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# Religious Faith and Depression Among Child Welfare Involved Mothers with Young Children

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## Introduction

Depression is recognized as a serious public health concern in the United States. A study sponsored by the National Institutes of Health estimated that approximately 7% of adults in the general population experience depression annually (Kessler et al., 2003). While the prevalence of depression is relatively high among the general population, evidence from the National Survey of Child and Adolescent Well-being (NSCAW) suggests that depression is much more prevalent among caregivers involved with the child welfare system, such that approximately one quarter (25%) of maternal caregivers of children under the age of five who have been referred to the child welfare system meet the clinical diagnostic criteria for major depressive disorder (U.S. Department of Health and Human Services [HHS], n.d.). Moreover, research on depression has shown that women, particularly those between 18 and 49 years of age, are significantly more likely than men to experience depression (National Alliance on Mental Health, 2009; Wu & Anthony, 2000), as well as more likely to experience a recurrence (Burcusa & Iacono, 2007). Given that the majority of caregivers for children referred to the child welfare system are female (HHS, 2005), these findings suggest that more should be done to understand maternal depression and how child welfare agency administrators and policy makers can help women access resources that may serve as protective factors against depression.

Until recently, conclusions about the buffering effect of religion[1] on depression have largely been based on clinical experience and personal observations, rather than rigorous scientific research (Moreira-Almeida, Neto, & Koenig, 2006). However, during the last two decades an increasing number of researchers have begun to examine the protective qualities of religion on mental health. Although the findings of these studies have been mixed, there is some evidence to suggest that religion may serve as a protective factor against depression. While some studies have investigated the relationship between maternal depression and child welfare involvement (e.g., HHS, n.d.; Kohl, Kagotho, & Dixon, 2011; Orton, Riggs, & Libby, 2009), virtually no studies have attempted to explore the role of religion for this vulnerable population and whether it may have a protective or buffering effect against depression. Using data from the Fragile Families and Child Wellbeing Survey of New Parents (Reichman, Teitler, Garfinkel, & McLanahan, 2001), this study attempts to bridge this gap in the knowledge base by exploring the association between religion and depression in a nationwide sample of mothers with young children who were referred to Child Protective Services (N=344). Given the dearth of literature on this specific topic, literature from three related bodies is overviewed to contextualize the study: 1) maternal depression and parenting 2) religion and depression, and 3) religion and maternal depression.

### Maternal Depression and Parenting

Kohl and colleagues (2011) note that the high rate of depression among mothers involved with the child welfare system is particularly concerning given our growing understanding of the impact it has on a mother's capacity to care for her child's physical and emotional needs. For example, Conron and colleagues (2009) performed a longitudinal analysis of NSCAW data of mothers who had been referred to a child

[1] For the purposes of this manuscript, "religion" includes religious faith, beliefs, and practices as conceptualized by Daaleman and Kaufman (2006).

welfare agency for maltreatment and found a positive relationship between maternal depression and psychological aggression against children aged 0-15 years. Similarly, an examination of parents involved with the child welfare system in Canada found that children with depressed mothers were more likely to be assessed as being at greater risk for being abused, more likely to need services, and more likely to have school behavior problems (Lescheid, Chiodo, Whitehead, & Hurley, 2005).

While there is evidence that supports the link between maternal depression and increased risk of child maltreatment, much of the research has been conducted with mothers from the broader population (e.g., Angold & Costello, 2001; Edhborg, Lundh, Seimyr, & Windström, 2003; Logsdon, Wisner, & Pinto-Foltz, 2006; Mustillo, Dorsey, Conover, & Burns, 2011). Although not specific to caregivers involved in the child welfare system, the findings from these studies provide important insight into the detrimental effects of depression for mothers and children. Results of these studies have shown that while depressed mothers are capable of positive interactions with their children, they are also at an increased risk of neglectful (Kohl et al., 2011) and harsh parenting practices (Chung McCollum, Elo, Lee, & Culhane, 2004; Lovejoy, Craczyk, O'Hare, & Neuman, 2000; Lyons-Ruth, Wolfe, Lyubchik, & Steingard, 2002). Studies have also shown that depression can have a strong influence on a mother's perception of her child's behavior. For example, two studies (Colletta, 1983; Weissman & Paykel, 1974) concluded that depressed mothers were more critical of their children than non-depressed mothers. In addition, Edhborg et al. (2003) found that depressed mothers tended to respond to their children more slowly and interacted less with their children than mothers who were not depressed. Moreover, other studies have found that mothers who are depressed tended to perceive themselves to be less competent than other mothers and frequently reported less satisfaction in their roles as mothers (Colletta, 1983; Webster-Stratton & Hammond, 1988).

**Religion and Depression**

While several studies have examined the association between religion and depression (Koenig, King, & Carson, 2012), the absence of valid instruments to measure different constructs of religion (i.e., religious faith, beliefs, and practices as conceptualized by Daaleman and Kaufman [2006]) has made it difficult for researchers to accurately assess the association between religion and depression (Daaleman & Kaufman, 2006). Hackney and Sanders (2003) note that religion is a multifaceted construct that is difficult to accurately capture because it includes cognitive, emotional, motivational, and behavioral aspects. Studies that have examined this topic vary greatly in how they have conceptualized and operationalized religion.

Regardless of how the concept of religion is operationalized, findings of prior studies show conflicting results about the role of religion in reducing or preventing depressive symptoms. For example, Baetz and colleagues (2004) evaluated the effect of religious involvement, operationalized as attendance at religious services and self-perceptions of spirituality/religiosity on depressive symptoms in a sample of 70,884 male and female respondents aged 15 or older. The authors found that respondents who reported regular attendance at religious services experienced fewer depressive symptoms. However, the authors also noted that respondents who perceived themselves to be spiritual or religious, as well as those who indicated that spiritual

values or faith were important reported higher levels of depressive symptoms. Furthermore, Strawbridge, Shema, Cohen, Roberts, and Kaplan's (1998) research, using a combination of religious variables, also yielded conflicting results. They evaluated the role of organizational (i.e., attendance at church and frequency of other activities at a place of worship) and non-organizational (i.e., religious practices and the saliency of beliefs) religiosity in a sample of 2,500 subjects to evaluate whether the different forms of religiosity moderated the association between stressful events and depression. Strawbridge et al. found that non-organizational religiosity was not associated with depression, while organizational religiosity was found to be inversely associated with depression. However, when controlling for different life stressors, the authors found that the association between organizational religiosity and depression weakened. The authors suggested that religion may be helpful for those individuals who are experiencing stressors that are non-family related (e.g., financial, health, and neighborhood problems), but may have an exacerbating effect for those experiencing family related stressors (e.g., abuse, issues with caregiving, marital problems). The mixed findings of these studies are further evidence of the complexity of measuring the effect of religion on depression.

**Religion and Maternal Depression**

While some studies have evaluated the effect of mothers' religiosity on depression in their children (e.g., Miller, Weissman, Gur, & Greenwald, 2002; Varon & Riley, 1999), to date, few studies have examined the association between religion and *maternal* depression. Miller and colleagues (1997) evaluated several questions related to religion and depression, including whether religion served as a protective factor against depression. Over a ten-year period (1982-1992), Miller and colleagues followed 60 mothers and 151 children. Mothers and children were asked to report on several dimensions of religion, such as the importance of religion, frequency of attendance at religious services, and their religious affiliation. The findings showed an inverse association between maternal religiosity and depression. A small qualitative study of 12 African American women who had experienced postpartum depression indicated that faith was a central component in the women's coping skills (Amankwaa, 2003). The women, who all self-identified as middle-class with educational backgrounds varying from high school graduate to doctoral program graduate, expressed that their belief in faith and prayer helped them overcome their depression. Similarly, Garrison, Marks, Lawrence, and Braun (2005) explored the relationship between religion and depression in 131 rural, low-income mothers. The findings were small but significant for an inverse association between religious beliefs and involvement with a faith community, and mothers' depressive symptoms. In contrast, using a control group design assessment of maternal depression and early attachment, Teti, Gelfand, Messinger, and Isabella (1995) found no significant differences between depressed and non-depressed mothers when evaluated by specific religious affiliations.

**Current Study**

The current study explores the association between religious faith, operationalized in this study as the importance of faith, and depression in a nationwide sample of mothers with young children who were referred to Child Protective Services. This study builds on

prior research as few studies have looked exclusively at the effect of religious faith on women who have been referred to the child welfare system, a population that is regarded by many experts to be at increased risk of experiencing depression (Chemtob, Griffing, Tullberg, Roberts, & Ellis, 2011; Conron et al., 2009). While several studies have been conducted examining the association between religion and depression, these studies have primarily been limited to mixed-gender samples or specific age groups, such as adolescents or those over 60 (e.g., Baetz et al., 2004; Braam, Hein, Deeg, Twisk, Beekman, & van Tilburg, 2004; Koenig, Hays, George, Blazer, Larson, & Landerman, 1997; Miller et al., 1997; Wink, Dillon, & Larson, 2005). By focusing the sample on mothers who have been referred to Child Protective Services, findings specific to this vulnerable population of families may help child welfare administrators develop more effective and culturally competent interventions for mothers that could help prevent and reduce child maltreatment. In addition, by utilizing a large data source such as the Fragile Families and Child Wellbeing Survey of New Parents, the analyses are based on a diverse sample of mothers from different ethnic and socio-economic backgrounds. The richness of the data allows for greater depth of analysis to understand what factors might affect depression among women with young children referred to the child welfare system. This study explores the following question: *What is the association between religious faith and depression among women with young children who have been referred to Child Protective Services?*

## Methods

### Data

This study utilized secondary data from the first and fourth waves of the Fragile Families and Child Well-being Study (see Reichman et al. [2001] for a complete description of the sample and design). The Fragile Families study is an ongoing, longitudinal, national birth cohort study designed to examine the characteristics of married and unmarried parents, the nature of their relationships, and how the parents' children fare on different child-wellbeing measures. Approximately 3,700 unmarried mothers and a comparison sample of 1,200 married mothers were surveyed. The study utilized a stratified, multistage, probability sample of 4,898 births that occurred between 1998 and 2000. Baseline interviews were conducted with mothers within 48 hours of the birth of their child, and again when the child was 1, 3, 5, and 9 years of age. Data from Wave 4 were collected between July 2003 and February 2006.

### Sample

Of the 4,898 mothers interviewed at the time of the child's birth in the Fragile Families baseline sample, 759 mothers who did not participate in Wave 4 of data collection and 3,795 mothers who reported that Child Protective Services had not contacted them since the focal child's birth were excluded from the analysis. Following these two exclusions, the final sample for this study included 344 mothers who reported that they had been referred to Child Protective Services at least once since the birth of the focal child. Mothers included in this sample were an average of 29.34 (SD = 5.51) years old and more likely to be African American/Black (54.9%) than Hispanic/Latino (22.7%) or Caucasian/White (20.1%). While more than one-third (40.4%) of the mothers reported having less than a high school education, 36.6% of the mothers reported having

completed some college-level courses. Almost half (48%) of the mothers reported that they were employed. With regard to relationship status, over half (54.4%) of the mothers reported that they were not married or cohabiting with anyone at the time of data collection. Concerning religious preference, a majority (86.6%) of the mothers reported having a specific religious preference (e.g., Buddhism, Christianity, Islam, Judaism). Approximately one third (32.6%) of the mothers reported that they attend a religious service at least once a week while only 12.5% reported never attending. An overwhelming majority (84.6%) reported that they agreed that their religious faith is an important guide for their daily life. Based on the criteria for depression used in this study, almost one third (31.1%) of the mothers in the sample reported experiencing a major depressive episode during the previous 12 months. Table 1 presents the demographic and background characteristics of mothers included in the sample.

**Table 1**.
Descriptive Characteristics of Mothers Referred to Child Protective Services (*N* = 344)

| | |
|---|---|
| **Personal Characteristics** | |
| Race/ethnicity | |
| African American/Black | 54.9 (189) |
| Caucasian/White | 20.1 (69) |
| Hispanic/Latino | 22.7 (78) |
| Other | 2.3 (8) |
| Mean age (range 20-50) | 29.34 (5.51) |
| Born in the United States | 95.9 (330) |
| **Personal and Financial Circumstances** | |
| Education | |
| Less than high school diploma | 40.4 (139) |
| High school diploma or GED | 19.5 (67) |
| Some college | 36.6 (126) |
| College degree or higher[a] | 3.5 (12) |
| Household income (% of the federal poverty level) | |
| 0-99% | 59.6 (205) |
| 100-199% | 25.6 (88) |
| (200% or higher) | 14.8 (51) |
| Employed | 48.0 (165) |
| Poor health status | 5.2 (18) |
| Number of children under 18 in the home (range 1-11) | 3.02 (1.64) |
| **Personal and Social Support** | |
| Relationship status | |
| Married | 18.0 (62) |
| Cohabiting | 27.9 (96) |
| Non-residential/No relationship | 54.4 (187) |
| Mean level of social support (range 0-3) | 2.27 (1.06) |
| **Has a Religious Preference** | 86.6 (298) |
| **Attends Religious Services** | |
| At least once a week | 32.6 (112) |
| Few times a month | 20.1 (69) |
| Few times a year | 34.6 (119) |
| Never | 12.5 (43) |
| **Faith is Important Guide for Daily Life** | 84.6 (291) |
| **Experienced Depression Within The Last 12 Months** | 31.1 (107) |

## Measures

***Dependent Measure*** Maternal depression served as the dependent variable of interest in this study. Depression was assessed at Wave 4 of the study and was operationalized as whether or not (*yes*/*no)* the mother likely experienced a major depressive episode lasting at least two weeks during the previous year. The dichotomous indicator is a summary measure based on responses to 15 items included in the depressive episode section of the Composite International Diagnostic Interview – Short Form (CIDI-SF), a widely used standardized screening tool based on the fourth edition of the Diagnostic

and Statistical Manual of Mental Disorders (Kessler, Andrews, Mroczek, Üstün, & Wiichen, 1998). Mothers were asked two stem questions regarding whether they had experienced two or more consecutive weeks of dysphoria (feelings of sadness or depression) or anhedonia (loss of pleasure) during the previous year. Mothers who answered affirmatively to either question and who reported that they experienced the symptom at least most of the day, almost every day during those 2 weeks, were asked additional questions about other potential symptoms of depression: loss of interest, feeling tired or low on energy, changes in weight, difficulties sleeping, diminished ability to concentrate, feeling down or worthless, and recurrent thoughts about death. In this study, mothers were classified as likely to have experienced a depressive episode if they answered affirmatively to one of the two stem questions (i.e., dysphoria or anhedonia) and at least three of the seven additional questions. See Nelson, Kessler, & Mroczek (2001) for a more in-depth discussion of the measure and scoring procedures.

***Independent Measure*** Religious faith was the primary independent variable examined. Within the context of this study, religious faith was operationalized as the importance of faith to the mother's daily life. During Wave 4 of data collection, mothers were asked to indicate whether they strongly agreed, agreed, disagreed, or strongly disagreed with the question: "My religious faith is an important guide for my daily life." For the purposes of this analysis, this variable was dichotomized (*agree/disagree*). This question was selected as an indicator of mothers' religious faith, as it was a more descriptive measure of mothers' beliefs about faith than religious attendance or religious affiliation.

***Background/Control Measures*** Many of the variables controlled for in this study are theoretically relevant characteristics and factors that have been shown in prior studies to correlate with maternal depression—the mother's age, socio-economic status, and overall level of social support are the contextual factors that influence a mother's day-to-day life and may contribute to or provide alternative explanations for depressive episodes. Thus, to minimize the possibility that maternal depression could be influenced by selection, a number of maternal background characteristics were used as controls: age, race/ethnicity, relationship status, immigration status, level of education, household income, health status, perceived level of social support, and specific religious preference. With the exception of race/ethnicity and immigration status, each of the controls included in this analysis were measured at Wave 4 of data collection. Race/ethnicity and immigration status were measured during the baseline interviews (Wave 1).

Mother's age was measured as a continuous variable. Mother's race/ethnicity was collapsed from four categories (e.g., African American/Black, Caucasian/White, Hispanic/Latino, and Other) and dichotomized to identify whether the mother self-identified as a member of a racial or ethnic minority (*minority/non-minority*). In addition, mother's immigration status was measured using a dichotomous variable that indicated whether the mother reported that she was born in the United States or a foreign country (*Other country/United States*).

Several measures of mother's educational and economic resources were also included. Mother's educational attainment was represented by a series of four dichotomous variables that indicated whether the mother's highest level of educational

attainment was: *less than a high school diploma, a high school diploma or GED, some college*, or *a college degree or higher*. Mother's employment status was measured as a dichotomous variable (*employed*/*not employed*) to indicate whether she was employed during the previous week. Mother's household income was measured using a variable that categorized income according to federal poverty level guidelines: 0-49%, 50-99%, 100-199%, 200-299%, and 300% and over. To reduce the number of variables included in the analysis to a more manageable level, these categories were collapsed into three dichotomous variables: *0-99%, 100-199%,* and *200% or higher*.

Two measures were included to provide a more complete picture of the mothers' circumstances and potential hardships. A dichotomous variable was created to indicate whether the mother's self-described health status was *poor* or *fair* and a continuous measure was included to indicate the number of children under the age of 18 residing in the home.

Two additional variables were included to capture the type of support available to the mother: relationship status and level of social support. Wave 4 of the Fragile Families data does not include a clear measure of mother's relationship status. Therefore, mother's relationship status was measured using four different variables that indicated whether or not the mother was married or cohabiting. Using these variables, three dichotomous variables were constructed to indicate the relationship status: married, cohabitating, and non-residential/no-relationship. While these are not ideal measures of relationship status, they provide a way to distinguish between mothers who have in-home support from a partner and mothers who do not have this support.

To gauge the level of social support that mothers had from family, friends, and other sources, mothers were asked three questions regarding different types of support that they might need in the next year, including: 1) whether she felt that someone could loan her $200 if she needed help, 2) if there is someone she could count on to provide her with a place to live if needed, and 3) if there is someone she could count on to provide childcare in the event of an emergency. Level of support was determined by adding the three items together to produce a scale ($\alpha$ = .74) with possible scores ranging from 0-3 where higher scores were indicative of increased levels of support.

The final control variables included a dichotomous measure of whether the mother reported having a specific religious preference (e.g., Buddhism, Christianity, Islam, Judaism), coded as *preference* or *no preference*, and four dichotomous variables to assess how often the mother reported attending religious services. The four frequency of attendance variables were *at least once a week, a few times a month, a few times a year,* and *never.*

**Procedures**

All analyses were performed using the Statistical Package for Social Sciences (SPSS) version 20.0. To maximize the use of available data and minimize bias, missing data for some covariates were imputed using SPSS' missing values analysis tool pack. Results were run on both the original and imputed data sets to check for bias in the imputed results. No substantial differences were found, making us confident that the imputed data set was non-biased. All reported results are based on the imputed data set. First, univariate analysis was used to describe the overall sample characteristics (Table 1). Second, t-tests, chi-square tests, and when appropriate, Fisher's Exact tests, were run

to assess bivariate relationships between mothers' depression status (*depressed* or *not depressed*) and mothers' personal background characteristics. Third, hierarchical logistical regression was conducted to measure the effect of religious faith on depression while simultaneously controlling for characteristics that may affect the likelihood of a mother becoming depressed. In the first block of the model, exogenous demographic characteristics were entered. The second block included variables related to mothers' personal resources and circumstances, such as educational attainment, income, and health. The third block of the model added measures of mothers' social support while the fourth block included a variable to determine whether the mothers indicated a specific religious preference, as well as a measure to assess how often the mother reported attending religious services. The fifth and final block of the model included all of the variables, including the primary variable of interest, religious faith. An alpha level of $p < .05$ was selected for all analyses.

## Results

### Bivariate Analyses

Results of the bivariate analysis assessing differences in personal and background characteristics between depressed and non-depressed mothers showed a number of significant differences between the two groups (see Table 2). Significant differences were noted between the proportion of depressed (46.7%) and non-depressed mothers (58.6%) who were African American ($\chi^2 = 4.232$, $df = 1$, $p = 0.040$). Among depressed and non-depressed mothers, significant differences between the two groups were noted with regard to household income and employment. Compared to non-depressed mothers, depressed mothers were much more likely to earn less than 100% of the federal poverty level (54.9% vs. 70.1%, respectively; $\chi^2 = 7.111$, $df = 1$, $p = 0.008$). Additionally, depressed mothers were significantly less likely to report being employed than non-depressed mothers (36.4% vs. 53.2%, respectively; $\chi^2 = 8.253$, $df = 1$, $p = 0.004$). With regard to relationship status, a greater proportion of non-depressed mothers (50.6%) than depressed mothers (62.6 %) reported that they were not in a relationship or cohabitating or married to their romantic partner at the time of the interview ($\chi^2 = 4.267$, $df = 1$, $p = 0.039$). Non-depressed mothers ($M = 2.41$, $SD = 0.97$) were also more likely than depressed mothers ($M = 1.96$, $SD = 1.17$) to report higher levels of support from family and friends ($t = 3.657$, $df = 342$, $p = 0.000$).

Some differences were observed with regard to frequency of attendance at religious services. Overall, mothers who were classified as depressed were less likely than non-depressed mothers to attend church with any regularity. For example, compared to mothers who were classified as depressed (10.4%), non-depressed mothers (24.5%) were more than two times as likely to attend services a few times a month ($\chi^2 = 9.055$, $df = 1$, $p = 0.003$). Furthermore, mothers who were classified as depressed (44.3%) were more likely than their non-depressed counterparts (30.4%) to attend church only a few times a year ($\chi^2 = 6.300$, $df = 1$, $p = 0.012$).

Finally, when evaluated at the .05 level, no significant differences were found with regard to racial/ethnic categories other than African American or Black, or with other potentially confounding variables including: mother's age, immigration status, any level of educational attainment, household incomes that were 100% or greater than the federal poverty level, mother's health status, number of children in the mother's home,

whether the mother was married or cohabitating, whether the mother indicated a specific religious preference, and whether the mother attended religious services at least once a week or never. Additionally, no significant differences were found with regard to the independent variable of interest, faith is important guide for daily life.

**Table 2.**
Bivariate Characteristics of Mothers Referred to Child Protective Services by Depression Status (N = 344)

| | **Depressed (*n* = 107)** | **Not Depressed (*n* = 237)** | **Fisher's Exact, $\chi^2$, or *t*-Statistic** | ***p*-Value** |
|---|---|---|---|---|
| **Personal Characteristics** | **% (#) / M (SD)** | | | |
| Race/ethnicity | | | | |
| African American/Black | 46.7 (50) | 58.6 (139) | 4.232 | 0.040* |
| Caucasian/White | 26.2 (28) | 17.3 (41) | 3.616 | 0.057 |
| Hispanic/Latino | 22.4 (25) | 23.4 (53) | 0.042 | 0.837 |
| Other [a] | 3.7 (4) | 1.7 (4) | 1.365 | 0.261 |
| Mean age (range 20-50) | 28.57 (4.98) | 29.69 (5.71) | 1.753 | 0.081 |
| Born in the United States [a] | 95.3 (102) | 96.2 (228) | 0.145 | 0.770 |
| **Personal and Financial Circumstances** | | | | |
| Education | | | | |
| Less than high school diploma | 46.7 (50) | 37.6 (89) | 2.578 | 0.108 |
| High school diploma or GED | 17.8 (19) | 20.3 (48) | 0.293 | 0.588 |
| Some college | 33.6 (36) | 38.0 (90) | 0.595 | 0.440 |
| College degree or higher[a] | 1.9 (2) | 4.2 (10) | 1.209 | 0.355 |
| Household income (% of the federal poverty level) | | | | |
| 0-99% | 70.1 (75) | 54.9 (130) | 7.111 | 0.008** |
| 100-199% | 19.6 (21) | 28.3 (67) | 2.893 | 0.089 |
| (200% or higher) | 10.3 (11) | 16.9 (40) | 2.541 | 0.111 |
| Employed | 36.4 (39) | 53.2 (126) | 8.253 | 0.004** |
| Poor health status | 8.4 (9) | 3.8 (9) | 3.165 | 0.075 |
| Mean number of children under 18 in the home (range 1-11) | 2.94 (1.55) | 3.06 (1.68) | 0.659 | 0.511 |
| **Personal and Social Support** | | | | |
| Relationship status | | | | |
| Married | 14.0 (15) | 19.8 (47) | 1.686 | 0.194 |
| Cohabiting | 24.3 (26) | 29.5 (70) | 1.005 | 0.316 |
| Non-residential/No relationship | 62.6 (67) | 50.6 (120) | 4.267 | 0.039* |
| Mean level of social support (range 0-3) | 1.96 (1.17) | 2.41 (0.97) | 3.657 | 0.000*** |
| **Has a Religious Preference** | 81.3 (87) | 89.0 (211) | 3.794 | 0.051 |
| **Attends Religious Services** | | | | |
| At least once a week | 30.2 (32) | 33.8 (80) | 0.424 | 0.515 |
| Few times a month | 10.4 (11) | 24.5 (58) | 9.055 | 0.003** |
| Few times a year | 44.3 (47) | 30.4 (72) | 6.300 | 0.012* |
| Never | 15.1 (16) | 11.4 (27) | 0.915 | 0.339 |
| **Faith is Important Guide for Daily Life** | 87.9 (94) | 83.1 (197) | 1.264 | 0.261 |

Significance of Fisher's Exact[a], chi-square, or t-statistic: *** p ≤ .001 ** p ≤ .01 * p ≤.05

**Multivariate Analysis**

Hierarchical logistic regression was used to model the effects of religious faith on maternal depression status in order to determine whether those who agreed that their religious faith was a guide for their daily lives were more or less likely, when adjusting for key characteristics, to have experienced depression within the last year. The results of the logistical regression model suggest that religious faith, when controlling for other contextual factors, was associated to a significant degree with mother's depression status (Block $\chi^2 = 8.090$, $p = 0.004$). As demonstrated in Table 3, when the associations were evaluated individually, mother's minority status, mother's employment status, whether the mother reported that she was cohabitating, mother's level of support, whether the mother attended religious services a few times a month, and mother's religious faith were all found to have a significant association with maternal depression. Compared to mothers who identified as Caucasian or White, mothers who reported that they were a member of an ethnic/minority were 60.4% less likely to have experienced depression during the previous 12 months (OR = .396, 95% CI = 0.21-0.77, $p = 0.006$). Mothers who reported that they were employed were 46.2% less likely to have experienced depression than mothers who reported that they were unemployed (OR = .538, 95% CI = 0.31-0.95, $p = 0.033$). Mothers who were cohabitating at the time of data collection were 58.6% less likely to have experienced depression during the last year (OR = .414, 95% CI = 0.22-0.80, $p = 0.009$). Higher levels of maternal social support decreased the probability of mothers experiencing depression during the last year. Specifically, each unit increase in mother's level of support was associated with a 32.8% reduction in the likelihood of the mother having experienced a major depressive episode during the previous year (OR = .672, 95% CI = 0.52-0.86, $p = 0.002$). The results also indicated that mothers who reported attending religious services a few times a month were 88.1% less likely to have experienced depression during the last year when compared to those than those who reported that they never attended religious services (OR = .119, 95% CI = 0.36-0.40, $p = 0.001$). Finally, the primary independent variable of interest, religious faith, was found to have a positive association with maternal depression, indicating that mothers who agreed with the statement that their faith was a guide for their daily life were slightly more than 3 times more likely than mothers who did not agree with this statement to have experienced depression within the last year (OR = 3.14, 95% CI = 1.37-7.20, $p = 0.007$) (See Table 3).

**Table 3.**
Multivariate Model Assessing the Association Between Religious Faith and Maternal Depression (N = 344)

| | Step 1 OR (95% CI) | Step 2 OR (95% CI) | Step 3 OR (95% CI) | Step 4 OR (95% CI) | Step 5 OR (95% CI) |
|---|---|---|---|---|---|
| **Personal Characteristics** | | | | | |
| Minority status | 0.521 (0.30–0.91)* | 0.432 (0.24–0.82)** | 0.425 (0.23–0.79)** | 0.472 (0.25–0.90)* | 0.396 (0.21–0.77)** |
| Mean age (range in years 20-50) | 0.964 (0.92–1.01) | 0.977 (0.93–1.03) | 0.965 (0.92–1.01) | 0.955 (0.91–1.01) | 0.953 (0.91–1.00) |
| Born in the United States | 0.646 (0.21–2.02) | 0.590 (.18–1.93) | 0.733 (.21–2.53) | 0.595 (0.17–2.15) | 0.603 (0.16–2.32) |
| **Personal and Financial Circumstances** | | | | | |
| Education | | | | | |
| (Less than high school) | | | | | |
| High school | | 0.742 (0.38–1.46) | 0.693 (0.35–1.39) | 0.695 (0.34–1.43) | 0.622 (0.30–1.30) |
| Some college | | 0.878 (0.50–1.55) | 0.891 (0.49–1.61) | 0.970 (0.53–1.79) | 0.847 (0.45–1.58) |
| College or higher[a] | | 0.530 (0.10–2.79) | 0.517 (0.10–2.81) | 0.485 (0.09–2.65) | 0.389 (0.07–2.20) |
| Household income (% of the federal poverty level) | | | | | |
| 0-99% | | 1.792 (0.79–4.08) | 1.18 (0.49–2.85) | 1.08 (0.43–2.70) | 0.926 (0.37–2.33) |
| 100-199% | | 1.072 (0.44–2.64) | 0.907 (0.36–2.28) | 0.80 (0.31–2.05) | 0.704 (0.27–1.83) |
| (200% or higher) | | | | | |
| Employed | | 0.552 (0.33–0.94)* | 0.521 (0.30–0.91)* | 0.557 (0.32–0.98)* | 0.538 (0.31–0.95)* |
| Poor health status | | 1.56 (0.56–4.38) | 1.637 (0.56–4.80) | 1.678 (0.55–5.11) | 1.320 (0.42–4.13) |
| Number of children under 18 in the home | | 0.949 (0.81–1.11) | 0.947 (0.81–1.11) | 0.936 (0.79–1.11) | 0.944 (0.80–1.12) |
| **Personal and Social Support** | | | | | |
| Relationship status | | | | | |
| Married | | | 0.585 (0.27–1.27) | 0.604 (0.27–1.34) | 0.591 (0.27–1.32) |
| Cohabiting | | | 0.503 (0.27–0.93)* | 0.448 (0.24–0.85)* | 0.414 (0.22–.80)** |
| (Non-residential/No relationship) | | | | | |
| Perceived social support (0-3) | | | 0.687 (0.55–0.87)** | 0.700 (0.55–0.89)** | 0.672 (0.52–0.86)** |
| **Has a Religious Preference** | | | | 0.633 (0.31–1.31) | 0.586 (0.28–1.23) |
| **Attends Religious Services** | | | | | |
| At least once a week | | | | 0.867 (.38–1.99) | 0.573 (.23–1.41) |
| Few times a month | | | | 0.190 (.06–.59)* | 0.119 (.36–.40)*** |
| Few times a year | | | | 1.08 (.48–2.43) | 0.784 (.33–1.86) |
| (Never) | | | | | |
| **Faith is Important Guide for Daily Life** | | | | | 3.143 (1.37–7.20)** |
| Block Chi Square = 8.090, p = .004** | | | | | |

Significance: *** p ≤ .001, ** p ≤ .01 * p ≤ .05
*Note:* OR = Odds Ratio and CI = Confidence Interval
*Note:* Variables in parentheses refer to reference categories

## Discussion

This study evaluated the association between religious faith and maternal depression. The finding of this study suggests that mothers who viewed their faith as a guide for their daily life were more than three times as likely to have experienced depression within the last year. This should not be misinterpreted to mean that having religious faith causes depression. Rather, this finding should instead generate discussion as to the possible explanations for this association.

One possibility is that for some women who value their faith, being referred to Child Protective Services may cause them to feel that they were not adhering to the tenets of their faith with regard to their responsibilities as caregivers. Furthermore, some women may view a referral to CPS as "punishment." These feelings may also result in an increased likelihood of being depressed. For example, in the Amankwaa (2003) postpartum depression study, some women reported that they believed that they were being "punished" for past wrongs. These women used religious faith not only as a coping mechanism, but also as an explanation; believing they had failed to live up to their religious faith provided a rationalization for why they were experiencing postpartum depression.

A different interpretation may be that individuals who report high levels of religious faith may use their faith as a mechanism for coping with stressors. Reliance on religious faith to cope with life's problems may result in mothers feeling that they have little control over what is happening. Doubts about their own personal capacity and ability to change their circumstances may contribute to an overall lack of self-efficacy (Schnittker, 2001). This lack of self-efficacy may contribute to depressive symptoms and to a passive approach to problem-solving. Relatedly, Yangarber-Hicks (2004) found that an individual's specific style of religious coping was a better predictor of psychological well-being than more general religious variables. In particular, Yangarber-Hicks found that individuals who used a collaborative coping style (sharing of responsibility between God and the individual) were more likely to be actively involved in addressing their own mental health concerns than were individuals who used self-directing (i.e., individual is fully responsible) or deferring and pleading (i.e., God is fully responsible and the individual is passive) coping styles. Some mothers who score high on measures of religious faith, particularly those who feel that they may have little control over their own external personal circumstances (e.g., poverty, lack of support) may use a deferring and pleading coping style and feel unable to effect change in their own situation. In addition, some mothers may feel shame about experiencing depressive symptoms and their inability to control them. Reliance on an external system of faith may also contribute to mothers being less likely to utilize professional mental health services, as they may believe that religious faith alone should be sufficient to eradicate depressive symptoms (Jesse, Walcott-McQuigg, Mariella, & Swanson, 2005; Payne, 2008). When religious faith alone is not able to do so, these mothers may feel shame that their faith is not strong enough. Additionally, feelings of personal shame or doubt about not being able to adequately care for their children, compounded by the judgment from family and peers that often accompanies involvement in the child welfare system (Colton, Drakeford, Roberts, Scholte, Casas, & Williams, 1997), may further serve to intensify depressive symptoms. These feelings of shame may inhibit their willingness to attend a religious

institution, and thereby deprive them of the potential social and emotional benefits that could be gained (Sullivan, 2008).

The above argument is further supported by the finding that mothers who attend religious services a few times a month were significantly less likely to experience depression than mothers who reported that they never attend. It may be that periodically connecting with other worshipers provides a certain amount of social support for the mothers. Prior studies have found that the tangible supports and resources that many churches offer may be helpful in buffering the stressors that often contribute to depressive symptoms. For example, Maselko, Gilman and Buka (2009) found that while high scores on measures of religious attendance and spiritual well-being did offer protection against depressive symptoms, high scores on measures of religious well-being did not. Garrison and colleagues (2005) reported that active involvement in a faith community may provide essential social supports and thus more protection against depressive symptoms. Furthermore, in a study looking at the impact of church attendance, frequency of prayer, and belief salience on psychological well-being, Leondari and Gialamas (2009) found that only church attendance was associated with better psychological health. These findings suggest that if respondents report high levels of religious faith but are not actively involved in a church community, they may not be receiving the potential benefits, including protection against depressive symptoms.

While child welfare agencies should approach the topic of faith with clients with the utmost sensitivity, this research suggests that mothers may benefit from assistance in identifying local religious organizations, including churches or other houses of faith, which complement the mother's beliefs and can serve as a support system. In keeping with the social work principle of self-determination, it should be emphasized that this process should be client driven and that workers should not suggest or require mothers adhere to a particular religion or belief system or participate with any specific frequency. Attempts to assist mothers in connections with faith-based organizations must also recognize that a mother's belief system is just one aspect of her personal identity, which has been formed by myriad of factors including her ethnic culture, generational influences, and socio-economic status. Appreciating the complexity of a person's identity will help ensure that interventions utilized by faith-based organizations are equipped to build on mothers' strengths and goals and will help ensure that interventions do not create unanticipated burdens or stressors. For example, workers need to recognize that outside factors (e.g., work hours, health concerns, transportation needs) may inhibit mothers' ability to fully participate in religious activities. Mothers should be encouraged to determine for themselves the manner and frequency of participation, as life factors allow and individual needs for support and fellowship require. Furthermore, the authors of this study caution that the association between religious faith and depression should not misinterpreted to assume that religious involvement is appropriate in all circumstances. In keeping with this sentiment, reactionary policies mandating mothers involved with the child welfare system to become active within a faith-based community or organization should be avoided.

## Limitations

A primary strength of the Fragile Families data is the breadth of factors the researchers were able to assess, such as mothers' relationships, prior involvement with the child welfare system, parenting behavior, and their mental and physical health. However the study has some important limitations that should be noted. First, this study relies on mothers' self-reported data for all of the variables that were included in this analysis. As the survey contains sensitive questions regarding mother's prior involvement with Child Protective Services and their mental and physical health, it is possible that mothers may have been inclined to report answers deemed more socially desirable. Second, the selectiveness of the sample limits the generalizability of the results, as interviews were conducted primarily with mothers living in large urban areas. A third limitation lies in the use of a single item to measure the concept of religious faith (faith is an important guide for daily life). Religious faith is a multifaceted concept that is difficult, if not impossible, to truly gauge with one question. The lack of additional questions regarding mothers' beliefs and actions limits the conclusions that can be drawn from this study, as we are not able to fully measure and understand the nuances and complexities that motivate mothers' religious beliefs. Fourth, although a broad array of factors was considered in the analyses, use of the CIDI-SF is a proxy measure for classifying depression. While some of the mothers in this sample may have had a formal clinical diagnosis of major depression, due to the self-report nature of the measure used, it is likely that the true incidence of depression may have been over or under-reported. Furthermore, it should be noted that this study does not consider mothers' personal history with depression, nor does it consider whether the mother may have a genetic predisposition to depression. Future research should include a more complete history of the mothers' experiences of depression.

## Conclusion

Given the link between child welfare involvement and maternal depression, it is imperative that child welfare agency administrators explore all avenues of support and treatment that may be available. The findings of this study suggest that for many mothers involved in the child welfare system, religious faith plays a key role in their lives. Because child welfare services are designed to be temporary in nature, it would be beneficial for child welfare workers and the mothers that they work with to identify long-term, natural support systems, such as those that are found in faith communities, to assist families in maintaining progress and minimizing safety risks in the home. An increased understanding of the impact of religious beliefs may provide faith communities with the information needed to develop more effective resources and supports for their members. Furthermore, understanding the role that religious faith plays in these mothers' lives may offer child welfare agencies additional strategies when working with mothers who desire faith-based interventions and help child welfare agencies to more effectively partner with faith-based entities to support these mothers. Child welfare advocates should consider the benefits of helping staff of faith-based organizations, including churches and other houses of worship, develop and implement early screening tools that can be used to refer mothers with depression to appropriate mental health services prior to the onset of major depressive disorder and/or child maltreatment.

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