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Religious Coping as a Moderator of the Relationship Between Stress and Depressive Symptoms

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This study examined whether religious coping (positive and negative) prospectively moderated the relationship between stress and depressive symptoms in young adults. Religious commitment was examined as a potential moderator of the effect of religious coping on the stress-depression relationship. Participants were 320 undergraduates from a small, private Christian university who reported weekly fluctuations in stress and depressive symptoms across an 8-week diary study. Data were analyzed using hierarchical linear modeling. Results indicated that negative religious coping moderated the relationship between stress and depression, but only for those who reported high levels of religious commitment. We found no evidence for positive religious coping as a buffer against the effects of stress on depressive symptoms.

Keywords: religious coping, stress, depression

Depressive symptoms and diagnoses increase markedly during adolescence and early adulthood, with 11.7% of Americans experiencing a major depressive episode by age 22 (Shanahan, Copeland, Costello, & Angold, 2011). Although exposure to stress predicts onset and course of depression (Kendler, Karkowski, & Prescott, 1999), contemporary cognitive–behavioral theories of depression hold that individual differences in the experience of and response to stress increase the risk of experiencing depressive symptoms (Abela, Aydin, & Auerbach, 2006; Hankin, Abramson, Miller, & Haeffel, 2004; Hyde, Mezulis, & Abramson, 2008). According to these theories, many factors that influence the development of depression do so by moderating the stress–depression relationship, either by buffering or exacerbating the effects of stress.

One factor that may influence the relationship between stress and depression is religiosity. There has been a recent increase in research on the impact of religiosity on mental health (Ano & Vasconcelles, 2005; Carpenter, Laney, & Mezulis, 2012; Davis, Ashby, McElroy, & Hook, 2014; Hall & Flanagan, 2013; Rasic, Kisely, & Langille, 2011; Sternthal, Williams, Musick, & Buck, 2010; Taylor, Chatters, & Abelson, 2012) with an emerging attention on religious coping strategies. Religious coping strategies refer to spiritual and religiously based cognitive, behavioral, and interpersonal responses to stressors (Pargament, Smith, Koenig, & Perez, 1998). Research indicates there are both positive and negative religious coping strategies that differentially impact an individual's mental health (Pargament, Feuille, & Burdzy, 2011; Pargament et al., 1998; Ramirez et al., 2012). Although religious coping has been consistently linked with mental health, few studies have examined religious coping as a moderator of the relationship between stress and depression in a prospective study (Carpenter et al., 2012; Pirutinsky, Rosmarin, Pargament, & Midlarsky, 2011). Additionally, there is evidence that the benefits of religious coping in response to stress may differ for those with higher levels of religious commitment relative to those with lower levels of religious commitment (Eliassen, Taylor, & Lloyd, 2005). The current study examines positive and negative religious coping as moderators of the effects of stress on depressive symptoms in an 8-week prospective study among young adults. Furthermore, we assess religious commitment as a moderator of the effect of religious coping on the stress–depression relationship.

Positive and Negative Religious Coping

Pargament et al. (1998) presented a framework for organizing the spiritually based cognitive and behavioral responses to stress that have protective or maladaptive consequences on mental health. Positive religious coping includes beliefs that God or one's high power will use the experience to strengthen one's faith, seeking help from clergy or spiritual support from others, and engaging in religious helping. In contrast, negative religious coping strategies are marked by beliefs of a hostile higher power and disconnect from one's religious community. Despite the similarities of these religious coping strategies with nonreligious coping behaviors, research indicates that religious coping accounts for unique variance in the outcomes following life stressors (Pargament, Koenig, & Perez, 2000).

Research on the effects of positive and negative religious coping on mental health has yielded results generally in the expected directions (Ano & Vasconcelles, 2005). Positive religious coping is significantly related to both increased positive adjustment (Lee, Nezu, & Nezu, 2014) and decreased negative adjustment (Gardner, Krägeloh, & Henning, 2014), whereas negative religious coping is associated with negative adjustment (Gardner et al., 2014; Lee et

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al., 2014). However, one of the limitations of the current religious coping and depression literature is the predominance of cross-sectional studies (Carpenter et al., 2012). Only recently has research emerged on prospective relationship between religious coping and depression, with findings in the expected directions (Bjorck & Thurman, 2007; Pirutinsky et al., 2011; although see Bryant-Davis, Ullman, Tsong, & Gobin, 2011). Despite the increase of prospective analyses of religious coping, few have investigated religious coping as a moderator of the stress–depression relationship prospectively (Carpenter et al., 2012).

Extant research on religious coping is limited in the scope of outcomes examined. A substantial portion of the research has examined religious coping as a predictor of adjustment to traumatic events (Feder et al., 2013; Henslee et al., 2014; Leaman & Gee, 2012; Smith, Pargament, Brant, & Oliver, 2000; Thomas & Savoy, 2014) and medical stress (Peterman, Fitchett, Brady, Hernandez, & Cella, 2002; Schreiber & Brockopp, 2012; Vallurupalli et al., 2012; Woods, Antoni, Ironson, & Kling, 1999). However, research suggests that community samples may adopt different religious coping patterns than clinical or medical participants (Koenig, Pargament, & Nielsen, 1998). Additionally, it may be that the magnitude of stress experienced in response to traumatic events or medical diagnoses responds differently to religious coping behaviors than the experience of comparatively minor, albeit frequent, hassles. Prospective research that examines the effect of religious coping within the range of normal stressors may shed light on the cumulative effect of individual's exposure to stress and their implementation of religious coping strategies.

Level of Religious Commitment as a Moderator

The effect of religious coping on the stress–depression relationship may itself be moderated by other factors, including individual difference in religious commitment. Individuals high in religious commitment, as evidenced by their engagement in religious activities such as prayer and attendance of religious services, may be particularly likely to be influenced by their religious coping style. Indeed, studies have demonstrated the differential impact of religious behaviors on depression as dependent on the level of religious commitment (Eliassen et al., 2005; Carpenter et al., 2012) or importance (Agishtein et al., 2013). However, Carpenter et al. (2012) note the variety of ways in which religious commitment can and has been measured, and the differing effects observed. These authors highlight the potential limitations of assessing commitment using self-reported affirmations of religious importance in contrast to reports of religious behaviors one has engaged in. We hypothesized that effects of positive or negative religious coping on depression would depend on the frequency with which individuals engage in religious activities, such that the effects of religious coping on depression outcomes should be strongest for those with high religious commitment.

The Current Study

The current study examined the impact of positive and negative religious coping on the stress–depression relationship in a private Christian university sample using a prospective study design. We hypothesized that positive religious coping would buffer individuals from the effects of stress, while negative religious coping would exacerbate the stress–depression relationship. Moreover, we hypothesized that the differences in religious commitment would moderate the effects of religious coping such that greater commitment would amplify the effects of both types of religious coping.

Method

Participants

Participants were 320 (71% female) undergraduate students recruited from a small, private Christian liberal arts university in the Pacific Northwest. Participants were at least 18 years old, with a mean age of 19.08 ($SD = 2.10$). Approximately 70% identified as Caucasian, 16% as Asian, 5% as Hispanic/Latino, 3% African American, 1% Native American, and 5% identified as another ethnicity. Participants received course credit for their involvement in the study. Importantly, although the university identifies itself as Christian, it does not require students to be affiliated with a religion. Furthermore, there is no requirement for worship service attendance or bible study participation. Thus, participants' endorsement of religious behaviors may not be conflated with institutional demands and active or passive exposure to religious behaviors in a classroom.

Procedure

Participants were recruited from undergraduate psychology courses to complete an 8-week prospective diary study. At week 1, participants completed a baseline set of questionnaires that included measures of positive and negative religious coping, participation in religious behaviors, and depressive symptoms. Each week for 7 consecutive weeks, participants completed online questionnaires in which they reported exposure to stress and their current depressive symptoms. Participants completed each weekly assessment during a 48-hr window to maintain an interval of approximately 1 week between assessments. All participants completed the initial questionnaire and at least one weekly questionnaire. Study retention was excellent. The average number of weekly assessments completed was 6.53 out of a possible 7. In total, 71.9% (230) of participants completed all seven weekly assessments, 19.1% (61) completed six assessments, 4.7% (15) completed five assessments, 1.6% (5) completed four assessments, and 2.8% (9) completed three or fewer assessments. Missing data analyses in Statistical Package for the Social Sciences (SPSS) 22 indicated that 4.32% total missing data were missing completely at random (MCAR), as determined by a nonsignificant Little's MCAR test result, $\chi^2(248) = 258.24$, $p = .314$.

Measures

Religious coping. Positive and negative religious coping were measured at baseline using the Brief RCOPE (Pargament et al., 1998), which consists of 14 items describing positive and negative religious coping responses. Participants were asked to indicate how typically they use each coping response when faced with stressful events using a 5-point Likert scale (1 = *not at all,* 5 = *a great deal*). The positive subscale consists of seven items reflecting seven coping strategies, such as benevolent religious reapprais-

als, collaborative religious coping, and seeking spiritual support. A sample positive item is "tried to see how God or a higher power might be trying to strengthen you in a situation." The remaining seven items were used to assess negative religious coping strategies, such as spiritual discontent, punishing God reappraisal, and demonic reappraisal. A sample negative item is "wondered whether my church abandoned me." Responses were summed to create composite scores for positive and negative religious coping. Internal consistencies were high for both positive religious coping ($\alpha = .94$) and negative religious coping ($\alpha = .89$).

Religious commitment. Religious commitment was measured using the formal practices subscale of the Religious Background and Behaviors Questionnaire (RBB; Connors, Tonigan, & Miller, 1996). The formal practices subscale consists of six items that assess an individual's frequency of engaging in religious behaviors over the past year (e.g., "in the past year how often have you prayed?" or "in the past year how often have you attended worship service?"). Participants were asked to indicate, on average, how often they engaged in each behavior on a 7-point Likert scale (0 = *never*, 3 = *twice a month*, 7 = *more than once a day*). Higher scores indicate greater levels of religious commitment. Internal consistency has been found to be high in prior studies (Connors et al., 1996); in our study, the internal consistency was $\alpha = .87$.

Stressful life events. Stressful life events were measured weekly using the Negative Events Scale—University (NES-U; Maybery, 2004), a 25-item scale measuring the occurrence of negative events common to a university population (e.g., "had a disagreement (including arguments) with a friend" or "did not get the grades you expected"). Participants indicated for each event whether it had occurred in the past week. The number of stressors for each participant was totaled for each week.

Depressive symptoms. Depressive symptoms were measured at baseline, and the following seven weeks using the Center for Epidemiological Studies Depression Scale Short Form (CES-D SF; Martens et al., 2006), which is a 9-item measure of depressive symptoms. Each week participants rated how they felt and behaved over the past week. Responses ranged from 0 (*rarely or none of the time*) to 3 (*most or all of the time*) for items such as, "I was hopeful about the future" and "I felt lonely." A total score was calculated ranging from 0 to 27, with higher values indicating greater depressive symptoms. In the current study, the alpha coefficients ranged from $\alpha = .84$ to $\alpha = .87$.

Results

Data Analytic Plan

Multilevel modeling in HLM 7 (Raudenbush, Bryk, Cheong, Congdon, & du Toit, 2011) was used to examine whether positive and/or negative religious coping moderated the effect of stress on depressive symptoms across the study period. Furthermore, we tested the moderating effect of religious commitment on each religious coping moderator. HLM allows for the analysis of nested variables within a multiwave design and for greater flexibility with missing data. For example, although participant retention across weeks was excellent, a participant missing a week can be retained in the overall model analysis rather than excluded through listwise deletion.

Our first set of analyses examined positive and negative religious coping as moderators of the stress–depression relationship. The dependent variable was depressive symptoms, and stress was included in the level 1 equation as a time-varying covariate to represent the main effect of weekly stress on weekly depressive symptoms over time. Religious coping was entered in level 2 as a between-subjects moderator, and baseline depression was entered as a covariate. An example equation for negative religious coping (NRC) is shown here:

Level 1:

$$Depression_{ij} = \beta_{0j} + \beta_{1j}(\text{Time}) + \beta_{2j}(\text{Stress}) + r_{ij}$$

Level 2:

$$\beta_{0j} = \gamma_{00} + \gamma_{01}(\text{CES} - \text{D baseline}) + \gamma_{02}(\text{NRC}) + u_{0j}$$
$$\beta_{1j} = \gamma_{10} + \gamma_{11}(\text{NRC}) + u_{1j}$$
$$\beta_{2j} = \gamma_{20} + \gamma_{21}(\text{NRC}) + u_{2j}$$

Finally, we examined the interaction between religious coping strategy and religious commitment. For example, the final model for religious commitment (RC) as a moderator of the interaction between negative religious coping and stress was as follows:

Level 1:

$$Depression_{ij} = \beta_{0j} + \beta_{1j}(\text{Time}) + \beta_{2j}(\text{Stress}) + r_{ij}$$

Level 2:

$$\beta_{0j} = \gamma_{00} + \gamma_{01}(\text{CES} - \text{D baseline}) + \gamma_{02}(\text{NRC}) + u_{0j}$$
$$\beta_{1j} = \gamma_{10} + \gamma_{11}(\text{NRC}) + u_{1j}$$
$$\beta_{2j} = \gamma_{20} + \gamma_{21}(\text{NRC}) + \gamma_{22}(\text{RC})\gamma_{23}(\text{NRC} \times \text{RC}) + u_{2j}$$

Preliminary Analyses

Means, standard deviations, and correlations among study variables are reported in Table 1. Score for both positive and negative religious coping ranged from 0–21. In line with previous research, participant means indicated a substantially larger use of positive religious coping strategies than negative religious coping strategies (Gaston-Johansson, Haisfield-Wolfe, Reddick, Goldstein, & Lawal, 2013; Lee, Roberts, & Gibbons, 2013; Pargament, Koenig, Tarakeshwar, & Hahn, 2004; Webb et al., 2010). Levels of commitment ranged from 0–42, and both the mean and standard deviation were consistent with findings in other demographically diverse samples (Hawes & Berkley-Patton, 2014; Hoeppner, Hoeppner, & Kelly, 2014). Age and gender were nonsignificant covariates and therefore were excluded from further analyses. As expected, a main effect of stress on depressive symptoms was observed. Stress and depressive symptoms covaried significantly over time such that participants who reported increased stress across the study also reported more depressive symptoms (see Table 2).

Does Positive Religious Coping Moderate the Stress–Depression Relationship?

Contrary to our hypothesis, positive religious coping did not moderate the effect of stress on depressive symptoms (see Table 3). Interestingly, however, positive religious coping moderated the

Table 1
Means, SDs, and Intercorrelations

	M	*SD*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1. Sex	—	—	—																		
2. Age	19.08	2.10	—	—																	
3. PRC	13.54	6.46	0.15**	−0.80	—																
4. NRC	4.70	4.96	0.05	−0.06	0.13*	—															
5. RC	22.70	9.08	0.11*	−0.9	0.74**	0.02	—														
6. CES-D W1	7.09	5.01	0.15**	0.01	−0.06	0.18**	−0.11*	—													
7. CES-D W2	6.99	5.37	0.09	−0.03	−0.09	0.12*	−0.14**	0.64**	—												
8. CES-D W3	6.54	4.95	0.09	0.00	−0.09	0.29**	−0.16**	0.55**	0.64**	—											
9. CES-D W4	6.24	5.05	0.05	−0.02	−0.12*	0.15**	−0.20**	0.59**	0.60**	0.64**	—										
10. CES-D W5	6.21	4.83	0.13*	0.05	−0.16**	0.13*	−0.24**	0.56**	0.59**	0.59**	0.66**	—									
11. CES-D W6	6.20	4.78	0.14*	0.00	−0.11*	0.18*	−0.17**	0.51**	0.55**	0.56**	0.57**	0.61**	—								
12. CES-D W7	6.53	5.18	0.09	0.06	−0.08	0.22**	−0.15*	0.55**	0.49**	0.55**	0.58**	0.58**	0.62**	—							
13. CES-D W8	5.85	5.04	0.07	0.11*	−0.14*	0.15*	−0.21**	0.45**	0.50**	0.54**	0.57**	0.58**	0.60**	0.69**	—						
14. Stressors W2	7.05	3.04	0.05	−0.09	−0.07	0.11	−0.13*	0.22**	0.32**	0.21**	0.30**	0.25**	0.25**	0.29**	0.22**	—					
15. Stressors W3	6.95	3.07	0.10	−0.10	−0.05	0.11	−0.07	0.15**	0.20**	0.25**	0.19**	0.12*	0.23**	0.20**	0.22**	0.44**	—				
16. Stressors W4	6.55	3.34	0.09	−0.04	−0.09	0.13*	−0.10	0.31**	0.30**	0.29**	0.39**	0.25**	0.25**	0.27**	0.29**	0.46**	0.53**	—			
17. Stressors W5	6.06	3.29	0.09	−0.03	−0.07	0.13*	−0.14*	0.27**	0.21**	0.22**	0.26**	0.24**	0.20**	0.26**	0.22**	0.47**	0.51**	0.61**	—		
18. Stressors W6	5.71	3.61	0.12*	−0.01	−0.08	−0.01	−0.13*	0.21**	0.16**	0.18**	0.19**	0.21**	0.24**	0.21**	0.23**	0.40**	0.46**	0.57**	0.62**	—	
19. Stressors W7	5.55	3.64	0.08	−0.03	0.00	0.02	0.02	0.17**	0.16**	0.15*	0.16**	0.13*	0.14*	0.23**	0.21**	0.45**	0.41**	0.53**	0.56**	0.67**	—
20. Stressors W8	6.02	3.52	0.03	−0.03	−0.13*	0.09	−0.13*	0.17**	0.14*	0.23**	0.19**	0.16**	0.16**	0.20**	0.27**	0.48**	0.44**	0.54**	0.54**	0.55**	0.67**

Note. PRC = positive religious coping; NRC = negative religious coping; RC = religious commitment; CES-D = Center for Epidemiological Studies—Depression Scale short form.
* $p \leq .05$. ** $p \leq .01$.

Table 2
Model Predicting Depressive Symptoms as a Function of Time and Stress

	Estimate (*SE*)	*t*	*p*
CES-D			
Intercept (β_0)	5.3297 (.34)	15.74	<.001
Week (β_1)	−0.0805 (.04)	−2.29	.022
Stress (β_2)	0.2178 (.03)	7.27	<.001

Note. CES-D = Center for Epidemiological Studies Depression Scale short form.

intercept of depressive symptoms at baseline such that participants reporting greater levels of positive religious coping had lower levels of baseline depressive symptoms, coefficient = −0.10, $t = -2.04$, $p < .05$. This suggests that although positive religious coping did not buffer against the effects of stress, it may still serve as a protective factor for depressive symptoms. Religious commitment did not moderate the effect of positive religious coping on the stress–depression relationship (see Table 3).

Does Negative Religious Coping Moderate the Stress–Depression Relationship?

Consistent with our hypothesis, negative religious coping moderated the effects of stress on depression, but only when this effect was itself moderated by the level of religious commitment (see Table 4). To interpret this interaction, we used a median split of

Table 3
Multilevel Models Predicting Depressive Symptoms as a Function of Stress, Positive Religious Coping, and Religious Commitment

	Estimate (*SE*)	*t*	*p*
	Model 1: PRC		
Intercept (β_{0j})			
Intercept	3.0614 (.73)	4.19	<.001
CES-D (T1)	0.5226 (.03)	15.83	<.001
PRC	−0.0953 (.05)	−2.04	.042
Week (β_{1j})			
Intercept	−0.1015 (.08)	−1.24	.214
PRC	0.0009 (.01)	0.17	.086
Stress (β_{2j})			
Intercept	0.1064 (.07)	1.60	.109
PRC	0.0063 (.01)	1.40	.162
	Model 2: PRC and RC		
Intercept (β_{0j})			
Intercept	3.1121 (.71)	4.41	<.001
CES-D (T1)	0.5180 (.03)	15.72	<.001
PRC	−0.0964 (.05)	−2.07	.040
Week (β_{1j})			
Intercept	−0.1030 (.08)	−1.26	.208
PRC	0.0010 (.01)	0.19	.850
Stress (β_{2j})			
Intercept	0.0701 (.10)	0.73	.465
PRC	0.0190 (.01)	2.30	.021
RC	0.0005 (.01)	0.09	.931
PRC × RC	−0.0004 (.00)	−1.26	.207

Note. PRC = positive religious coping; RC = religious commitment; CES-D = Center for Epidemiological Studies Depression Scale short form.

Table 4
Multilevel Models Predicting Depressive Symptoms as a Function of Stress, Negative Religious Coping, and Religious Commitment

	Estimate (*SE*)	*t*	*p*
	Model 1: NRC		
Intercept (β_{0j})			
Intercept	1.6023 (.05)	3.46	.001
CES-D (T1)	0.5094 (.03)	15.26	<.001
NRC	0.0563 (.06)	0.96	.338
Week (β_{1j})			
Intercept	−0.1104 (.05)	−2.27	.023
NRC	0.0045 (.01)	0.63	.526
Stress (β_{2j})			
Intercept	0.1842 (.04)	4.32	<.001
NRC	0.0010 (.01)	0.19	.849
	Model 2: NRC and RC		
Intercept (β_{0j})			
Intercept	1.5511 (.46)	3.36	.001
CES-D (T1)	0.5086 (.03)	15.28	<.001
NRC	0.0673 (.06)	1.15	.251
Week (β_{1j})			
Intercept	−0.1068 (.05)	−2.20	.028
NRC	0.0037 (.01)	0.52	.602
Stress (β_{2j})			
Intercept	0.3544 (.08)	4.62	<.001
NRC	−0.0212 (.01)	−1.93	.054
RC	−0.0075 (.00)	−2.65	.008
NRC × RC	0.0010 (.00)	2.31	.021

Note. NRC = negative religious coping; RC = religious commitment; CES-D = Center for Epidemiological Studies Depression Scale short form.

religious commitment and created two separate level 1 files for low and high levels of religious commitment. This allowed us to examine the effect of negative religious coping for individuals who were either low or high on their religious commitment relative to the rest of the sample. For low levels of religious commitment, the effect of negative religious coping on the stress–depression relationship was nonsignificant, $b = -0.0081$, $t = -1.07$, $p = .287$. For high levels of religious commitment, the effect of negative religious coping was significant, $b = 0.0167$, $t = 2.15$, $p = .032$. Together, these effects suggest that for those high in religious commitment, individuals who engage in negative religious coping are more likely to experience depressive symptoms in response to stress. In contrast, this effect was not present for those low in religious commitment. Results are presented in Figures 1 and 2.

Discussion

The purpose of this study was to examine the effect of positive and negative religious coping on the relationship between stressful life events and depressive symptoms. We hypothesized that individuals reporting greater positive religious coping behaviors would show less depressive symptoms in response to stress, and those reporting greater negative religious coping would exhibit higher depressive symptoms. Furthermore, we expected the moderation of both positive and negative religious coping to be contingent upon the self-reported importance of religion for each individual, such that those reporting more religious commitment would demonstrate more profound effects of each religious coping pattern on depressive symptoms.

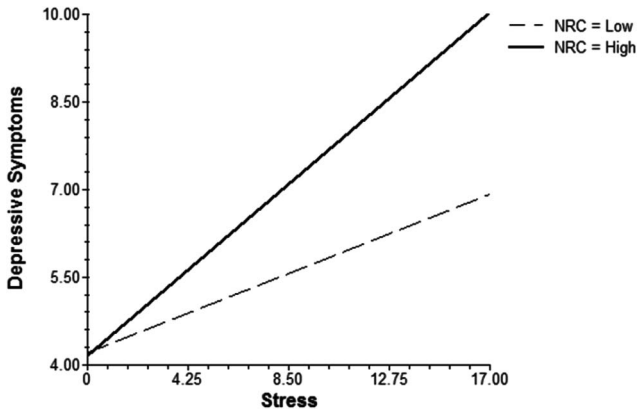

Figure 1. Graph depicting CES-D depression scores as a function of stress for individuals high (75th percentile) and low (25th percentile) in negative religious coping (NRC) and high in religious commitment.

The results of our study did not support our hypothesis regarding positive religious coping as a moderator of the stress and depression relationship. We observed a main effect of stress over time predicting depressive symptoms; however, this did not vary as a function of one's level of positive religious coping. This finding is in contrast to previous research, which has demonstrated cross-sectional support for the role of positive religious coping as a buffer from the effects of stress on depression (Bjorck & Thurman, 2007). Nevertheless, previous authors have indicated that any effects of positive religious coping should be detectable given our large sample size and the statistical power requirements for the moderation analysis (Carpenter et al., 2012). Furthermore, we found no evidence of a three-way interaction between stress, positive religious coping, and religious commitment. Consistent with the extant literature, however, was our finding that positive religious coping was negatively associated with baseline depression symptoms. Taken together, these patterns suggest that although positive religious coping may be related to increased quality of life and decreased psychological distress, it may not serve as a buffer against the effects of everyday stressful events.

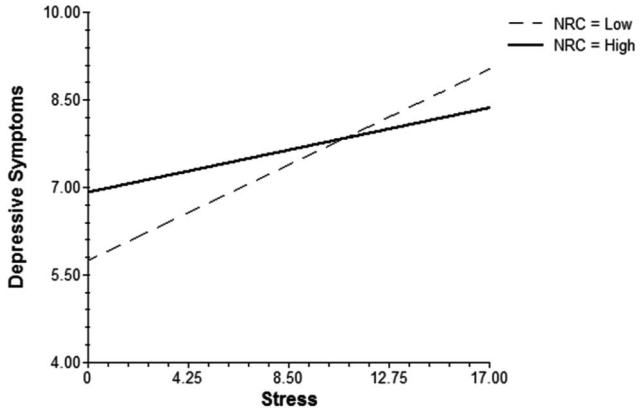

Figure 2. Graph depicting CES-D depression scores as a function of stress for individuals high (75th percentile) and low (25th percentile) in NRC and low in religious commitment.

Our examination of negative religious coping as a moderator of the stress and depression relationship suggested that the relationship may be more complex than simple moderation. We found that negative religious coping moderated the effect of stress on depression, but only for individuals with a high level of religiosity. Individuals who reported the greatest religious commitment and who engaged in more negative religious coping exhibited more depressive symptoms in response to stress, a finding consistent with previous attempts at modeling this three-way interaction (Carpenter et al., 2012). Although previous research suggests that negative religious coping is associated with greater mental health distress, the findings of the present study highlight the particular potency of negative religious coping for those who are more committed to their faith.

Strengths and Limitation

One of the strengths of this study is its use of prospective analyses to evaluate the effects of religiosity on the stress–depression relationship. Additionally, the use of normative stressors provides a context for understanding the role of religion in everyday circumstances. Although we do not discount the utility of religion in coping with severe trauma and life-changing medical issues, the comparatively normal exposure to everyday stressors is understudied yet applicable to a wider population. Our study adds to a small body of prospective examinations of religious variables and more routinely experienced stressors.

A particularly important limitation warrants mention as a potential opportunity for future research. The sample for this study was composed of undergraduates at a small, private, Christian university. Students at universities with strong religious affiliation may not be representative of the individuals of the same faith in a less religiously oriented setting. This may explain the uniformly low endorsement of negative religious coping observed. As can be seen in Table 1, the mean level of negative religious coping was significantly lower than that of positive religious coping, potentially restricting the amount of variability for our model. It could be that students at this university were less likely to engage in negative religious coping. Furthermore, there are differences in religious coping for each faith (Phillips, Michelle Cheng, Oemig, Hietbrink, & Vonnegut, 2012), making generalizations beyond the current sample characteristics difficult. Thus, future research would benefit from examining these variables in a community-based sample, incorporating greater diversity in religious affiliation, ethnicity, and gender.

Conclusions

The current study offers further evidence of the complex relationship between religion and mental health. Although religion may be a resource that improves overall psychological well-being, there appear to be conditions under which it may have harmful effects, particularly among those with stronger religious conviction. This study identifies the conditions under which a cognitive vulnerability such as negative religious coping exacerbates the relationship between stress and depression.

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