

Religious Change and Depressive Symptoms among Youth in Foster Care With or Without a History of Sexual Abuse

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Research suggests that trauma, such as childhood sexual abuse (CSA), disrupts key social-cognitive assumptions including religious beliefs. Limited previous studies examined adult reports and compared group means on measures of religiosity. Yet CSA may both increase and decrease religiosity, and, therefore, group means may be deceptive. The current study explored religious change and depression among adolescents in foster care with and without CSA over a two-year period ($n = 407$). Results indicated that youth with a history of CSA were no more likely to report changes in religious affiliation or belief over the study period, as compared to youth without a history of CSA. Among youth without a history of CSA, changes in religious affiliation and beliefs were associated with increased depression. For youth with a history of CSA, religious changes were unrelated to depressive symptoms. It appears that the impact of religious change is context-dependent, and further research using longitudinal designs appears warranted and necessary.

Research and theory suggest that trauma can disrupt basic assumptions about the world and oneself in key social-cognitive areas such as safety, trust, power, and self-esteem, leading to distress (McCann & Pearlman, 1990; Resick, Monson, & Rizvi, 2008). For some, these basic assumptions are linked to religious and spiritual beliefs. Therefore, many hypothesize that trauma may disrupt religion and spirituality (Falsetti, Resick, & Davis, 2003; Walker, Reid, O'Neill, & Brown, 2009). Considerable research has documented the negative impact of childhood sexual abuse (CSA) on multiple indices of psychological functioning (Jumper, 1995; Paolucci, Genius, & Violato 2001), and qualitative studies indicate that CSA survivors report negative images of God (Imbens & Jonkers, 1992), lower religious practices and beliefs (Hall, 1995; Lawson, Drebing, Berg, Vincelle, & Penk, 1998), and spiritual disconnection (Flaherty, 1992). On the other hand, religion and spirituality can be protective, as other studies have found that they help survivors reduce distress (Weber & Cummings, 1999), maintain resilience (Valentine & Feinauer, 1993), and construct meaning (Glaister & Abel, 2001).

Quantitative research has been limited and results mixed, with some studies reporting less belief among adults with a history of CSA and others more belief (see Falsetti et al., 2003 and Walker et al., 2009 for reviews). Previous studies have almost exclusively utilized retrospective reports of adults, comparing those with a history of CSA to those without such history on mean level of religiosity and spirituality. Yet the influence of CSA on religiosity and

spirituality is likely bi-directional; while some seek new sources of spiritual support and significance to cope, others may find their beliefs shattered (e.g., "God would not have allowed this to happen") and renounce them (Pargament, Desai, & McConnell, 2006). As demonstrated by Bonanno and colleagues (2002), aggregating data obscures divergent patterns of response to trauma, as cross-sectional designs examining group means cannot capture individual increases and decreases. Consequently, longitudinal research examining individual trajectories of change is necessary.

Religious Change and Distress

The psychological impact of CSA-related religious and spiritual change remains unclear. A large body of research suggests that religion plays a pivotal role in helping patients adjust and cope with stress, grief, and trauma (Koenig, George, & Siegler, 1988; Pargament, 1997). Common religious coping strategies include seeking a supportive relationship with God, benevolent religious reappraisals (e.g., seeing one's situation as part of God's plan), and obtaining interpersonal religious support (Pargament, 1997). Meta-analytical research suggests that positive forms of religiosity (e.g., intrinsic religiosity and positive religious coping) decrease distress (Smith, McCullough, & Poll, 2003). With regard to CSA, there is some evidence that religion can moderate the development of Axis I disorders among survivors of CSA (Walker et al., 2009).

However, it is widely recognized that religion and spirituality can also have a negative influence on psychological functioning (see Exline & Rose, 2005 for a review). For example, religious coping may take a negative form, including anger at God, passive religious deferral (e.g., not doing anything and expecting God to solve one's problems), religious doubts, and interpersonal religious struggles (Pargament, Smith, Koenig, & Perez, 1998). Thus, while religion generally correlates with decreased

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psychological distress, spiritual struggles such as religious doubt and change are related to increased distress (Ano & Vasconcelles, 2005; Smith et al., 2003).

The vast majority of these studies have been cross-sectional (Paloutzian, Richardson, & Rambo, 1999), and the long-term outcome of spiritual struggles remains unclear. For example, spiritual struggles may lead to religious transformations with long-term positive effects (James, 1902). This may be particularly apparent where traumatic events, such as CSA, have damaged existing beliefs, since spiritual struggles leading to the transformation of these damaged beliefs may be beneficial. As suggested by cognitive therapies for traumatic stress (Resick et al., 2008), recovery from trauma-related psychopathology includes reinterpretation of the event and restructuring of trauma-induced cognitions. Religious change may be an important avenue through which some survivors of CSA transform distressful beliefs about the world and themselves.

The current research aimed to address the limitations of previous research by exploring CSA, religious change, and depressive symptoms over a two-year period. Although the terms religion and spirituality often have distinct meanings—spirituality a broad term encompassing anything regarded as sacred, and religion a specific term referring to culture-based forms of relating to the sacred (Hill & Pargament, 2003)—the current study uses both terms loosely, reflecting the broad measures utilized to measure religious and spiritual change. The study was conducted among older adolescents in foster care, as recent research suggests that adolescence may be a particularly sensitive period for enduring religious change and development (Good & Willoughby, 2008). Our hypotheses were twofold. First, we predicted that youth with a history of CSA would report greater religious change over the study period. Second, we predicted that religious changes would increase depression among youth without a history of CSA (reflecting spiritual struggles), while among CSA survivors, depression would decrease as they transform beliefs to more adaptive views.

Method

Participants

Participants were 407 youths in foster care residing in Missouri, 178 (44%) males and 226 (56%) females, ranging in age from 16 to 17 years ($M = 16.33$, $SD = .47$) at Time 1. Ethnicity varied with 1% ($n = 3$) American Indian, 51% ($n = 206$) African-American, 44% ($n = 178$) Caucasian, and 4.1% ($n = 12$) Other. Average age of entry to foster care was 10.85 years ($SD = 4.48$), and average length of current placement was 20.5 months ($SD = 36.91$). Current living situations included 8% residing with their biological parent(s) after a stay in out-of-home care, 19% in kin foster care, 29% in non-kin family foster care, 41% in congregate care, and 3% in semi-independent living situations. Religious affiliation at Time 1 included 7.7% ($n = 31$) Catholic, 53.7% ($n = 217$) Protestant, 2% ($n = 1.2$) Muslim, 31.7% ($n = 128$) None, and 6.7% ($n = 27$) Other.

Procedure

The current study analyzed data from the Mental Health Service Use of Youth Leaving Foster Care Survey (McMillen, 2010) conducted from December 2001 to May 2003. The Missouri Children's Division identified 647 youth in their custody who resided in one of eight Missouri counties and were turning 16 years and nine months of age (see Larrabee-Warner and McMillen (2010) for a full description). Approximately 30% of these youths were excluded from the study because they (a) were no longer in custody; (b) had a reported IQ below 70; (c) did not speak English; (d) lived outside the study area; or (e) had runaway status. Of the resulting 451 (70%) youths, 39 (8%) declined to participate, 4 (1%) could not be contacted, and one interview was not completed, resulting in a final sample of 407 youths. Interviews were conducted near each youth's 17th birthday (Time 1) and again 24 months later (Time 2) at their residence. Although phone interviews were conducted in the intervening period, religious variables were only assessed in the initial and final interviews, and the current study used data from those waves exclusively. Wherever statistically feasible, missing data was imputed using IVEware (Raghunathan, Solenberger, & Van Hoewyk, 2002). Missing data unable to be imputed was deleted case-wise for each analysis. The Human Subjects Committee of Washington University's Institutional Review Board approved all procedures. Consent was provided by each youth's custodial case manager and the youths assented to participate.

Measures

Childhood sexual abuse. History of sexual abuse was assessed through three previously used items (Auslander, McMillen, Elze, Thompson, Jonson-Reid, & Stiffman, 2002), which read: (a) "Has anyone ever made you touch their private parts, against your wishes?" (b) "Has anyone ever touched your private parts (breasts or genitals) against your wishes?" and (c) "Has anyone ever had vaginal sex, oral sex, or anal sex with you against your wishes?" Youths who responded "yes" to any of these were defined as having a history of CSA, and youths who responded "no" to all three were defined as having no history of CSA.

Religious affiliation. At Time 1 and Time 2, youths were asked, "What is your religious preference?" Response choices were Catholic, Protestant, Jewish, Muslim, None, or Other. They were then assigned a religious change category based on the discrepancy between their affiliation at Time 1 and Time 2. Those reporting identical affiliations at each time were assigned to either "remained religious" or "remained irreligious," while those reporting different affiliations were assigned to one of three change categories: "none to religion," "religion to none," and "religion to religion."

Religious belief. Belief was measured using the Multidimensional Measure of Religiousness/Spirituality (Fetzer Institute & National Institute on Aging, 1999). It contained seven items rated on a four-point scale ranging from *strongly disagree* to *strongly agree*. Items included "I

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Table 1

Model 1: Religious affiliation change, CSA, and depressive symptoms

Variable	Step 1			Step 2			Step 3		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Time 1 Depressive Symptoms	.32***	.04	.37	.32***	.04	.36	.32***	.04	.36
CSA	.16	.26	.03	.14	.25	.03	.11	.27	.02
Religious change									
Change vs. no change				.76***	.19	.19	.57**	.20	.14
Change: to R ¹ vs. to N ²				.02	.24	.01	.07	.24	.01
Change: N to R vs. R to R				-.91*	.42	-.10	-.73	.43	-.08
Remaining: R vs. N				-.01	.33	-.002	-.24	.36	-.04
Religious change X CSA									
Change vs. no change							-.53**	.20	-.14
Change: to R vs. to N							.14	.24	.03
Change: N to R vs. R to R							.66	.43	.07
Remaining: R vs. N							-.44	.36	-.07
ΔR^2	.14	.18	.02						
<i>F</i> for ΔR^2	31.90***	6.13***	2.66*						

Note. ¹R = religion; ²N = none; * $p < .05$; ** $p < .01$; *** $p < .001$.

have faith in a power greater than me” and “I am not a religious person.” Internal consistency was adequate (Time 1 $\alpha = .87$, Time 2 $\alpha = .87$).

Depressive symptoms. Depressive symptoms were measured using the Depression-Arkansas Scale, which has demonstrated adequate reliability and validity in previous studies in adult samples (Smith et al., 2002; Walter, Meresman, Kramer, & Evans, 2003). It consists of 11 items, drawn from DSM-IV-TR criteria for depression, that asked how often youths experienced depressive symptoms on a four-point scale ranging from “not at all” to “nearly every day for at least 2 weeks.” Items were summed to form a continuous measure of depressive symptoms (Time 1 $\alpha = .84$, Time 2 $\alpha = .81$).

Statistical Analysis

To examine the relationship between CSA and religious change, a chi-square test was conducted comparing those with a history of CSA to those without a history of CSA on the religious affiliation change categories described above. An independent groups t-test comparing these groups on mean change in religious beliefs over the study period was also conducted. Because change scores in opposite directions may average out, squared change in religious beliefs was also examined. To assess the relationship between religious change and depression, we conducted a hierarchical regression predicting depression at Time 2, controlling for depressive symptoms at Time 1. Model 1 included change in affiliation, CSA, and interaction terms. Model 2 assessed change in religious beliefs (linear and quadratic), CSA, and interaction terms. Model 3 was a combined model that

included both change in religious affiliation and belief, CSA, and interaction terms.

Results

Change in self-reported religious affiliation was common in the sample (45%, $n = 171$), with 15% ($n = 58$) reporting a change of “none to religion,” 12% ($n = 45$) reporting a change of “religion to none,” and 14% ($n = 68$) reporting a change of “religion to religion.” Many youths also reported variation in the strength of religious beliefs with 313 (79.8%) reporting a change of less than 1 *SD*, 49 (12.5%) reporting a change of 1-2 *SDs*, and 21 (21%) reporting a change of greater than 2 *SDs*. Preliminary analyses comparing youths reporting a history of CSA ($n = 138$, 35%) to youths reporting no history of CSA ($n = 254$, 65%) revealed that religious affiliation at Time 1 ($\chi^2(4, N = 388) = 3.14, p = .55$) and mean religious belief over the two time-periods ($t(391) = 1.71, p = .19$) did not differ significantly between these groups. Zero-order correlations between religious belief and depression at Time 1 were not significant ($r = .01, p = .73$). However, consistent with previous research, higher religious *belief* at Time 2 was significantly correlated with lower depression at Time 2 ($r = -.12, p = .02$) while religious *affiliation* was unrelated to both depression at Time 1 ($t(390) = 0.61, p = .54$) and 2 ($t(390) = 1.60, p = .11$).

With regard to Hypothesis 1, results indicated that affiliation change ($\chi^2(4, N = 388) = 2.32, p = .68$), change in belief ($t(392) = 0.18, p = .86$), and squared change ($t(392) = 0.71, p = .48$) were unrelated to CSA. This suggests that, contrary to our predictions in Hypothesis 1, CSA may be unrelated to religious change. Hierarchical regression testing

Table 2

Model 2: Religious belief change, CSA, and depressive symptoms

Variable	Step 1			Step 2			Step 3		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Time 1 Depressive Symptoms	.33***	.04	.37	.32***	.04	.36	.33***	.04	.37
CSA	.16	.26	.03	.22	.25	.04	.52	.29	.10
Change in beliefs (linear)				-.26	.22	-.06	-.20	.24	-.04
Change in beliefs (quadratic)				.51***	.14	.17	.39*	.15	.13
CSA x beliefs (linear)							.05	.24	.01
CSA x beliefs (quadratic)							-.31*	.15	-.12
ΔR^2	.14	.03	.01						
F for ΔR^2	31.88***	7.56***	4.18*						

Note. * $p < .05$; ** $p < .01$; *** $p < .001$.

Hypothesis 2 indicated that changes in religious affiliation from Time 1 to 2 were related to increased depressive symptoms, but CSA significantly moderated this relationship (Model 1, Table 1). A plot of predictions (Figure 1) and post-hoc tests suggested that among youth with a history of CSA, religious change was unrelated to depressive symptoms ($B = .04, t(370) = 0.12, p = .90$). In contrast, among youth with a history of CSA, change in religious affiliation was associated with increased depressive symptoms ($B = 1.10, t(370) = 4.78, p < .001$). Categories of change (e.g., “none to religion,”

“religion to none”) did not differ significantly on depressive symptoms, suggesting that the impact was equivalent regardless of the direction of religious changes.

Model 2 examined the influence of change in belief on depressive symptoms at Time 2, controlling for depressive symptoms at Time 1. Results indicated that change in religious belief was quadratically related to depressive symptoms (Table 2), such that those with the greatest change (positive or negative) reported increased depressive symptoms at Time 2 (Figure 2). This was moderated by CSA

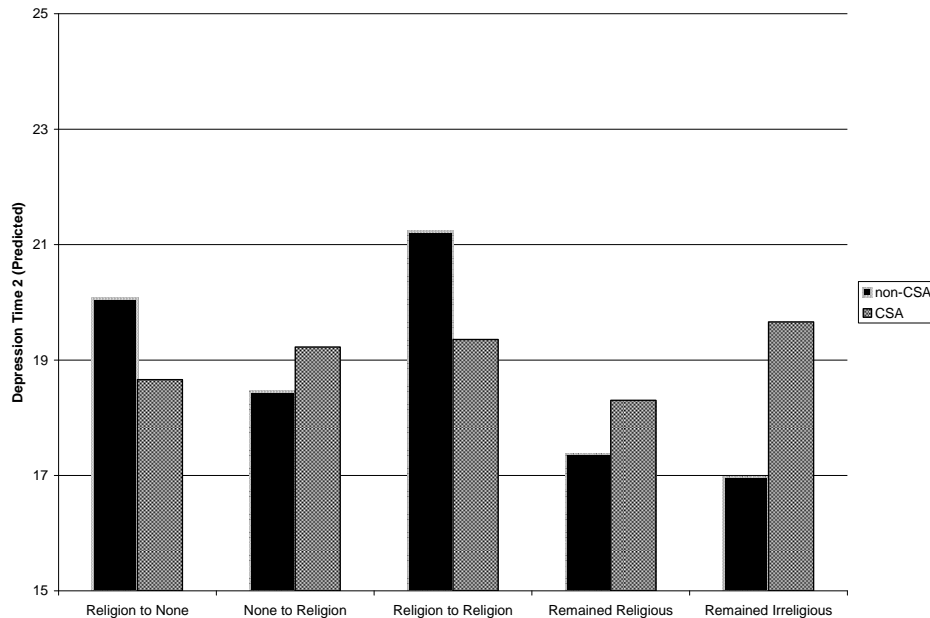


Figure 1. Depression at Time 2 by CSA and Religious Affiliation Change

Note. Adjusted for depression at Time 1.

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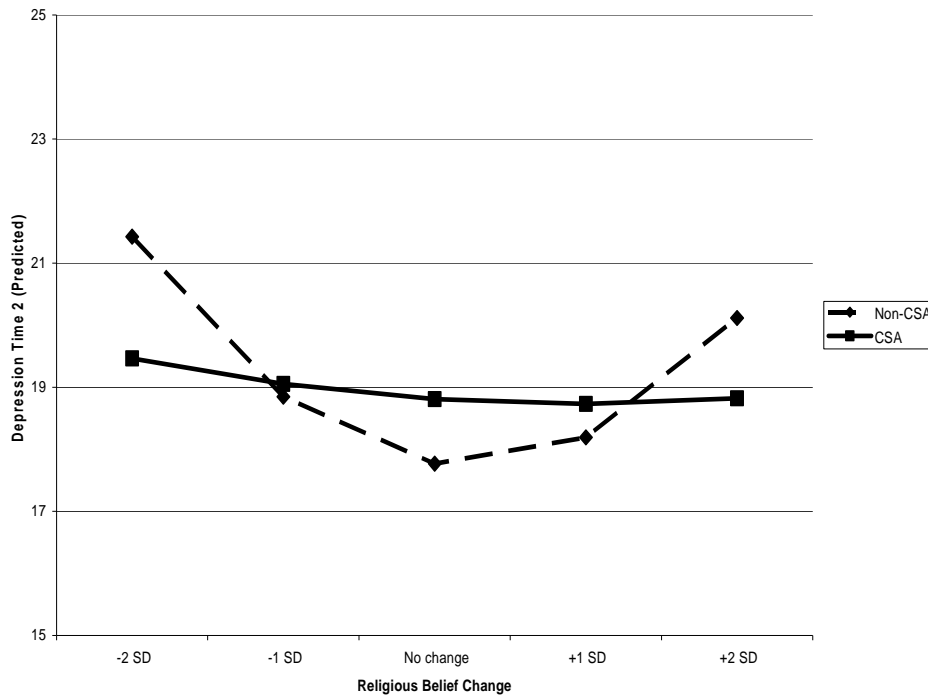


Figure 2. Depression Symptoms at Time 2 by Change in Religious Beliefs and CSA

Note. Adjusted for depression at Time 1.

history. That is, for youth without CSA, change in religious beliefs (quadratic) was related to significantly increased depression at Time 2 ($B = .70$, $t(386) = 4.13$, $p < .001$), while among youth with CSA these were unrelated ($B = .08$, $t(386) = 0.31$, $p = .76$).

The results of Model 3 indicated that religious belief and affiliation remained significant predictors of depression even controlling for each other's effect. In terms of interactions between changes in affiliation and changes in belief, increased religious beliefs among those who changed affiliation from "religion to none" was significantly related to sharply increased depression ($B = .96$, $t(364) = 3.36$, $p = .001$). No other interactions were significant, including three-way interactions with history of CSA ($\Delta R^2 = .01$, $F(8, 352) = 0.56$, $p = .85$). In summary, results indicated that religious change of any type was related to increased depression among youths without a history of CSA, but was unrelated to depression among youth with a history of CSA.

Discussion

Research suggests that CSA relates to both increased and decreased religiosity and spirituality (Falsetti et al., 2003; Walker et al., 2009). However, these studies have been primarily retrospective, and CSA can have bi-directional influences on religion and spirituality. Therefore, only examining the average level of religiosity in those with and without CSA likely obscures important changes.

Furthermore, the impact of religious change on psychological functioning remains unclear. The current research therefore explored CSA, religious change, and depressive symptoms among foster-care youth over a two-year period. We hypothesized that youth with a history of CSA would report greater religious change over the study period, as compared to youth without a history of CSA (Hypothesis 1). We also expected that these changes would relate to increased depressive symptoms among youth without CSA and decreased symptoms among those with CSA (Hypothesis 2).

Contrary to expectations, in the present study, youths with a history of CSA were no more likely than those without a history of CSA to report changes in religious affiliation or belief over the study period. This suggests that CSA does not systematically influence religious change. However, our sample was comprised of older foster care youths who were transitioning from foster care to independent living, and there was a high degree of religious change in the entire sample (47% reported change in affiliation, and 21% reported changes of at least 2 SDs in religious belief). Consequently, the specific impact of CSA may not be apparent in youth experiencing such high levels of environmental changes. In addition, only superficial measures of religiosity (affiliation and belief) were available, and these may not capture more nuanced changes in religion and spirituality resulting from CSA (Gall, Basque, Damasceno-Scott, & Vardy, 2007). Furthermore, the age at which CSA occurred was not reported and important religious changes may have occurred prior to

the collection of Time 1 data. The nature and timing of CSA may alter its influence as well, as repeated sexual abuse at an early age may have very different effects on religious development and change than a single isolated incident at age 16.

The present study results further suggest that among youth without a history of CSA, change in religious affiliation and beliefs was associated with increased depressive symptoms, likely reflecting spiritual and religious struggles (Exline & Rose, 2005). This was equally true of those experiencing an increase or decrease in religious belief and of those relinquishing or acquiring an affiliation. Inconsistent changes, such as increased belief and affiliation change from “religion to none,” were related to sharply increased depression. These results parallel previous cross-sectional findings (Exline & Rose, 2005) and suggest that religious change is related to increased distress longitudinally. This may be due to intra-psyche factors such as loss of meaning (Park, 2005), insecure attachment to God (Kirkpatrick, 2005), or negative religious coping (Pargament, 1997), or may reflect psychosocial changes such as loss of religious social support and community (Putnam, 2009). In contrast, for youth with a history of CSA, religious changes were unrelated to depressive symptoms, perhaps because, as hypothesized, religious change included positive transformations of their meaning-system (Park, 2005). Further research should consider using prospective longitudinal designs and statistical techniques such as growth modeling (e.g., Bonnano et al., 2002) that allow consideration of individual trajectories and the nuanced processes supported by our results.

Beyond theoretical implications and directions for future research, these findings have applications in the treatment of youth with a history of CSA. In particular, religious and spiritual change, although potentially distressful to caregivers and involved adults, may be a normative and health-promoting process of transformation that can have positive mental health consequences and may be a component to healing from trauma. Consequently, foster parents, caseworkers, parole officers, and clergy should support and encourage youth to adjust their meaning system in adaptive ways. Moreover, explicit incorporation of religious, spiritual, and existential themes in psychotherapeutic treatment of CSA survivors may be indicated and helpful.

However, although the study of the relationship between religion and mental health has generated considerable recent interest (e.g., Smith et al., 2003), integrating religious and spiritual struggles into treatment presents challenges, since individuals may be hesitant to bring these issues to professionals (Pirutinsky, Rosmarin, & Pargament, 2009), and clinicians receive little training (Walker, Gorsuch, & Tan, 2004) and can be reluctant to explore these issues (Turner-Essel & Waehler, 2009). One possible reason for this gap is the lack of empirical research integrating spiritual struggles into current conceptualizations of mental illness and clinical treatment (Pirutinsky, Rosmarin, Pargament, & Midlarsky, 2011). There is, however, a small body of research

demonstrating that positive aspects of religion and spirituality can be successfully integrated into existing treatments (e.g., McCullough & Larson, 1999), suggesting that negative aspects of spirituality can be similarly addressed.

One promising treatment for this integration in the context of childhood sexual abuse is Cognitive Processing Therapy (CPT; Resick, Monson, & Rizvi, 2008). The fundamental focus of this treatment is to reintegrate prior beliefs and new beliefs, thereby reconstructing a coherent and positive worldview. To achieve these aims, TFP incorporates a number of techniques. First, patients are asked to write an impact statement focusing on how the traumatic event has impacted their beliefs about themselves and others. This statement is used to conceptualize how the event has led to distorted or overgeneralized attributions of meaning. These faulty ideas are then challenged through Socratic questioning, disputing thoughts, worksheet exercises, and the development of alternative, more balanced beliefs. Religious struggles and doubts involve similar processes whereby an individual’s previous worldview is challenged and disturbed in some way, resulting in distress. Similar techniques such as writing down the implications of these changes in worldview, identifying distorted or exaggerated conclusions, challenging these ideas, and developing more balanced and integrated alternatives, may be a fruitful avenue to address trauma-related religious and spiritual doubts, struggles, and transformations.

Limitations

This research has several limitations. There were no prospective pre-CSA reports on religion or depressive symptoms available, and information concerning the nature of CSA (e.g., age of occurrence, repetition, violence, perpetrator identity) was not available. It also relied on cursory measures of religiosity, which may not reflect the particular beliefs, behaviors, and emotions relevant to CSA and mental health. Furthermore, spirituality, conceptualized as any manner of relating to the sacred, can be distinct from culture-based religiosity (Hill & Pargament, 2003), and the measures utilized did not fully explore these constructs. Future research should utilize more nuanced and proximal measures of religiosity and spirituality. In addition, the sample was subject to an overall high degree of stress and change, and those disruptions may have been confounded with religious change. However, given the difficulty of conducting longitudinal research of this type, these data give a much-needed glimpse into the impact of CSA and religious change on youth. As discussed above, further carefully designed research appears warranted and necessary.

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