Organized Religious Involvement and Mental Health Among Caribbean Black Adolescents

Theda Rose 1 · Nadine Finigan-Carr 1 · Sean Joe 2

Published online: 10 August 2016
© Springer Science+Business Media New York 2016

Abstract Though religion has been related to better mental health, the aspects of organized religious life most salient for the mental health of Caribbean Black adolescents in the US, beyond religious service attendance, has been understudied. This research utilized a sub-sample of Caribbean Black adolescents from the NSAL-A, a nationally representative U.S. dataset, to examine (1) the prevalence of organized religious involvement (e.g., participation in religious service activities, choice to attend religious services) and (2) the relationship between organized religious involvement and mental health. Results showed that 62 % of Caribbean Black adolescents attend religious services regularly (at least a few times a month) and 49 % or more attend religious services or participate in religious activities (e.g., youth groups) by choice. Additionally, various aspects of organized religious involvement were positively related to coping and self-esteem, and negatively related to depressive symptoms. Religious service attendance was not related to any of the mental health indicators. Study results can inform the development of individual and group level interventions targeted at supporting the mental health of Caribbean Black adolescents.

Keywords Religion · Mental health · Caribbean Black · Adolescents

Organized religious involvement plays a prominent role in Black Caribbean life by providing spiritual, emotional, and tangible support to families, particularly during transition to the United States (US); connecting families (both parent and adolescent) to social networks that reinforce their cultural values and attitudes; and providing moral and cultural teachings in support of messages parents give to their children (Waters, 1999). This type of religious involvement centers on activities and behaviors that occur within religious settings, such as attendance at religious services, participation in activities during service (e.g., singing in choir), and participation in religious activities outside of religious services (e.g., Taylor, Chatters, & Joe, 2011). In the context of adolescent development, religion has been cited as a significant agent of socialization promoting pro-social values (e.g., volunteering) and lower involvement in health risk behaviors (e.g., substance use) (Donahue & Benson, 1995; Wallace, Jr., Brown, Bachman, & Laveist, 2003). Furthermore, religious involvement provides access to coping mechanisms that assist adolescents in successfully negotiating stressful or challenging situations (Smith, 2003), potentially leading to better mental health. However, less is known about Caribbean Black adolescents’ religious involvement and associated health risk behavior or wellness outcomes. Research on Caribbean Blacks is needed, given a rising share of the U.S. Black population is foreign-born, particularly from the Caribbean (Anderson, 2015).

Though there is a growing body of literature on organized religious involvement and mental health among adolescents, there is a dearth of literature on these relationships among Caribbean Black adolescents in the US. This is due, in part, to the utilization of terms like African American or Black to be an all-encompassing label in research among Black adolescents (e.g., Rumbaut, 1994),...
which limits our understanding of within group experiences during adolescent development (Coll et al., 1996; Rum- baut, 1994). Few studies of Black adolescents’ development, health, and behavior have examined ethnic group differences. Accordingly, this study will explore the prevalence of organized religious involvement and association between organized religious involvement and mental health among Caribbean Black adolescents in the US. The next section reviews the sparse literature on religion and mental health among this population. Our review will include studies on adolescents in general, Black or African American adolescents, and adolescents living in the Caribbean to give some context about the concepts we are exploring.

Prevalence of Religion Among Adolescents

The literature suggests that further research on the effect of religious involvement in adolescence is important (Smith, Denton, Faris, & Regnerus, 2002), in light of the number of adolescents who profess some level of religious involvement. The majority of American teens are affiliated with a religious institution (Smith et al., 2002; Wallace, Jr. & Forman, 1998). National data on American teens, 13–17, show that 84 % believe in God, 61 % attend religious services at least once per month, and 39 % participate in a religious youth group (Denton, Pearce, & Smith, 2008). Ohene, Ireland, & Blum (2005) report that among youth residing in the Caribbean, 84 % identify affiliation with a religious denomination (e.g., Christian, Muslim). Research also shows that Black adolescents highly esteem religion, exhibit more frequent attendance and participation than other subgroups of adolescents, and turn to religious practices as a means of coping during adversity (Donahue & Benson, 1995; Smith et al., 2002; Wallace, Jr. et al., 2003). Though some information about prevalence exists for Black adolescents in the US as a whole, scant research exists on the prevalence of religious involvement and participation among Caribbean Black adolescents in the US. These statistics would be important to understand the level and type of religious involvement among this ethnic subgroup.

Religion as a Protective or Promotive Resource

Smith (2003) proposes nine interrelated factors that theoretically help to explain how and why religion supports positive developmental outcomes among youth. These nine factors are clustered within three dimensions: moral order, learned competencies, and social and organizational ties. Moral order promotes normative ideas (e.g., of right and wrong) grounded in the cultural traditions of the religious organization. Within moral order, the three factors of moral directives (e.g., self-control), spiritual experiences within the religious setting (e.g., witnessing a miracle), and adult and peer role models help youth internalize standards and values used to guide and evaluate their decisions and behavior (C. Smith). Others religion researchers may consider this as a mechanism of social control (Regnerus, 2003; Wallace Jr. & Forman, 1998), where the moral values, standards, and norms of suitable behaviors of the religious group are fortified by consistent interaction among group members. This sense of moral order or inculcation of standards and norms may promote less inclination to engage in risky or deviant behaviors (Milot & Ludden, 2009; Regnerus, 2003) and protect against negative psychological functioning.

Smith (2003) further suggests that religion affords youth opportunities to develop learned competencies including community and leadership skills, coping skills, and cultural capital (e.g., acquisition of musical skills). Through the development of these skills, religion contributes to enhanced wellbeing, positive development, and improved life chances among adolescents. For example, a sense of shared values, beliefs, and practices (Milot & Ludden, 2009; Smith, 2003) may foster the development of cognitive and behavioral mechanisms. This, in turn, may help adolescents cope with typical as well as difficult life experiences, engage in productive problem solving, and deal with challenging emotions, resulting in enhanced wellbeing (Milot & Ludden, 2009; Regnerus, 2003; Smith, 2003).

Finally, organized religious involvement is a mechanism for the development of social and organizational ties that can extend beyond the religious setting. Smith (2003) suggests that this develops through factors of social capital, network closure (e.g., other adult monitoring), and extra-community links (e.g., connections to other community organizations). Thus, organized religious involvement can afford adolescents opportunities to develop non-familial social ties and caring relationships with adults who provide emotional and physical support (Koenig, 2001; Milot & Ludden, 2009; Regnerus, Smith, & Fritsch, 2003), as well as link youth to other beneficial resources in the larger religious and secular communities (Smith, 2003). For Caribbean immigrant adolescents, these social and organizational ties foster a sense of identity and belonging (Waters, 1999). Key messages from the religious setting may also integrate customs and traditions from their native country (Butler-Barnes et al., 2016). Both the sense of belonging and key messages may support the Caribbean adolescent’s transition to the US.
Mental Health

Mental Health Problems Among Black and Caribbean Black Adolescents

Consistent with the pattern of adolescents in general, Black adolescents on the whole are resilient; however, they may be at higher risk for adverse behavioral and psychosocial outcomes, due to overrepresentation in stressful environments and disadvantaged social contexts created by higher poverty levels (e.g., DeNavas-Walt, Proctor, & Smith, 2009; Hammack, 2003; Lewis, Byrd, & Ollendick, 2012). In the US, studies show a slightly higher prevalence of any disorder (e.g., mood disorders) for non-Hispanic Black adolescents compared to non-Hispanic White adolescents (46 vs. 42 %) (Kessler et al., 2012). For adolescents born and residing in the English speaking Caribbean, the literature reports a similar and concerning trend. Fifteen percent of these adolescents reported significant emotional distress in the Caribbean Youth Health Survey (Blum et al., 2003). Similarly, moderate to severe depression was reported among adolescents in specific English speaking Caribbean countries such as St. Kitts & Nevis (24.5 %; Lowe et al., 2009), Trinidad (24 %; Maharajh, Ali, & Konings, 2006), and Jamaica (40.6 %; Lipps et al., 2010).

A Broader Conceptualization of Mental Health

Historically, the term mental health has been used to represent solely the absence of mental illness (Smith, 1959). However, Kazdin (1993) contends that mental health incorporates “the absence of dysfunction in psychological, emotional, behavioral, and social spheres...optimal functioning or well-being in psychological and social domains” (p. 128). Other definitions underscore a more positive conceptualization of mental health. For example, the U.S. Department of Health and Human Services (USDHHS) defined mental health as a “state of successful mental functioning, resulting in productive activities, fulfilling relationships, and the ability to adapt to change and cope with adversity” (USDHHS, 2013, para. 2). These definitions suggest the inclusion of positive mental health factors such as self-concept and mastery, and successful coping and problem solving in addition to negative functioning indicators, such as depression. Much less is known about positive mental health functioning among adolescents (Knopf et al., 2008) and factors promoting better functioning. Consequently, and consistent with Kazdin’s definition (1993), this study will include positive mental health indicators such as self-esteem, mastery, coping, and life satisfaction in addition to more common mental health problem indicators such as depression, when conceptualizing mental health.

Religion and Mental Health

Discrepant findings have been noted in the literature on religion and mental health among adolescents. Religious service attendance has been protective of suicide ideation (Ali & Maharajh, 2005), depressive symptoms (Maharajh et al., 2006) and incidences of rage (Blum et al., 2003) among English speaking Black youth residing in the Caribbean. Concomitantly, greater desire to participate in religious activities (Schapman & Inderbitzen-Nolan, 2002) and positive support from religious organization members (Pearce, Little, & Perez, 2003) was associated with less depressive symptoms among diverse samples of adolescents. Similarly, Rose, Joe, Shields, and Caldwell (2014) found that choice to attend organized religious activities, such as youth groups, was related to lower psychosocial wellbeing problems among African-American and Caribbean Black youth. Qualitative data also suggests that African-American youth dealing with depression find emotional support through their religious organizations particularly in regards to being encouraged to seek treatment (Breland-Noble, Wong, Childers, Hankerson, & Sotomayor, 2015). In contrast, no significant associations were found between religious service attendance and depression (Milot & Ludden, 2009) or suicidal attempts and thoughts (Nonnemaker, McNeely, & Blum, 2003) among adolescents, generally.

Organized religious involvement also fosters better mental health outcomes. For example, religious service attendance has been related to better self-esteem and psychological functioning among African-American female youth (Ball, Armistead, & Austin, 2003). Similarly, religious service attendance and active participation in church was related to religious coping (e.g., collaborative coping) among African American adolescents (Molock, Puri, Matlin, & Barksdale, 2006). Further, Rose et al. (2014) found that choice to attend organized religious activities was related to better psychosocial wellbeing among African American and Caribbean Black youth. This concept was found to be important in understanding overall organizational participation among youth (Rose et al., 2014). However, religious service attendance did not predict better self-esteem among African-American or Caribbean Black youth in the same sample (Butler-Barnes et al., 2016).

In general, the equivocal findings suggest a lack of specificity about the aspects of organized religious involvement that are protective for mental health problems. The research also evinces a gap in the literature regarding the association between organized religious involvement and positive aspects of mental health (e.g., mastery, life-satisfaction).
Current Study

The literature revealed that among Caribbean Black adolescents in the US there is limited information about the prevalence of organized religious involvement; minimal research examining which aspects of organizational involvement are related to mental health problem outcomes, besides religious service attendance; and very little research about the association of organized religious involvement and positive mental health outcomes (e.g., self-esteem, mastery). Compounding this challenge is the lower representation of Black adolescents, including Caribbean Black adolescents, in mental health research (USDHHS, 2001), which limits our understanding of factors that support better mental health among these youth. This exploratory study aims to begin to address these gaps in the literature. Our research questions are (1) What is the prevalence of organized religious involvement among Caribbean Black adolescents in the US? and (2) What is the relationship between organized religious involvement (e.g., religious service attendance, participation during religious services) and mental health (e.g., self-esteem, depressive symptoms) among Caribbean Black adolescents in the US? For the purpose of this study, organized religious involvement includes commonly explored concepts such as religious service attendance, religious activity participation, and participation during religious services. We also include less explored constructs connected to organizational involvement such as receiving emotional support from religious institution members and choice to attend religious services and participate in religious activities. Consistent with our conceptualization, mental health indicators include active coping, self-esteem, mastery, life-satisfaction, and depressive symptoms.

Method

Study Design, Sampling, and Data Collection

This study utilizes data from the adolescent sample of the 2001–2003 National Survey of American Life (NSAL; Jackson et al. 2004), conducted by researchers at the Program for Research on Black Americans through University of Michigan’s Institute for Social Research. The NSAL is an IRB-approved nationally representative household survey which utilized a stratified and clustered sample design to obtain a nationally representative sample of 3570 African American (AA), 1006 non-Hispanic Whites, and 1621 Blacks of Caribbean descent (CBs) aged 18 years and older (see Jackson et al., 2004 for more information on the NSAL). To produce the NSAL-Adolescent sample (NSAL-A), every AA and CB household that included an adult participant in the NSAL was assessed for an eligible adolescent living in the household. Adolescents were subsequently selected using a randomized procedure. If multiple adolescents in the household were eligible, up to two adolescents were selected for the study, and where possible, the second adolescent was of a different gender (Sweetman, Baser, Rafferty, Torres, & Matusko, 2009). The NSAL-A weight was calculated to adjust for variation in probabilities of selection within households, and non-response rates for adolescents and households. The weighted data were post-stratified to approximate the national population distributions for gender (male and female subjects) and age (13, 14, 15, 16, and 17 years old) subgroups among Black adolescents (Joe, Baser, Neighbors, Caldwell, & Jackson, 2009).

Before the interview, informed consent was obtained from the adolescent’s legal guardian and assent acquired from the adolescent. Most adolescent interviews (82%) were conducted in their homes, by trained interviewers, using a computer-assisted instrument. About 18% were also conducted either in part or fully by telephone. Respondents were paid $50 for their participation in the study; the overall response rate was 80.6% (80.4% for AAs and 83.5% for CBs) (Joe et al., 2009). Only AA and CB adolescents were interviewed.

Measures

Religion

Religious Emotional Support This scale measures how often adolescents receive emotional support from members of their religious institutions. Sample items include “How often do the people in your place of worship express interest and concern in your well-being?” The items were derived from the Fetzer Institute measures of family support (Fetzer Institute/National Institute on Aging Working Group, 1999). Participants responded 1 (very often) to 4 (never). All items were reverse scored, summed, and the mean calculated so that higher scores indicate a greater level of support. Reliability for the scale in the NSAL-A is α=.72 for the Caribbean Black sample.

Religious Service Attendance Religious service attendance was measured by the question, “How often do you usually attend religious services?” Participant responses ranged from 1 (nearly every day—4 or more times a week) to 6 (never). The responses were coded such that a higher number represented greater religious service attendance.
Religious Participation During Service

Religious service participation was measured by the question, “Do you do things like sing in the choir, read scripture, or other things like that during service?” The variable was coded such that 0 = no service participation and 1 = service participation.

Religious Activity Participation Adolescent participation in activities at a religious institution, outside of church service, was measured by the question, “Besides regular services, how often do you take part in other activities at your place of worship?” The responses ranged from 1 (nearly every day—4 or more times a week) to 5 (never). For this variable, higher numbers represented greater participation.

Choice to Attend Religious Service and Choice to Attend Religious Activities These were two separate constructs representing choice. They were measured with the questions: “Do you go to religious services because you want to, or because your parents/guardians make you go?” and “Do you go to these other [religious] activities because you want to, or because your parents/guardians make you go?” Participants responded either 1 (choose), 2 (parents/guardians make you go), or 3 (both). Responses were coded so that higher values represent adolescent self-directed choice to attend and lower numbers represent the parent making the adolescent attend.

Mental Health

Self-esteem The Rosenberg Self-Esteem scale (Rosenberg, 1965), which assesses global self-esteem, includes 10 items, scaled on 4-point responses, ranging from 1 (strongly agree) to 4 (strongly disagree). Sample items from the scale include “On the whole, I am satisfied with myself” and “I feel that I have a number of good qualities.” Positively worded items were reverse scored. Higher scores indicate better self-esteem. Internal consistency for the scale has been reported at .92. Additionally, validity tests of the scale indicate good criterion and construct validity (Fischer & Corcoran, 2007). Reliability for the scale in the NSAL-A is \( \alpha = .69 \) for the Caribbean Black sample.

Active Coping The John Henryism scale (James, 1996) is a 12-item measure of high effort coping. A sample item from the scale is “I’ve always felt that I could make of my life pretty much what I wanted to make of it”. For the NSAL-A study, the rating items include responses ranging from 1 (completely true) to 4 (completely false), a slight adaptation of the original 5-point scale. Each item was reverse scored and summed to obtain a total score, with higher scores representing higher levels of John Henryism. Internal consistency for the scale has been reported to vary between .70 and .80 (James, 1994). In addition, both convergent and discriminant validity have been established for the scale (Fernander, Duran, Saab, Llabre, & Schneiderman, 2003). Reliability for the scale in the NSAL-A is \( \alpha = .66 \) for the Caribbean Black sample.

Mastery The Pearlin’s Mastery scale assesses individuals’ sense of control over their own life chances (Pearlin & Schooler, 1978). The scale includes seven items, scaled on 4-point responses, ranging from 1 (strongly agree) to 4 (strongly disagree). A sample item from the scale is “I can do just about anything I set my mind to”. Positively worded items were reversed scored, and averaged so that higher mean scores indicate greater mastery. Satisfactory internal consistency (i.e. \( \alpha = .77 \)) (Marshall & Lang, 1990) and validity has been established (Pearlin & Schooler, 1978). For the current study, mean scores were recalculated to reflect the seven questions from the original mastery scale, as the NSAL-A data utilized an adapted version. Reliability for the scale in the NSAL-A is \( \alpha = .74 \) for the Caribbean sample.

Life Satisfaction This single item question asked adolescents “How satisfied with your life as a whole would you say you are these days?” Responses ranged from 1 (very satisfied) to 4 (very dissatisfied)? Items were coded such that higher scores represented greater life satisfaction.

Depression Depressive symptoms were measured using the 12-item CES-D scale (Radloff, 1977), which assesses depressive symptoms in the past week. Participants consider the past week in response to statements such as “I felt depressed” and “I was happy”. Rating items include responses ranging from 0 (rarely or none of the time; less than 1 day) to 3 (most or all of the time; 5–7 days). Positively worded items were reversed scored. Higher scores indicate greater depressive symptoms. Reliability for the scale is \( \alpha = .71 \) for the Caribbean Black sample.

Data Analysis

To obtain prevalence rates for religion among Caribbean Black adolescents, descriptive data was analyzed. Specifically, weighted frequencies were used to calculate prevalence of all religion variables, in general and by age group except for religious emotional support where weighted means were employed. Pearson’s correlation analysis was used to examine associations between religious activities and mental health indicators. Correlational data reported here are unweighted.
Results

Participants

The original NSAL-A Caribbean Black adolescent sample consisted of 360 adolescents ranging in age from 13 to 17 years. This is the sample used for analysis and to examine our questions of interest. The majority were U.S. born (60.0 %) and had one or both parents born in the Caribbean (72.2 %). Most of the sample’s (75.3 %) ancestral ties were from six Caribbean countries, including Jamaica (32 %), Haiti (18.7 %), Trinidad and Tobago (10.5 %), Guyana (5.6 %), Barbados (4.7 %), and Puerto Rico (3.8 %) (Butler-Barnes et al., 2016). There were slightly more girls than boys in the sample (54.2 vs. 45.8 %). Further, slightly more than half of the families reported income in the $18,000–$54,999 range (56.3 %). Average household income for the sample was $38,829. Finally, 27 % reported being Catholic followed by Protestant (23.9 %; e.g., non-denominational), Baptist (16.5 %), and Pentecostal (13.7 %). Only three percent reported no denomination.

Religious Prevalence

Results from Table 1 show that Caribbean Black adolescents receive a moderate level of emotional support from church members (X = 2.96, SE 0.02). About 37 % of the sample attends religious services one or more times a week, with 62 % attending a few times a month or more. When they attend, 37 % participate during the services. Additionally, 21 % report attending activities outside of service at least once a week, with about 40 % attending a few times a month or more. Caribbean Black adolescents in this sample are choosing to attend religious services (49.4 %) and/or choosing to attend religious activities (80.3 %) on their own.

Differences in prevalence are reported when examined by age of adolescents (early vs. late adolescence; Table 2). 66 % of late adolescents attended religious services a few times a month or more compared to 54 % of early adolescents. However, late adolescents did not participate during the services as much as the early adolescents (33 vs. 47 %). More early adolescents made the choice to attend religious services (72 vs. 41 %) and activities (85 vs. 78 %) compared to late adolescents.

Religion and Mental Health

Evidence of significant relationships between religion and mental health were observed for active coping, self-esteem, and depressive symptoms (Table 3). A positive correlation was found between active coping and both participation during religious services (r = 0.13; p < 0.05) and in religious activities (r = .15; p < .05). Receiving religious emotional support was also positively correlated with active coping (r = .24; p < .05). Choice to attend religious services was directly related to greater active coping (r = .16; p < .05), higher self-esteem (r = .17; p < .05), and lower depressive symptoms (r = -.12; p < .05). The results also indicate that choice to attend religious activities was related to lower depressive symptoms (r = -.16; p < .05). Religious service attendance was not related to any of the mental health indicators. Neither mastery nor life satisfaction were related to any of the religion variables.

Discussion

Findings from this exploratory study provide us with an initial view of organized religious involvement for Caribbean Black adolescents in the US. The majority report participating in some organized religious activity. Caribbean Black adolescents attend religious services weekly more than participating in other kinds of activities related to religious involvement (e.g., youth groups, bible study). Of those who do attend and participate in organized religious activities, close to half are choosing to go and don’t feel compelled to do so by parents. This may be because Caribbean Blacks are more orthodox in their religious beliefs than say African Americans (Waters, 1999), and due to the resources and activities available at religious institutions. These findings are aligned with the extant literature, which shows that Black adolescents exhibit relatively high attendance and participation in religious activities (e.g., Smith et al., 2002; Wallace Jr. et al., 2003). The study also showed that a lower percentage of older adolescents, compared to younger adolescents, report choosing to attend both religious services and activities. This speaks more to their developmental stage than their ethnicity, particularly for choosing to attend religious services. Older adolescents are expected to desire increased autonomy over personal issues, especially moral and religious issues (Daddis, 2011), and may perceive attendance as a restriction of their autonomy.

Findings in the present study related to active coping are consistent with the supposition of Milot and Ludden (2009), for example, who suggest that participation in religious organizations fosters coping mechanisms that help adolescents successfully handle both normal and challenging life circumstances. Specifically, in this sample, active coping was directly related to religious emotional support and increased with religious participation during service, religious activity participation, and the choice to
attend religious services. These religious activities provide opportunities for the adolescent to interact with peers and other adults in an environment where there are similar belief systems (Schnittker, 2001), and choosing to attend may reflect a growing sense of independence, for both younger and older adolescents. To maximize the impact of this and promote mental health, better coping mechanisms may be fostered by emotional support provided by non-familial caring adults, like those found at religious institutions, as well as by connecting adolescents to prosocial or like-minded peers through participation in religious activities.

As self-esteem was positively related to choice to attend religious services, it is possible that this is directly related to adolescent’s developmental need for autonomy. Choosing to attend encourages identity development and allows youth to express their decision-making skills. Interestingly, a greater proportion of younger adolescents, compared to older adolescents, made the choice to attend religious services. It is possible that older adolescents involved in organized religion desire greater opportunity to interact with peers (e.g., through participation in religious activities), thus the choice to attend religious services may actually diminish over the course of adolescence. For African American adolescents, high cultural self-esteem leads to high individual self-esteem (Constantine, Donnelly, & Myers, 2002). Religious involvement has also been found to foster a sense of identity and belonging to a cultural group for Caribbean Black adolescents (Waters, 1999). Taken together, there may be a similar relationship between cultural identity and belonging and individual self-esteem in this sample of Caribbean Black adolescents.

Meta-analyses of numerous studies have shown negative correlations between religious involvement broadly defined and depressive symptoms (Smith, McCullough, & Poll, 2003). As aforementioned, our understanding of this trend among both African American and Caribbean Black adolescents is limited due to their lower representation in mental health research. Our findings that choice to attend religious services and activities are related to lower depressive symptoms, while preliminary, suggests that for Caribbean Black adolescents some forms of religious involvement may serve as a protective mechanism for mental health problems such as depression. Further research can explore the pathways that support this proposition.

Contrary to expectations, this study did not find correlations between religious service attendance and any of the mental health variables. These findings are consistent with other research (e.g., Milot & Ludden, 2009) that did not find a relationship between religious service attendance and depression. It is possible that for these adolescents, physical attendance at religious services represents conforming to family expectations or is based on parental influence. Thus, attendance, by itself, or adolescent sense of obligation to attend religious services would not necessarily encourage a sense of wellbeing.

Limitations and Areas of Future Research

There are some limitations to consider when reviewing these findings. The purpose of this paper is to address the gaps in the literature related to religious involvement and mental health among Caribbean Black adolescents. It utilizes data from a nationally representative dataset to derive its findings. However, as the study is cross-sectional in design and uses retrospective self-report data, causal

Table 1 Prevalence of organized religious involvement among Caribbean Black youth

| Religion variable | Religious emotional support [Mean(SE)] | %wt\(^a\) | 95 % CI |
|-------------------|--------------------------------------|----------|---------|
| Religious service attendance | 2.96(0.02) | 4.2 | 0.7–21.3 |
| Never | 9.2 | 4.6–17.6 |
| Less than once a year | 24.5 | 21.8–27.4 |
| A few times a year | 24.8 | 15.2–37.7 |
| A few times a month | 32.1 | 22.1–44.0 |
| At least once a week | 5.2 | 3.0–9.0 |
| Near every day |
| Religious activity participation | | | |
| Never | 29.4 | 25.1–34.2 |
| A few times a year | 30.2 | 18.1–45.8 |
| A few times a month | 19.5 | 15.2–24.8 |
| At least once a week | 17.5 | 11.8–25.2 |
| Near every day | 3.4 | 1.6–7.2 |
| Religious participation during service | | | |
| No | 63.3 | 52.9–57.1 |
| Yes | 36.7 | 36.7–47.1 |
| Choice to attend religious service | | | |
| Parents make you go | 31.2 | 27.9–34.8 |
| Both | 19.4 | 11.5–30.9 |
| Adolescent choice | 49.4 | 38.5–60.3 |
| Choice to attend religious activities | | | |
| Parents make you go | 8.3 | 5.2–13.0 |
| Both | 11.4 | 5.4–22.7 |
| Adolescent choice | 80.3 | 68.1–88.6 |

All weighted estimates are weighted to be nationally representative of the given population and subpopulations in the contiguous 48 states of the United States. Standard errors are adjusted for the sampling stratification, clustering, and weighting of the data.

\(^a\) Weighted

SE standard error, CI confidence interval
Table 2 Prevalence of organized religious involvement among Caribbean Black youth by age group

| Religion variable | Age group                        | Early adolescence (13–15) | Late adolescence (16–17) |
|-------------------|----------------------------------|---------------------------|--------------------------|
|                   | N = 126                          | N = 231                   |
| Religious emotional support [Mean(SE)] | 3.05 (.16)                     | 2.93 (.06)                |
|                   | N<sup>a</sup> %wtb | N<sup>a</sup> %wtb |
| Religious service attendance |                        |                           |                          |
| Never             | 3                                | 11.7                      | 4                        | 0.9                      |
| Less than once a year | 13                              | 13.7                      | 24                       | 7.3                      |
| A few times a year | 27                              | 20.3                      | 45                       | 26.3                     |
| A few times a month | 24                              | 16.4                      | 50                       | 28.5                     |
| At least once a week | 51                              | 34.1                      | 92                       | 31.2                     |
| Nearly every day  | 8                                | 3.9                       | 16                       | 5.8                      |
| Religious activity participation |                        |                           |                          |
| Never             | 19                               | 12.0                      | 56                       | 35.7                     |
| A few times a year | 34                              | 27.0                      | 60                       | 31.3                     |
| A few times a month | 27                              | 36.0                      | 36                       | 13.6                     |
| At least once a week | 27                              | 18.6                      | 43                       | 17.1                     |
| Nearly every day  | 3                                | 6.4                       | 8                        | 2.3                      |
| Religious participation during service |                        |                           |                          |
| No                | 58                               | 53.3                      | 113                      | 66.9                     |
| Yes               | 52                               | 46.7                      | 90                       | 33.1                     |
| Choice to attend religious service |                        |                           |                          |
| Parents make you go | 27                              | 18.6                      | 49                       | 35.7                     |
| Both              | 14                               | 9.6                       | 25                       | 22.9                     |
| Adolescent choice | 68                               | 71.7                      | 129                      | 41.4                     |
| Choice to attend religious activities |                        |                           |                          |
| Parents make you go | 11                              | 9.6                       | 16                       | 7.7                      |
| Both              | 6                                | 4.9                       | 8                        | 14.6                     |
| Adolescent choice | 74                               | 85.4                      | 123                      | 77.8                     |

All weighted estimates are weighted to be nationally representative of the given population and subpopulations in the contiguous 48 states of the United States. Standard errors are adjusted for the sampling stratification, clustering, and weighting of the data

<sup>a</sup> Unweighted, <sup>b</sup>Weighted

SE standard error, CI confidence interval

Table 3 Correlations between religion and mental health among Caribbean Black youth

| Religion variable | Coping | Self-esteem | Depressive symptoms | Mastery | Life satisfaction |
|-------------------|--------|-------------|---------------------|---------|-------------------|
| Religious emotional support | .24* | .07 | .02 | .05 | .05 |
| Religious service attendance | −.04 | .07 | −.01 | .07 | .06 |
| Religious activity participation | .15* | .03 | .02 | −.05 | .08 |
| Religious participation during service | .13* | .01 | .04 | .05 | .04 |
| Choice to attend religious service | .16* | .17* | −.12* | .05 | .09 |
| Choice to attend religious activities | .04 | .09 | −.16* | .11 | .06 |

Correlations are unweighted. r Pearson correlation

* p < .05
inferences cannot be made. In addition, the findings are only generalizable to adolescents of similar backgrounds in the US, but not to adolescents in the Caribbean or a broader African American or adolescent population.

Notwithstanding, this study provides important new information on Caribbean Black adolescents’ involvement in organized religious activities. The findings suggest that organized religious activities were important for Caribbean Black adolescent mental health. Specifically, for these adolescents, participation in certain aspects of religious life fosters a sense of coping, which is consistent with the function of religion among adults. An important finding to emerge was that those who chose to attend versus being forced to go appear to derive more benefit of their participation in religious life. Similar to self-determination in social work, this construct was associated with better mental health outcomes as well as lower mental health problems. This idea of choosing to attend is important to our understanding of the role of organized religious involvement in an adolescent’s life and should be further explored. Future research should also consider within group differences among Caribbean Black adolescents (e.g., gender, age group, religious denomination) when examining the relationship between organized religious involvement and mental health outcomes. Further, multivariate analysis can be applied to better understand predictive relationships between religious and mental health constructs and possible mediators or moderators of those relationships. Concomitantly, longitudinal studies can provide a better understanding of how these relationships vary over time during adolescence. Finally, as religious involvement is often construed as an aspect of social control, future research could examine how deviation from accepted norms and values of the religious institution may influence mental health and other health-related behaviors.

**Implications for Social Work**

Religion is a concern to social work research, education and practice; and, it is important for practitioners to consider the needs of those clients for whom religion is important. How religious issues are addressed can affect the wellbeing and identity of clients. This may be particularly important for Caribbean Black adolescents as they may be simultaneously negotiating identity development within their peer groups as well as potentially within a new culture. Social work practitioners “start where the client is” and inherently apply a strength-based perspective in practice. Thus, it is important for social workers to assess and further explore the role organized religious involvement may play in promoting better mental health among Caribbean Black youth. Identifying these strengths and assets are also significant to the development of the practice relationship. Given that coping was correlated with various aspects of organized religious involvement (e.g., religious activity participation, religious emotion support), adolescents could be encouraged to draw upon their religious involvement, through teachings or connection with peers and caring adults, to help them cope with challenging circumstances.

Based on the prevalence of religious involvement among Caribbean Black youth, social workers may also foster potential linkages with religious or faith-based organizations to collaborate or partner in the service delivery process. These identified networks would be an additional source of emotional and tangible support for youth and their families. Moreover, on a macro level, social workers could assist religious organizations to examine and evaluate the effectiveness of programs within the religious organization that serve or focus on youth. Summarily, social workers and program developers can use the study results to inform the development of individual and group level interventions targeted at supporting the mental health of Caribbean Black adolescents.

**Funding**

The NSAL is supported by the National Institute of Mental Health (NIMH; U01-MH57716) with supplemental support from the OBSSR Office of Behavioral and Social Science Research and the National Institute on Drug Abuse at the National Institutes of Health (NIH) and the University of Michigan to Dr. James S. Jackson. Dr. Joe was supported by a Grant (R01-MH82807) from the National Institute of Mental Health.

**References**

Ali, A., & Maharajh, H. D. (2005). Social predictors of suicidal behaviour in adolescents in Trinidad and Tobago. *Social Psychiatry and Psychiatric Epidemiology, 40*(5), 186–191. doi:10.1007/s00127-005-0846-9.

Anderson, M. (2015). A rising share of the U.S. Black population is foreign born; 9 percent are immigrants: and while most are from the Caribbean, Africans drive recent growth. Washington, DC: Pew Research Center.

Ball, J., Armistead, L., & Austin, B. J. (2003). The relationship between religiosity and adjustment among African-American, female, urban adolescents. *Journal of Adolescence, 26*(4), 431–446. doi:10.1016/S0140-1971(03)00037-X.

Blum, R. W., Halcón, L., Beuhring, T., Pate, E., Campell-Forrester, S., & Venema, A. (2003). Adolescent health in the Caribbean: Risk and protective factors. *American Journal of Public Health, 93*(3), 456–460. doi:10.2105/AJPH.93.3.456.

Breland-Noble, A. M., Wong, M. J., Childers, T., Hankerson, S., & Sotomayor, J. (2015). Spirituality and religious coping in African-American youth with depressive illness. *Mental Health, Religion & Culture, 18*(5), 330–341.

Butler-Barnes, S. T., Martin, P. P., Copeland-Linder, N., Seaton, E. K., Matusko, N., Caldwell, C. H., & Jackson, J. S. (2016). The protective role of religious involvement in African American and Caribbean Black adolescents’ experiences of racial discrimination. *Youth & Society, doi:10.1177/0044118x15626063.*
Rumbaut, R. G. (1994). The crucible within: Ethnic identity, self-esteem, and segmented assimilation among children of immigrants. *The International Migration Review*, 28(4), 748–794. doi:10.2307/2547157.

Schapman, A. M., & Inderbitzen-Nolan, H. M. (2002). The role of religious behaviour in adolescent depressive and anxious symptomatology. *Journal of Adolescence*, 25(6), 631–643. doi:10.1006/jado.2002.0510.

Schnittker, J. (2001). When is faith enough? The effects of religious involvement on depression. *Journal for the Scientific Study of Religion*, 40(3), 393–411. doi:10.1111/0021-8294.00065.

Smith, M. (1959). Research strategies toward a conception of positive mental health. *American Psychologist*, 14, 673–681. doi:10.1037/h0040030.

Smith, C. (2003). Theorizing religious effects among American adolescents. *Journal for the Scientific Study of Religion*, 42(1), 17–30.

Smith, C., Denton, M. L., Faris, R., & Regnerus, M. (2002). Mapping American adolescent religious participation. *Journal for the Scientific Study of Religion*, 41(4), 597–612. doi:10.1111/1468-5906.00148.

Smith, T. B., McCullough, M. E., & Poll, J. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin*, 129(4), 614–636. doi:10.1037/0033-2909.129.4.614.

Sweetman, J., Baser, R., Faison, K., Rafferty, J., Torres, M., & Matusko, N. (2009). The national survey of American life: Methods and analysis. Unpublished manuscript.

Taylor, R. I., Chatters, L. M., & Joe, S. (2011). Non-organizational religious participation, subjective religiosity, and spirituality among older African Americans and Black Caribbeans. *Journal of Religion and Health*, 50(3), 623–645.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—a supplement to mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK44243/

U.S. Department of Health and Human Services. (2013). *Healthy people 2020 Topics and Objectives*. Retrieved from http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28

Wallace, J. M., Jr., Brown, T. N., Bachman, J. G., & Laveist, T. A. (2003). The influence of race and religion on abstinence from alcohol, cigarettes and marijuana among adolescents. *Journal of Studies on Alcohol*, 64, 843–848.

Wallace, J. M., Jr., & Forman, T. A. (1998). Religion’s role in promoting health and reducing risk among American youth. *Health Education & Behavior*, 25(6), 721–741. doi:10.1177/1090198819802500604.

Waters, M. C. (1999). *Black identities: West Indian immigrant dreams and American realities*. New York: Russell Sage Foundation.