Journal of Affective Disorders 132 (2011) 401–405

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research report

Does negative religious coping accompany, precede, or follow depression among Orthodox Jews?

Steven Pirutinsky [a,*], David H. Rosmarin [b,c], Kenneth I. Pargament [d], Elizabeth Midlarsky [a]

[a] Teachers College, Columbia University, New York, NY, United States
[b] McLean Hospital, Belmont, MA, United States
[c] Harvard Medical School, United States
[d] Bowling Green State University, Bowling Green, OH, United States

ARTICLE INFO

Article history:
Received 7 December 2010
Received in revised form 9 February 2011
Accepted 2 March 2011
Available online 24 March 2011

Keywords:
Spirituality
Religion
Spiritual struggles
Jewish

ABSTRACT

Background: Cross sectional research suggests that negative religious coping (e.g., anger at God and religious disengagement) strongly correlates with depression and anxiety. However, causality is difficult to establish as negative coping can accompany, cause, or result from distress. Among Orthodox Jews, some studies have found correlations between negative religious coping and anxiety and depression, while others found that high levels of negative coping related with decreased distress. We therefore examined longitudinal relationships between negative coping and depressive symptoms among Orthodox Jews.
Methods: Participants (80 Orthodox Jews) completed the Jewish Religious Coping Scale and the Center for Epidemiologic Studies' Depression Scale at two times. Using Structural Equation Modeling, we compared four models describing possible causal patterns.
Results: Negative religious coping and depressive symptoms were linearly related. Furthermore, a model including negative coping as a predictor of future depression fit the data best and did not significantly differ from a saturated model.
Limitations: This research was limited by reliance on self-report measures, an internet sample, and examination of only negative religious coping.
Conclusions: Consistent with a "primary spiritual struggles" conceptualization, negative religious coping appears to precede and perhaps cause future depression among Orthodox Jews. Clinical interventions should target spiritual struggles, and more research integrating this construct into theory and practice is warranted.

Religion is important to many Americans (Spilka et al., 2003), and the relationship between religion and mental health has generated considerable interest. The majority of this research has focused on positive domains, and suggests that religiousness and spirituality are associated with greater physical and mental health (Koenig et al., 2001; Smith et al., 2003), including reduced suicidality (Colucci and Martin, 2008). Religion, however, can also have negative effects, particularly in the context of spiritual struggles. The term spiritual struggles encompasses several interrelated dimensions of tension including difficulty relating to the Divine, intrapersonal religious doubts, and interpersonal religious conflicts (Exline and Rose, 2005; Pargament et al., 2005). The current study focused on a widely studied aspect of spiritual struggles — negative religious coping. For many, a personal connection with God provides comfort, support, and hope in times of distress. For some, however, this connection can be troubled and distressing. In response to negative life events, individuals may get angry at God, question if God cares about them, and doubt if God can do anything (Pargament, 1997). Multiple meta-analyses have established that negative forms of religious coping correlate

* Corresponding author at: Department of Clinical and Counseling Psychology, Teachers College, Columbia University, Box 303, 525 West 120th St., New York, NY 10027, United States. Tel.: +1 845 323 6443.
E-mail address: sp2813@columbia.edu (S. Pirutinsky).

0165-0327/$ – see front matter © 2011 Elsevier B.V. All rights reserved.
doi:10.1016/j.jad.2011.03.015

with increased psychological distress (Ano and Vasconcelles, 2005; Smith et al., 2003).

Pargament (2009) distinguished between primary spiritual struggles in which struggles lead to increased distress, secondary spiritual struggles in which distress leads to struggles (e.g., by decreasing engagement in religious activities, increasing guilt, activating negative beliefs about God, and promoting doubts), and complex spiritual struggles in which struggles are both a cause and an effect of distress. It is also possible that spiritual struggles simply accompany distress as a domain within which negative thoughts and feelings are experienced. With respect to primary struggles, a few longitudinal studies found that negative religious coping was associated with increased distress over time (e.g., Dew et al., 2010; Pargament et al., 2004), suggesting that negative religious coping can cause psychological distress. However, the vast majority of this research has been cross-sectional (Ano and Vasconcelles, 2005; Smith et al., 2003) and to our knowledge, models directly comparing various causal patterns have not been tested. Consequently, the direction of influence between negative religious coping and mental health remains ambiguous.

Specific to Orthodox Jews, research in community samples has found correlations between negative religious coping and self-reported anxiety and depression (Rosmarin et al., 2009a, b,c), and research in clinical samples has found correlations between clinician-rated religious struggles and GAF scores (Pirutinsky and Schechter, 2009). However, Rosmarin et al. (2009b) found that participants with high levels of spiritual struggles reported increased mental health, suggesting that struggles may be associated with post-traumatic growth among Orthodox Jews. Moreover, participants in previous longitudinal studies were almost exclusively Christian, and given Orthodox Judaism's profound integration of religion into everyday cognition, emotion, and behavior (see Pirutinsky, 2009), it is particularly difficult to generalize causal and temporal patterns from other groups.

Accordingly, the current research explored the longitudinal relationship between negative religious coping and depressive symptoms among Orthodox Jews, comparing four possible causal models. Specifically, if negative religious coping is simply a domain in which distress is expressed, we would expect that that negative coping and depression would be correlated within each time period and auto-correlated across times (e.g., Time 1 depression with Time 2 depression). Once these concurrent and auto-correlations are controlled for, however, we would expect that negative coping at Time 1 would not significantly predict depression at Time 2, and depression at Time 1 would not significantly predict negative coping at Time 2 (Model 1). Alternatively, if depression causes increased negative coping, we would expect that above the influence of concurrent and auto-correlations, depression at Time 1 would significantly predict increased negative coping at Time 2 (Model 2 — Secondary Struggles). If negative coping causes depression, we would expect that negative coping at Time 1 would significantly predict increased depression at Time 2 (Model 3 — Primary Struggles). Finally, if negative coping is both a cause and result of depression, we would expect both paths to be significant (Model 4 — Complex Struggles).

1. Method

This study involves secondary analyses of the control group of a randomized control trial of a spiritually integrated treatment for sub-clinical anxiety among religious Jews. Complete study procedures and primary analyses are reported in Rosmarin et al. (2010). A brief description follows.

1.1. Procedure and participants

Jewish individuals age 18 or older were recruited via Jewish mental health organizations, community organizations, and web sites to participate in a brief, internet-based treatment study for "worry and stress". Participants were randomized without stratification to receive a spiritually integrated treatment, progressive muscle relaxation, or no treatment. Participants completed on-line measures at pre-treatment (T1) and post-treatment (T2) two weeks later. Given that stigma is a barrier to treatment generally (Corrigan, 2004), and particularly among religious Jews (Pirutinsky et al., 2010), procedures were conducted on-line to ensure anonymity.

Analyses in the present study were conducted with 80 Orthodox Jewish individuals randomized to the no treatment group. Participants ranged in age from 20 to 77 years ($M = 40.35$; $SD = 12.99$) and 81% ($n = 65$) were female. Most participants (84%; $n = 48$) reported having a college degree, and the majority were American (60%; $n =$), with additional participants from Canada (5%; $n = 4$), Israel (25%; $n = 20$), Europe (7.6%; $n = 6$), and Australia (2.6%; $n = 2$). Self-reported religious affiliation in the sample varied with 8.8% Hassidic ($n = 7$), 46.3% Yeshiva Orthodox ($n = 37$), and 45% Modern Orthodox ($n = 36$; see Pirutinsky, 2009).

2. Measures

2.1. Negative religious coping

We utilized the 4-item negative subscale of the Jewish Religious Coping Scale (JCOPE), which has previously demonstrated reliability and validity (Rosmarin et al., 2009c). Participants rated how frequently they generally engaged in religious methods of coping with stressful problems on a 5-point Likert-type scale. Items included, "I got mad at G-d", "I questioned whether G-d could really do anything", "I wondered if G-d cares about me", and "I questioned my religious beliefs, faith and practices." Internal consistency was adequate (Time 1 $\alpha = 0.75$; Time 2 $\alpha = 0.70$).

2.2. Depressive symptoms

We used the Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977), a widely-utilized and cross-culturally valid 20-item scale, to measure depressive symptoms. Participants were asked to rate how frequently they experienced symptoms over the past week on a 4-point Likert-type scale. Internal consistency was adequate (Time 1 $\alpha = 0.76$; Time 2 $\alpha = 0.61$).