Academic Journal of Current Research
Vol.7, No.11; November-2020;
ISSN (2343 – 403X);
p –ISSN 3244 - 5621
Impact factor: 6.37

RELIGIOUS COMMITMENT AND RESILIENCE AS PREDICTORS OF DEPRESSION AMONG ADOLESCENTS WITH PHYSICAL CHALLENGES

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Abstract: This study investigated religious commitment and resilience as predictors of depression among adolescents with physical challenges. It was hypothesized that religious commitment and resilience will significantly predict depression among adolescents with physical challenges.Participants in the study were 78 adolescents (41males and 37 females) with physical challenges who were drawn from three schools of special education in Enugu State and Anambra State in Southeast Nigeria. They were aged 12 to 21 years with mean age 15.92 years (SD = 2.79 years). The design was cross-sectional. Participants completed Religious Commitment Inventory (RCI -10), Resilience Scale (RS-14), and Self Rating Depressive Scale.Results showed that resilience was a significant negative predictor of depressive symptoms (β = .29, $p < .05$). Intrapersonal component of religious commitment did not significantly predict depressive symptoms (β = -.03, $p < .01$). Interpersonal religious commitment was a significant negative predictor of depressive symptoms (β = -.51, $p < .001$). It was concluded that depression may be best avoided or reduced in adolescents with physical challenges by building self-confidence and a sense of optimism in them before they enter this phase of their lives i.e. during childhood stage. Again adolescents with physical challenges are enhanced by their social experiences in religious environments or religious gathering than with their private practices and thus are advised to have confidants or a sufficient social network to avoid mental health difficulty.

Keywords: Religious Commitment, Resilience, Depression, Adolescents, Physical Challenges

INTRODUCTION

Researchers have explored and documented the construct of religious commitment, resilience and depression and how these constructs are related as regards adolescent's development. However, there is still need to explore further how these constructs are related as regards adolescents with physical challenges. This research provides evidence for the study of religious commitment and resilience as predictors of depression among adolescents with physical challenges. Each of these constructs are examined individually and in their relation to each other Research has shown that millions of young people between the ages of 10 to 24 are physically challenged (Groce, 2004). Despite the increasing number of this group of adolescents, they are most often excluded from the global assessment of educational, social and economic development. Because this group is socially marginalized, they have different kinds of both social and emotional disturbances as stated by Adesokan (2003) when he said that the physically challenged suffer from rejection, isolation and maltreatment from other members of the society. In the society today, physical ability and

effective motor functioning are highly valued such that people with physical challenges are in most cases regarded as burden to the society (Hussain, 2006). This supports the view of Adesokan (2003) that challenged persons are shown negative attitude since they are seen as objects of ridicule, shame and pity. Most of them from a very poor family background do not achieve even the least level of education and other benefits due for individual of their age. They stay at home and face the challenge of their impairment. Only those who are by birth opportune to have wealthy and educated parents, stand to have the chances of mixing with the outside world. Some of them in the Nigerian situation are seen along the roadside begging; some are used by older adults to make profit for themselves.

In most cases these adolescents who are in schools face a lot of challenges from others due to their disability. They are mostly isolated from others in the school. Some of the adolescents with visual impairment who the researcher encountered before carrying out the research complained that they don't copy notes in the class because they have nobody to read the notes for them to copy. This happens because due to financial constrain, they could not afford the Braille which the blind use in writing. For those who have it other students sometimes find it difficult to dictate the lesson notes from the teachers for them. They see them as burden and try as much as possible to avoid them. Hence disability prevents the adolescents from having access to all the facilities in the environment where they are (Okoye, 2010; Viney, 2006). This is one of the major problems they face and this can lead to frustration; as a result they may be unable to actualize their dreams. Many adolescents with physical challenge encounter problems in going about their daily activities. Some of them who are pupils or students in secondary schools find it difficult to assess places like their class rooms, hostels, they also find it difficult to get to the refectory for meals, to the lavatory and other areas in the school premises without other peoples assistance; they face the problem of moving around freely and associating with others and other places within the school premises. They also face the challenges of qualified special education teachers, like sign language; some of them with visual impairment don't have access to Braille, and those who have can't get people to help them with the teaching because there are no textbooks in Braille which they can read on their own (Okoye, 2010). Other students mostly see them as burden and charge them for helping. They are always treated as outcast from among the others. Some of them said that even their family members regret having them in the family because they constitute a burden for them. One of them said openly that she is tired of living. Some of them don't finish their education because of these things. With the lack in all these things, adolescents with physical challenges may not benefit much in the school.

According to Lawal-Solarin (2010), physically challenged is an inability to perform some or all tasks of daily life or a medically diagnosed condition that makes it difficult to engage in the activities of daily life. Nai and Anuradha (2014) were of the view that physical challenge/ disability is a person's limitation to function a particular action in everyday life which may have several causes, the prenatal disabilities before birth; it can be of diseases, genetic disorders, or lack of oxygen. Also there can be post-natal disabilities gained after birth such as due to accidents, infection or illness etc. (Nai & Anuradha, 2014). Disability may also be referred to as a condition that substantially limits one from more basic physical activities, such as walking, reading etc. (Okoye, 2010). Saliu, Rabiu and Alabi (2016) stated that there are many challenges or disability, both physically and mentally which include blindness, deafness, and deformity, loss of limbs, mental illness etc. Many causes and condition can impair mobility and movement. The inability to use arms, legs, or the body trunk effectively

because of paralysis, stiffness, pain or other impairments is common. It can be due to the result of birth defects, disease, age or accidents (Nai &Anuradha, 2014). Disability, impairment and handicap are related but they do not really mean the same thing. There is little difference in their meanings (Okoye, 2010). In the process of this paper, they may be used interchangeably just like other researchers have used them. Crisp (2002) tried to differentiate the three. He came up with the view that a person who has a physical or intellectual problem is said to be impaired e.g. a person who has short-sightedness has a vision impairment. In a situation whereby the person's impairment means that he is unable to function in the same way as most people in that particular area, then he is considered disabled. For example, a person who has glaucoma does not have a full field of vision as most people and therefore has a visual disability. Then, if the person's disability means that he cannot have access to the same things as the majority of people, he is considered handicapped. For example a blind person who does not have access to assistive devices such as the cane, glasses, guide dog and so on is said to be visually handicapped (Crips 2002 as cited in Okoye 2010).

Crisp (2002) also attempted to distinguish physically disability and handicap. According to him, physical disability is not a synonym for disability handicap. Rather handicap is a disadvantage that occurs as a result of a disability or impairment. It refers to the external circumstances, which place people with disabilities at a disadvantage in relation to their peers and the norms of society. Handicaps include physical barriers such as inaccessible entrances to buildings, barriers to education, employment opportunities and negative public attitudes (Crips, 2002) as in (Okoye, 2010).

In most cases being an adolescent with physical disability is one of the most difficult things in the life of adolescents. This is because they do not understand why they are made in such condition while others are normal. This disability limits them to certain activities and even impairs some of their daily functioning; and as a result emotional disturbances like depression may set in. Pizzi (2008) stated that it is not easy to live with a physical disability. It is draining on one's emotions, specifically, because not enough people understand physical disabilities or show a high enough level of compassion for people suffering from a disability (Pizzi, 2008). In the process of writing this report, adolescents with physical challenges are referred to as adolescents with physical disability. Hence, according to WHO, (1996), disability is any restriction or lack of ability to perform an activity in a manner or within a range considered normal for a human being. The ability to cope with disability depends on the individual and the area of the disability. If the aids are provided for those with disability, it will prevent them from being handicapped. For example, a person with visual impairment who is not totally blind can be aided with glasses, one who has hearing impairment that can be aided with hearing aids; those who use wheel chair can move around with it except in a place where the wheel chair cannot move around (Okoye, 2010). Some of these adolescents may have been born with the disability or may develop it as a result of accidents, wars, diseases such as polio, natural disasters, malnutrition (Okoye, 2010). These disabilities prevent the individual from doing what others of his/age is doing. In this study, adolescents within the following disability categories were studied: deaf and hard of hearing (hearing impaired) and blind and low vision (visual disability).

Depression according to Comer (2008) is "a low, sad state in which life seem dark and its challenges overwhelming" (Comer, 2008, p. 187). It is an internal sadness which comes with feelings of hopelessness, despair, helplessness, low self-worth and loss of control (Rostami, Bahmani, Bakhtyar, & Movallali, 2014). Depression was defined by Thapar, Collishaw, Pine and

Thapar (2012) as a cluster of specific symptoms with associated impairment. Some researchers (Lewinsohn, Pettit, Joiner, & Seeley, 2003; Thapar, Collishaw, Potter, &Thapar, 2010) have found that the clinical and diagnostic features of depression are similar in both adolescents and adults. Depression in adolescents may stem from a wide variety of situations that involve social interactions such as, failure, loss of a person, rejection and so on, but in some cases depression can be caused by physical disability especially when it impairs the adolescent's normal functioning (Fellinger, Holzinger, &Pollard, 1998). The negative consequences of depression make adolescence a critical time for prevention of efforts and identifying factors that promote well-being (Pearce, Little, &Perez, 2003).

Watt and Davis (1991) used the revised Beck's Depression Inventory (BDI) to investigate the prevalence of depression among 50 deaf adolescents in a deaf residential school. Results showed that deaf participants were significantly more depressed as a group (M = 10.52) than hearing participants (M = 6.59). Other researches (e.g. Dai, Landsberger, Povlinski, Shewerd, &Scully, 2013; Ligh & Anthony 2001) also found a positive correlation between depression and the physically challenged. Lin, Jau-Hong, Ju et al. (2009) investigated do bodily disabilities affect self-perceived quality of life among adolescents? It includes the population of 157 adolescents of 15 to 18 years who are attending their high school. The method of survey was conducted and the findings include that a significant differences was not found in overall quality of life score between both the groups but the body disabled group was little poor in fitness and solid well-being. Young people with body disabled scored suggestively higher in overall subjective quality of life and the dominions were examined. Analysis of stratified reflect that older and female students who have body disabled, their life satisfaction is lower in one of the domains and a significant differences was not found in an objective or subjective basis. Nai, and Anuradha (2014) investigated self-esteem among physically disabled and visually disabled late adolescents using Rosenbergs self-esteem scale of 10 items. The population was 120 physically disabled and visually disabled adolescents. Result revealed that there is a significant different on self-esteem between physically disabled and visually disabled late adolescents with visual disabled late adolescents having more self-esteem. They also found out that there is no gender difference in self-esteem of physically disabled and visually disabled late adolescents.

Several researches have been conducted on depression and physically challenged. Findings have shown that self-efficacy, self-concept and self-worth and some other factors are associated with depression of both normal and physically challenged adolescents, but there is still a few or none on the action of religious commitment and resilience on depression among adolescents with physical challenge. This research therefore will examine whether religious commitment and resilience will significantly predict depression among adolescents with physical challenge.

Religious Commitment and Depression

Religiousness is a factor which supposedly may promote well-being in physically challenged adolescents. Though this fact has not really been explored in this population, but it has been proved to be positive in respect to human feelings and reactions. Pollack (1995) defined religion as a universal human pursuit, affecting many different cultural parameters, moral concepts, and ideals, and influencing human thinking and behavior by offering answers on the meaning of human existence. Religion provides a comprehensive and sympathetic insight on the human orientation in the world and is an important element of human culture (Agorastos, Demiralay, &Huber, 2014). It is the adherence to the beliefs and practices of an organized church or religious

institution‖ (Shafranske& Maloney, 1990, p.72). However, religiousness is extenttowhichanindividualiscommittedtothereligionheors heprofessesanditsteachingssuch that his or her attitudes and behaviors reflect this commitment (Johnson, Joon Jang, Larson, & De Li, 2001 in Pearce, Little, &Perez, 2003). Religiousness and spirituality have long been important to most humans and are generally associated with better health outcomes (Koenig, & Larson, 2001). In an attempt to distinguish between the two Miller and Thoresen (2003) stated that religiousness is a reflection of a social entity entailing particular beliefs, customs, and boundaries, whereas spirituality is concerned with transcendent aspects of personal existence. Religious commitment in the other hand is a term loosely used to reflect degree or level of religiosity. It attempts to capture how internally committed the person is to his religion (laedein-Zawawi, 2015). Religiosity explains the cognitive (intrapersonal) and behavioral (intrapersonal)dimensions (Mokhlis & Spartks, 2007).The intrapersonal religious dimension is related to religious identities, religious attitudes, values, and beliefs, while the interpersonal religious dimension reflected religious affiliation and religious activities in society (Mokhlis & Spartks, 2007).

One of the best indicators of religious commitment is the estimation of intrinsic religious motivation or intrinsic religiosity (Alaedein-Zawawi, 2015). Persons described as having an intrinsic orientation to religion have been described as living their religious beliefs, the influence of which religion is evident in every aspect of their life (Joshi, &Kumari, 2011). Worthington et al. (2003) defined religious commitment as “the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living” (p. 85).In other words, religious commitment indicates the amount of time spent in private religious involvement, religious affiliation, the activities of religious organization, and importance of religious beliefs, which are practiced in intrapersonal and interpersonal daily living (Worthington et al., 2003).

Gray (1987) reported that adolescents who reported having religious or spiritual beliefs had significantly lower mean depression scores than those without these beliefs. Later, Wright, Frost, and Wisecarver (1993) and Schapman and Inderbitzen-Nolan, (1999) also reported that adolescents who frequently participated in religious activities and who reported that their religious beliefs were highly meaningful had lower depression scores than others. These studies were conducted using normal adolescents. There have also been researches on religiousness and depression with the adult population. Some of those studies showed adults who participated in religious activities reported lower depressive symptoms. Some studies (e.g. Strawbridge, Shema, Cohen, Roberts, & Kaplan,1998) have also shown that when stressors in the family increase, individuals who engage in frequent private and organizational religious practices were more likely to be depressed than those who reported infrequent engagement in religious practices while some other researches contrasted that (e.g., Kendler, Gardner, & Prescott, 1997). This shows that some types of religiousness (e.g. extrinsic religious orientation) are positively associated with depression. Thus the manner in which one operationalizes religiousness alters the relation between religiousness and depression (Pearce, Little, &Perez, 2003; Rabins, Fitting, Eastham, & Fetting, 1990). Smith, McCullough and Poll (2003) had a systematic review of religiousness and depression among normal adolescents. They used meta-analysis to summarize the results of 147 independent investigations involving a total of 98,975 subjects on the association between religiousness and depressive symptoms. The authors found that religiousness is modestly associated with lower level of depressive symptoms (effect size -0.096).

Resilience and Depression

Not all people who undergo major stress also develop clinical anxiety and depression (Bear, Connors & Paradiso, 2007).There are certain genetic predispositions that are responsible for the development of depression and other anxiety disorders (Choudary et al., 2005; Fiocco et al., 2006; Muller et al., 2007; Sanacora et al., 2000). This disposition to depression is due to the Hypothalamic-Pituitary-Adrenal axis and malfunctions of the glutamate and GABA systems which reduce serotonin and dopamine (Sanacora, Mason,& Krystal, 2000;Choudary et al., 2005; Fiocco, Wan,Weekes, Pim, & Lupien, 2006;Muller &Schwartz , 2007). There are also other behavioral factors that have been associated with depression. These factors as listed by Hopko, Hopko and Lejuez,(2007) are negative self-evaluation, depressive attributional style, distorted cognitive processing, deficiencies in social skills and avoidance behaviors. But then individuals who do not develop depression and other anxiety disorders are those who hold strong beliefs and are also committed to them. These belief and commitment towards them will help to bounce back in after stress or traumatic experience. This belief in recent years has been termed resilience. This belief according to research is the ability to bounce back in the face of stressors. Resilience has been applied in the fields of ecology, microbiology, engineering, business and economics. It has also been attributed to human beings in the field of psychiatry and psychology. Resilience is the ability of an individual to function competently in the face of adversity or stress (Murphy, Barry & Vaughn 2013). An adolescent who is resilient is likely to enter adulthood with a good chance of coping well - even if he or she has experienced difficult circumstances in life (Murphy, Barry & Vaughn 2013).Resilience is a measure of stress coping ability (Connor et al., 2003) which encompasses personal competence, trust in one's instincts, positive acceptance of change, control and spiritual influences (Connor et al., 2003). Resilience is the ability to handle stress positively(Murphy, Barry & Vaughn 2013).Adolescents' stress can come from multiple directions - school; relationships (with friends, romantic partners, and parents); hormonal and physical changes associated with adolescence; impending decisions about college and career; pressures to conform or to engage in risky behaviors; family financial problems; dangerous neighborhoods; and more(Murphy, Barry & Vaughn 2013).

Adolescents with physical challenge also have these experiences added to the stress of being physically challenged. Hence this study intends to contribute to the existing literature and to our understanding of religious commitment and resilience with depression.

In this study therefore, the researcher hypothesized that Religious commitment would not significantly predict depression among physically challenged adolescents; resilience would not significantly predict depression among physically challenged adolescents.

Method

Participants

Seventy –eight students and pupils who were drawn from College of Immaculate conception (CIC) Enugu, St. John of God Awka Anambra state and Special Educationcentre for the blind, deaf and dumb Orji River Enugu state participated in this study. They comprised 41 males and 37 females (9 students from CIC Enugu, 9 students from St John of God Awka and 60 students from Special Education Centre Orji). Their age ranged from 12 to 21 years, with a mean age of 15.92 years (SD = 2.79). 76 of the participants were Christians while 2 were Muslims. Among the participants, 49 (62.8%) are blind where 29 (37.2%) are deaf; 35(44.9%) were born with the disability where 43(55.1%) were not.

Instruments

Religious Commitment Inventory (RCI – 10), the 14-item Resilience Scale (RS-14) and Self rating depressive scale were used for data collection.

Religious Commitment Inventory (RCI – 10) was developed by Worthington, et al. (2003). It assesses one's level of religious adherence in daily life and the extent to which an individual interprets life events based on his/her religious views.The 10 items of the inventory are arranged on a 5-point Likert scale: not at all true of me (1), somewhat true of me (2), moderately true of me (3), mostly true of me (4) and totally true of me (5). It has two subscales, namely, intrapersonal religious commitment (6 items) and interpersonal religious commitment (4 items). Examples of items of the scale include: 'my religious beliefs lie behind my whole approach to life' (intrapersonal), and 'I enjoy working in the activities of my religious organisation' (interpersonal). Worthington, et al. (2003) reported 6 different studies for the development and refinement of RCI – 10, in large heterogeneous samples. As reported by the developers, scores on the RCI–10 had strong estimated internal consistency with Cronbach's alpha ranging from .93 - .96. Cronbach's α of the subscales was .92 (intrapersonal religious commitment) and .87 (interpersonal religious commitment). Ifeagwazi and Chukwuorji, (2012) obtained Cronbach's α of .83 (full scale), .78 (intrapersonal religious commitment) and .71 (interpersonal religious commitment). The two-factor structure of RCI-10 was replicated in a Nigerian study (Ifeagwazi & Chukwuorji, 2012) showing the validity of the RCI-10 in Nigeria.

RS-14 was developed by Wagnild and Young (1993) to measure the capacity to withstand life stressors, thrive and make meaning from life's challenges. It is scored using a7-point response format ranging from 1(strongly disagree) to 7 (strongly agree). Some items in RS-14 include: I usually take things in stride; my life has meaning; etc. Cronbach's are liability coefficients ranging from .91 to .93 across several studies was reported by Wagnild and Young (1993). The concurrent administration of RS-14 and some other measures by the developers revealed significant discriminant validity coefficients with life satisfaction (r=.37) morale (r =.31) depression (r =-.41), self reported health status(r=-.30) and a highly adequate convergent validity with the 25-item Resilience Scale(r=.97). In a study aimed at validatingRS-14 in Nigeria, Abiola and Udofia (2011) reported a Cronbach's coefficient of .81, a convergent validity of .97 with RS-25 as well as discriminant validity coefficients of-.28(Depression subscale of Hospital Anxiety Depression Scale, HADS) and -.26 (Anxiety subscale of HADS). Ifeagwazi, Chukwuorji and Zacchaeus (2014) carried out a principal component factor analysis using extraction method and obtained a homogenous, one-factor structure. Hence the RS-14 can be used as a unidimensional scale. Highers cores on the RS-14 indicate more resilient characteristics.

The Self Rating Depression Scale (SDS) was developed by Zung (1965) to measure depression as a clinical disorder. It is a 20-item inventory designed to assess the cognitive, affective, psychomotor, somatic and social interpersonal dimensions of depression. A coefficient validity of .79 was obtained by Zung (1965) between SDS and Hamilton Rating Scale (HRS) by Hamilton (1960); between SDS and the depression scale of MMPI, the coefficient is .70. A three –day interval test-retest coefficient of reliability of .93 was obtained by Obiora (1995) with a Nigerian population.

Procedure

Questionnaire forms prepared by the researcher were administered to the students and pupils by the researcher and research assistants. The participants were approached in their class rooms and the researcher and her assistants after establishing adequate rapport and explaining the purpose of the visit, the forms were

distributed and the research assistants who were mostly the teachers in each school visited distributed the forms to the students. The visual impaired students were helped in filling their questionnaires. Also the participants in the primary section at the special Education Centre for the blind, deaf and dumb, Orji River were helped to fill their own. Their teachers helped in using sign language to explain the questionnaires for them.The researcher rewarded the participants for accepting to participate in the study. Eighty-five (85) copies of the questionnaire were distributed but seventy-eight (78) copies were returned and the 78 returned copies yielded usable data for analysis.

Design/Statistics

This study adopted a cross-sectional design. Correlations were conducted to establish the relationship between the study's variables. Hierarchical multiple regression was used to analyse the data and test the hypotheses. Some preliminary analyses were also conducted using One-way analysis of variance and independent samples t-test in order to check for possible differences in depressive symptoms on account of such factors like gender, educational level, type of disability, being born with the disability, and parent's educational status.

Results

Results of the preliminary analyses showed that there was no significant gender differences in depressive symptoms among the participants, $t = .43$, $p = .671$. Males had a mean score of 46.54 ($SD = 8.34$) while females had a mean score of 45.73 ($SD = 8.33$). Participants who had primary education ($M = 46.98$, $SD = 8.39$) did not differ from those who had secondary education ($M = 44.83$, $SD = 8.10$) in depressive symptoms, $F\ (1, 76) = 1.24$, $p = .269$. Parental educational status did not have a significant influence on depressive symptoms among the physically challenged persons, $F\ (3, 374) = .96$, $p = .415$. Those who were visually impaired ($M = 46.48$, $SD = 7.86$) did not significantly differ from those who had auditory impairment ($M = 46.35$, $SD = 9.18$) in depressive symptoms scores, $t = -.09$, $p = .93$. Being born with the impairment did not have a significant influence on depressive symptoms, $t = -.40$, $p = .69$.

Table 1

Correlations of age, resilience, religious commitment and depressive symptoms

	Variables	1	2	3	4
1	Age	-			
2	Resilience	$.35^{**}$	-		
3	Intrapersonal religious commitment	.07	$.50^{***}$	-	
4	Interpersonal religious commitment	.07	$.28^{*}$	$.61^{***}$	-
5	Depression	-.06	$-.29^{*}$	.12	$-.26^{*}$

$^{***}p < .001$; $^{**}p < .01$; $^{*}p < .05$.

In Table 1, results of the correlations showed that age was positively related to resilience ($r = .35$, $p < .01$), but the relationships of age with the other variables were not significant. Resilience was positively related to intrapersonal religious commitment ($r = .50$, $p < .001$), interpersonal religious commitment ($r = .28$, $p < .05$), and

negatively related to depressive symptoms (r = -.29, p < .05). Intrapersonal religious commitment positively correlated with interpersonal religious commitment (r = .61, p < .001), but the relations between intrapersonal religious commitment and depressive symptoms was not significant (r = .12). Interpersonal religious commitment was negatively related to depressive symptoms (r = -.26, p < .05).

Table 2

Hierarchical multiple regression results predicting depressive symptoms by resilience and religious commitment

Variables	Step 1			Step 2			Step 3		
	B	Beta (β)	t	B	Beta (β)	T	B	Beta (β)	t
Resilience	-.09	-.29	-2.61*	-.09	-.31	-2.37*	-.09	-.29	-2.42*
Intrapersonal RC				-.06	-.03	-.24	.54	.29	2.03
Interpersonal RC							-1.10	-.51	-3.89***
R^2	.09			.09			.24		
ΔR^2	.09			.00			.16		
ΔF	6.49 (1, 74)*			.06 (1, 73)			15.14 (1, 72)***		

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

Results of the multiple regression in Table 2 showed that resilience was a negatively significant predictor of depressive symptoms (β = .29, p < .05) in step 1. The B (-.09) indicated that for every one unit rise in resilience, depressive symptoms reduces by -.09 units. It accounted for 9% of the variance in depressive symptoms (ΔR^2= .09).The F change associated with resilience in relation to depressive symptoms was significant, $F\Delta$ = 6.49 (1, 74), p < .05.

In step 2, intrapersonal religious commitment did not significantly predict depressive symptoms (β = -.03), and it did not account for any variance in depressive symptoms (ΔR^2= .00). The F change associated with intrapersonal religious commitment in relation to depressive symptoms was not significant, FΔ = .06 (1, 73).

In step 3 of the regression, interpersonal religious commitment was a negatively significant predictor of depressive symptoms (β = -.51). The B (-1.10) indicated that for every one unit rise in interpersonal religious commitment, depressive symptoms reduces by -1.10 units. Interpersonal religious commitment accounted for 16% of the variance in depressive symptoms (ΔR^2= .16).The F change associated with interpersonal religious commitment in relation to depressive symptoms was significant, $F\Delta$ = 15.14 (1, 72), p < .001.

Summary of Major Findings

1. Resilience was a negatively significant predictor of depressive symptoms.
2. Intrapersonal religious commitment did not significantly predict depressive symptoms
3. Interpersonal religious commitment was a negatively significant predictor of depressive symptoms

Discussion

The aim of the study was to examine the relationship between religious commitment, resilience and depression among adolescents with physical

challenges. The findings of this study indicated that resilience was a negatively significant predictor of depressive symptoms. This supports the findings of other researchers with a similar popular (e.g., Brionez et al., 2010; Erim et al., 2010; Holden et al., 2012); they found an inverse relationship between the resilience scores and anxiety and depression scores, which suggests that high resilience scores may protect against the development of psychiatric diseases, of which there is high prevalence in chronic conditions.

The result also shows that intrapersonal religious commitment did not significantly predict depressive symptoms. However, interpersonal religious commitment was a negatively significant predictor of depressive symptoms. This is in line with the findings ofKoenig et al., (1990) who conducted a prospective study investigating the impact of religiousness on the course of depressive disorders. They found out that among 87 depressed senior adults hospitalized for medical illness, intrinsic religious motivation was associated with faster remission from depression in a median follow-up time of 47 weeks.The correlation between religious commitment and depression is consistent with other findings with normal population (e.g. Vasegh & Mohammadi, 2007; Rasic, Kisely, & Langille, 2011;Sahraian et al., 2013; Kamble, Watsonb, Marigoudara, & Chenc,2014). Ghorbani Watson, Geranmayepour, and Chen (2014) also found in a sample of 627 Iranian university and Islamic seminary students that Muslim experiential religiousness correlated positively with satisfaction with life, and negatively with depression. The findings of this study also support the arguments of some researchers(e.g., Phillips& Henderson, 2006; Kamble et al., 2014) that religious commitment is proactive against depression and that religious people are more likely to be optimistic about their future, life-Satisfaction; purpose and meaning of life than those who are not religious (Koenig & Larson, 2001). Individuals who show close relationship with God experience less depression and other mental health problems than those who do not (Hill & Pargament, 2008). The finding also supports other previous findings which suggested that increased religious participation leads to enhanced well-being over time (Strawbridge, Shema, & Cohen, 2001). The results of the Merrill et al. (2008) had a similar finding with normal individual. They found that religiosity raised the confidence that an individual had in themselves to overcome major life stressors; also that a higher level of religiosity gave rise to the potential to prevent negative outcomes and also promote positive outcomes from stress.

Conclusion

The major aim of the study was to examine the relation between depressive symptoms, religious commitment and resilience. The finding was that depressive symptoms were negatively related to resilience and interpersonal religious commitment; no significant relationship was found between intrapersonal religious commitment and depressive symptoms. This in other words mean that the psychological well being of adolescents with physical challenges are enhanced by their social experiences in religious environments or religious gathering than with their private practices. This is in line with the findings of Alloway and Bebbington (1987) that highlighted the importance of supportive relationships. These findings are in accord with research demonstrating that negative interpersonal exchanges can have adverse effects on wellbeing (Rook, 1998). The cognitive attribution theories of depression provide further explanation. Depression is characterized by cognitive disturbances, such that the depressed tend to have negative information processing about the self, the world, and the future (Beck, 2002).

Depressed adolescents may engage in or selectively attend to negative interactions with people and interpret benign comments or requests as critical and demanding. Indeed, negative temperament may put individuals at risk

of having negative social interactions with others (Thomas & Chess, 1977), which may then contribute to the development and maintenance of depressive symptoms.

These findings may be applied to therapy interventions in several ways. First, depression may be best avoided or reduced in adolescents with physical challenges by building self-confidence and a sense of optimism in them before they enter this phase of their lives. For example, this might be accomplished by the kinds of activities recommended by Seligman (1998), Gill-ham et al., (2008) and Gill-ham et al., (2006), which focus upon developing resilience among adolescents, and which may prepare them to face the stressors they will encounter in life because of their disability. Hence it can be concluded that there were adverse impact of disabilities on adolescent's social, emotional and psychological development. They basically feel worthless and inferior to their normal age mates because of their disability. Thus disability restricts functioning of the adolescents and also constitutes a problem in the development of self image of these adolescents such that depression sets in as they progress in life. Again adolescents with physical challenges are enhanced by their social experiences in religious environments or religious gathering than with their private practices. This is in line with assumptions of the social theory that having few social relationships contributes to psychological distress and that those individuals who do not have, or do not perceive that they have, confidants or a sufficient social network are much more likely to have mental health difficulty, especially when faced with a significant social stressor. Joiner, Coyne and Blalock (1999) wrote: "regardless of what other factors may be involved, the interpersonal context affects greatly whether a person becomes depressed, the person's subjective experience while depressed, and the behavioral manifestations and resolution of the disorder; consideration of the interpersonal context is simply a necessity for an adequate account of the disorder" (p. 3).This is in line with the findings of Alloway and Bebbington (1987) that highlighted the importance of supportive relationships. One major limitation of this study is that the population for the study was small and thus findings may not be confidently generalized.

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