
EO	-0.21	0.24	1.00												
QO	0.09	-0.05	-0.22	1.00											
GNDR	-0.07	-0.11	0.09	0.18	1.00										
AGE	-0.08	0.13	-0.01	**-0.34** *	0.13	1.00									
LOE	-0.09	0.10	0.26	-0.12	0.20	-0.04	1.00								
LOI	-0.10	0.20	0.22	-0.15	-0.21	0.12	**0.34 ***	1.00							
RACE	-0.06	0.20	0.09	-0.26	-0.04	0.16	**0.32 ***	0.13	1.00						
PLS	0.03	-0.25	-0.03	-0.06	0.11	0.02	-0.03	0.21	0.10	1.00					
MS	-0.12	0.09	0.08	-0.18	0.11	**0.34 ***	0.01	0.10	0.08	-0.12	1.00				
CI	0.06	-0.11	0.01	-0.11	0.13	**0.43 ****	-0.06	-0.06	-0.08	**0.39** **	0.02	1.00			
RB	0.13	-0.06	-0.08	0.13	0.05	-0.01	0.01	-0.16	-0.04	-0.20	0.25	-0.07	1.00		
DNM	-0.18	0.04	0.10	-0.26	-0.11	0.24	-0.27	**-0.31** *	-0.02	-0.21	0.16	0.08	0.17	1.00	
FRA	-0.12	**0.34** *	0.26	-0.03	0.01	0.14	0.00	-0.16	0.04	**-0.32** *	0.04	-0.14	-0.01	0.25	1.00

*Levels of Significance: * $\alpha > 0.05$ ** $\alpha > 0.01$ *** $\alpha > 0.001$ All other values are not significant*

Table B. Correlation Matrix Between All Variables for English Language Tradition

	BDI	*IO*	*EO*	*QO*	*GNDR*	*AGE*	*LOE*	*LOI*	*RACE*	*PLS*	*MS*	*CI*	*RB*	*DNM*	*FRA*
BDI	1.00														
IO	0.22	1.00													
EO	-0.05	**-0.39 ****	1.00												
QO	0.09	-0.22	**0.56 *****	1.00											
GNDR	-0.02	0.09	-0.04	0.14	1.00										
AGE	-0.12	-0.24	0.14	-0.10	**-0.40 ****	1.00									
LOE	**-0.28 ***	-0.15	-0.03	-0.18	**-0.31 ***	**0.31 ***	1.00								
LOI	-0.06	-0.01	0.03	-0.25	-0.26	**0.27** *	**0.48 *****	1.00							
RACE	0.03	-0.16	0.05	-0.05	-0.22	0.21	**0.51 *****	0.12	1.00						
PLS	0.24	**0.29 ***	0.03	0.20	0.04	-0.23	-0.02	**0.27 ***	-0.07	1.00					
MS	-0.21	-0.04	0.11	0.13	0.09	0.22	0.24	0.14	**0.27** *	0.03	1.00				
CI	0.25	0.10	0.13	-0.03	-0.06	0.24	-0.15	-0.13	0.02	0.02	0.08	1.00			
RB	**-0.30 ***	**-0.27 ***	0.21	0.08	**-0.29 ***	0.22	0.19	-0.08	0.06	-0.25	0.15	-0.07	1.00		
DNM	-0.12	-0.03	0.11	**0.28 ***	0.20	0.07	-0.10	-0.08	**-0.31 ***	-0.01	-0.13	0.05	-0.13	1.00	
FRA	-0.23	**-0.45 ****	**0.61 *****	**0.41 ****	-0.17	**0.38 ****	-0.01	-0.06	-0.06	**-0.33 ***	0.14	0.20	**0.27 ***	**0.22**	1.00

*Levels of Significance: * $\alpha > 0.05$ ** $\alpha > 0.01$ *** $\alpha > 0.001$ All other values are not significant*