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# Religious Social Support, Discrimination, and Psychiatric Disorders among Black Adolescents

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## Abstract

Discrimination is a common experience for Black youth that can jeopardize their mental health. However, research suggests that various dimensions of religion have positive effects on youths' mental health and well-being. Additionally, exposure to discrimination may vary by youths' socio-demographic factors, such as gender and ethnicity. Numerous studies identify the protective effects of emotional and tangible religious social support on the mental health of Black adults reporting discrimination. Conversely, fewer studies address the influence of emotional and tangible religious social support on mental health for Black adolescents experiencing discrimination, while also accounting for socio-demographic heterogeneity among Black adolescents. Historically, religion has played an instrumental role in the diverse narratives of the Black Diaspora in the United States. It is important to account for its potential protective effects for Black youth. Examining these factors using a compensatory risk and resilience model, our study finds that Black adolescents who experience discrimination are also more likely to meet criteria for a psychiatric disorder. Additionally, those who report experiencing religious social support are less likely to meet criteria for a psychiatric disorder. These findings were not moderated by the sociodemographic factors of race or ethnicity. To date, this investigation is one of the first to examine the effect of different types of religious social support in the presence of discrimination on psychiatric illness among African American and Caribbean Black adolescents.

### Keywords

religion; social support; discrimination; psychiatric disorder; Black youth

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Previous research has documented the harmful effects of discrimination on mental health and well-being among Black populations (Paradies, 2006; Williams, 2009). More recently, in addition to mental health and well-being, studies have also provided evidence of discrimination's harmful effects on mental disorders among Black populations (Assari, Watkins, & Caldwell, 2014). Scholars have also identified protective factors that buffer the harmful effects of discrimination on psychiatric disorders; one such protective factor is religious social support. Religious social support has been linked to a wide range of positive mental health outcomes (Koenig, 2012; Salsman, Brown, Brechting, & Carlson, 2005; Wong, Rew, & Slaikeu, 2006). Despite a growing literature on the influence of religion in Black adolescents' lives (Butler-Barnes et al., 2016; Rose, Finigan-Carr, & Joe, 2016; Rose, Joe, Shields, & Caldwell, 2014), few studies examine the specific role of religious social support as a buffer against discrimination for this population. The current study aims to examine the effects of discrimination while simultaneously accounting for the protective effects of religious social support. Specifically, this study examines the promotive effects of emotional and tangible religious support on youths' psychiatric disorder outcomes. We hypothesize that emotional and tangible religious social support have direct, independent, and positive effects on youths' psychiatric disorder outcomes, even within the context of discrimination.

## Discrimination

Discrimination occurs when individuals are treated unjustly because of particular identities (e.g. race, ethnicity, age, gender). In the United States, discrimination is a common experience for Black Americans, and it is associated with psychiatric outcomes (Seaton, Caldwell, Sellers, & Jackson, 2008; Seaton, Caldwell, Sellers, & Jackson, 2010a; Seaton, Caldwell, Sellers, & Jackson, 2010b), such as depressive or anxiety symptoms (Banks, 2006; Gaylord-Harden & Cunningham, 2009; Kessler, Michelson, & Williams, 1999). A recent meta-analysis provides confirming evidence that exposure to racial discrimination negatively impacts Black Americans' mental health (Pieterse, Neville, Todd, & Carter, 2012). Pieterse, Todd, Neville, and Carter (2012) also report that racial discrimination had stronger effects on psychiatric symptoms and general distress than on life satisfaction and self-esteem. These findings support arguments that discrimination is a form of trauma and this experience should be considered within that context (Carter, 2007; Helms, Nicolas, & Green, 2010).

## Discrimination and mental health among Black adolescents

The negative effects of mental health and psychiatric outcomes among adults have been well documented (Pieterse et al., 2012; Matthews et al., 2013; Williams et al., 2008; Williams & Mohammed, 2009). In contrast, a small, but growing literature provides insight into the negative influence of discrimination on Black adolescents' mental health (Brody et al., 2006; Greene, Pahl, & Way, 2006; Butler-Barnes et al., 2016). Among Black youth, discrimination has been associated with higher rates of stress (Butler-Barnes at al., 2016), increased depressive symptoms (Greene, Pahl, & Way, 2006; Butler-Barnes at al., 2016), increased depression (Brody et al., 2006), and decreased self-esteem (Greene, Pahl, & Way, 2006; Butler-Barnes at al., 2016). Adolescence is a unique developmental period during which

youth may become more aware of their identities, and therefore, more attuned to experiences related to these identities (Phinney & Tarver, 1988; Phinney, 1989). Reflective of this, explication of the associations between discrimination experiences and poor mental health outcomes among adolescents is particularly important (Eccles, 1993; Wong, Eccles, & Sameroff, 2003). Over 90% of African American adolescents reported having had at least one experience of racial discrimination (Gibbons et al., 2004). Black adolescents also report experiencing discrimination across settings, including in school (Cooper, McLoyd, Wood, & Hardaway 2008; De-Cuir-Gunby, Martin, & Cooper, 2012). Furthermore, the negative impact of racial discrimination experiences on African American adolescents' psychological outcomes persist over time (Brody et al., 2006; English, Lambert, & Ialongo, 2014). Therefore, it is important to identify and actively address the negative contributions of discrimination to Black adolescents' psychiatric outcomes.

Acknowledging the heterogeneity that exists among Black adolescents—a group with diverse and unique cultural experiences that may influence their exposure to and experience with racial/ethnic discrimination—is of utmost importance. Exposure to discrimination and its negative effects on health outcomes may vary by socio-demographic factors (e.g., gender and ethnicity). For example, in an adult sample, Assari, Watkins, & Caldwell (2014) found that everyday discrimination was associated with a higher risk of depression. However, the strength of this relation differed by gender and ethnicity. Among Caribbean Black men who viewed race as a barrier to social mobility, the association between discrimination and depression was weaker, yet this belief did not change the strength of this relation among Caribbean Black women, African American men, or African American women (Assari, Watkins, & Caldwell, 2014). Given these findings, it is important to examine similar questions among adolescent samples. Seaton, Caldwell, Sellers, & Jackson (2010b) report that among adolescents, the association between discrimination and psychological well-being was stronger for Caribbean Black adolescent girls than for Caribbean Black adolescent boys, and African American adolescent boys and girls. Specifically, Caribbean adolescent girls who experienced discrimination also had higher depressive symptoms and lower life satisfaction than their Caribbean adolescent boys or African American adolescent peers (Seaton, Caldwell, Sellers, & Jackson, 2010b). Given the transitional nature of adolescence and the dynamic qualities of identity development, factors such as gender or ethnicity may increase or decrease in salience for Black individuals. In a similar vein, as Black youth transition into emerging adulthood, they may be more or less sensitive to gender- or ethnicity-based discrimination over time. In sum, the extant literature finds that the relation between discrimination and mental health differs by gender and ethnicity. This underscores the importance of exploring how socio-demographic factors relate to distinctive experiences and outcomes that Black adolescents in the United States may face (Assari, Watkins, & Caldwell, 2014; Perry, Harp, & Oser, 2013; Seaton, Caldwell, Sellers, & Jackson, 2010b).

## Theoretical Frameworks

Risk and resilience frameworks are used to examine how positive and negative experiences influence youth (e.g. Fergus & Zimmerman, 2005; Masten, 2011). Risk and resilience models often examine the simultaneous contributions of stressors that youth face within the

context of supports that youth can access. Such stressors can range from intrapersonal to environmental factors. Compensatory models of risk and resilience evaluate a direct counter effect of a promotive factor (resources or assets that reduce or eliminate negative outcomes) on the independent direct effect of a risk factor. This framework posits that, though some youth face stressful situations, they may also have access to positive attributes and influences that mitigate the potentially harmful effects of the stressors they face.

In addition, the risk and resilience framework emphasizes positive development, which focuses on strengths over deficits (Fergus & Zimmerman, 2005). Our study employs a compensatory risk and resilience model to highlight the contributions of promotive factors that lead to healthy development for youth exposed to adversity. Specifically, this study conceptualizes the relation between religious social support and psychiatric disorders among ethnically diverse Black youth.

## Religion as a Promotive Factor

Within the narratives of Black Americans in the United States, churches, mosques, and other religious communities have long provided environments where individuals can engage in and access a wide range of services and programs that address political, civic, social, and spiritual matters. Two significant aspects of involvement within these contexts include religious engagement and religious social support. Increased religious engagement, defined as event attendance, community activity participation, and adherence to traditions and practices (Maselko, Kubzansky, Kawachi, Seeman, & Berkman, 2007), often corresponds with more opportunities to connect with others and to form and maintain relationships. A wide range of relationships may be available in these settings, reflective of the structure and culture of religious communities. First, participants may form relationships with each other, as well as with ordained and lay leaders in their religious community. Second, these relationships also encompass their individual and collective relationships to and with God. Reflective of this, religious engagement can function as a gateway to potential religious social support (Crawford, Wright, & Masten, 2006). For example, religious engagement for Black adults who identify as African American was associated with more religious social support over time (Le, Holt, Hosack, Huang, & Clark, 2016). As such, potential contributions of religious social support may have widespread implications.

Like many other types of social support, religious social support can manifest in many forms. In this study, two forms of religious social support, instrumental (tangible) and emotional support, are explored. Instrumental support typically focuses on tangible assistance, e.g., providing a ride to church or providing school supplies (Kanu, Baker, & Brownson, 2008). Emotional support involves feelings and expressions of care, regard, and concern; for example, feeling loved or expressing interest in another's welfare (Cutrona, 2000). Although religious social support, in general, significantly contributes to Black American outcomes. Our work, focusing on religious social support as a promotive factor, specifies the type of religious social support that is being offered to participating recipients. To date, this study is one of the first to examine different forms for religious social support available to African American and Caribbean Black adolescents living in the United States.

Religious social support is conceptualized as a promotive factor because it has been shown to be a significant and likely asset associated with faith communities (Le, Holt, Hosack, & Clark, 2016; van Olphen, Schulz, Israel, Chatters, Klem, Parker, & Williams, 2013). Further, religious social support provides links to a wide range of medical, mental health, and social benefits that promote resilience (Holt, Schulz, Williams, Clark, & Wang, 2013). In addition, Debnam, Holt, and Southward (2012) found that, compared to general social support, religious social support was predictive of more positive health behaviors. Positive impacts of religious social support on mental and emotional outcomes include fewer depressive symptoms and lower levels of psychological distress (Chatters, Taylor, Woodward, & Nicklett, 2015).

## Black adolescents and religious social support

Across the lifespan, religion plays a significant role in the daily lives of Black individuals in the United States, influencing proximal and distal worldviews and shaping relationships, and informing their identity processes. However, research reflective of this tends to examine the experiences and trajectories for older Black individuals. Black Americans tend to have strong religious orientation, which serves as one of the most pervasive cultural assets – they tend to exhibit higher levels of church attendance, are more strongly subjectively identified with their church, and tend to be members of a church-related group (Riggins, McNeal, & Herndon, 2008). It is important to ascertain whether religion (and the attendant support) plays such a substantial role for younger participants' trajectories and outcomes as well.

Black youth rank religious faith as being of higher importance than do their counterparts in other racial groups (Smith et al., 2003). Black adolescents often attend church (or other houses of worship) because their families emphasize attendance as an important part of family life. Halgunseth, Jensen, Sakuma, and McHale (2015) found that parental religious beliefs and practices were significantly associated with adolescents' religious beliefs and practices, for both boys and girls. For some adolescents, religious engagement may not be something that they independently choose to do. As such, they may undervalue or discount the relationships within the religious community that provide support, not viewing them as worthwhile or beneficial. For other adolescents, particularly those who may not have adequate support in other relationships, religious social support may be especially important. Religious engagement may provide these adolescent with access to religious social support and its attendant benefits. For example, African American adolescents attending predominantly Black churches who reported greater religious social support tended to have higher levels of thriving (Gooden & McMahon, 2016).

Numerous sources and outlets for religious social support exist within religious communities, such as peers, other adults, God, and religious leader(s). Religious supports can be either tangible, emotional, or a combination of both. Tangible religious social support, for example, includes the long-standing support of many predominantly Black churches for educational programs for youth. Leaders tend to be willing to incorporate additional educational programming into their churches' existing services (Coyne & Schoenbach, 2000), such as after-school tutoring programs. In addition, some congregations adopt neighborhood schools, providing resources within scholastic contexts. Emotional

religious social support may be found in some communities through mentorship opportunities, where youth can participate in formal or informal connections with a trusted member of the community. Religious communities can also provide physical and social safety for Black adolescents who live in high-risk, high-crime neighborhoods. Church programs may offer social or enrichment programs that provide outlets that safeguard adolescents from physical and social risks in their immediate neighborhood. African American youth who reside in inner city neighborhoods and are involved in church activities report fewer psychological problems and less involvement in criminal activity (Cook, 2000; Johnson et al., 2000). Church programs such as these provide avenues through which adolescents obtain both tangible and emotional religious social support.

## The Current Study

This investigation tests the effect of religious social support on psychiatric outcomes of African American and Caribbean Black adolescents in the presence of discrimination. We hypothesize that religious social support will be associated with lower prevalence of psychiatric disorder for both groups of Black youth reporting discrimination. Additionally, we hypothesize that the effect of religious social support on lifetime psychiatric disorder will vary by youths' gender, such that the effects will be stronger for girls than boys. Previous research has found gender differences in the types of religious social support received (see Krause, Ellison, & Marcum, 2002). Therefore, we hypothesize that there will be gender differences in the type of religious support (i.e., emotional vs. tangible) received. Finally, we hypothesize that the effects of religious social support on lifetime psychiatric disorder will vary by youths' ethnicity (e.g., African American or Caribbean Black). Given limited information about the importance of ethnicity in relation to religious social support, discrimination experiences and mental health among Black youth, we provide no specific prediction about the directionality of ethnic variation.

## Method

### Design and Setting

This study used a cross-sectional design. Data came from the National Survey of American Life-Adolescent Supplement (NSAL-A), 2003 (Seaton, Caldwell, Sellers, & Jackson, 2010; Taylor, Caldwell, Baser, Faison, & Jackson, 2007), conducted as a part of the Collaborative Psychiatric Epidemiology Surveys (CPES) (Heeringa, Wagner, Torres, Duan, Adams, & Berglund, 2004). The NSAL-A is the largest and most updated national mental health survey of Black youth in the United States (Jackson, Torres, Caldwell, Neighbors, Nesse, Taylor, et al., 2004).

### Ethics

The NSAL was approved by the Institute Review Board of the University of Michigan, Ann Arbor. All participating adolescent's legal guardians provided informed written consent. Assent was also obtained from the adolescent. Each respondent received financial compensation of US$50 for their time. The study was funded by the National Institute of Mental Health (NIMH).

## Participants

The NSAL enrolled 1,170 Black adolescents. This number was composed of 810 African American and 360 Caribbean Black youth ranging in age from 13 to 17 years old. At the time of the study, all participants resided in the United States. For a full description of sampling strategy, please review Heeringa et al. (2004) and Jackson et al. (2004).

## Sampling

The NSAL-Adolescent sample is based on the NSAL-Adult sample, a national probability sample of adult Blacks in the United States. Using the NSAL-Adult sample, in the first step, all African American and Caribbean Black households were screened for eligible adolescents living in the households. Adolescents living in households with adults were selected for participation. In the presence of more than one eligible adolescent in a household, two adolescents were selected based on the gender of the first selected adolescent, a strategy resulting in non-independence for adolescent samples. In response, the adolescent supplement data was weighted to adjust for non-independence of the selection probabilities within the households, as well as non-response at the household and individual levels. The weighted data were then post-stratified to represent the national estimates based on gender and age among African American and Caribbean Black adolescents (Seaton, Caldwell, Sellers, & Jackson, 2010; Seaton, Caldwell, Sellers, & Jackson, 2010).

As described by Krause (2002), the quality of relationships in religious communities (e.g., church) may influence individuals' pattern of attendance. We did not limit our sample to the respondents who had attended church at least once in the past year, as we believe limiting the sample to those who attended church in the last year will overestimate positive social interactions and any resulting relationships or religious social support within or related to religious community settings.

## Data Collection and Interview

All the interviews were conducted in English. For approximately 82 % of the interviews, data collection occurred during in-person interviews conducted in the adolescents' homes. The remaining 18 % of interviews were conducted entirely or partially by telephone. Computer-assisted personal interviews (CAPIs) were used for all in-person interviews. CAPI, an interviewing technique in which a computer is used by trained interviewers to conduct the interview, is the preferred method of interview for long and complex questionnaires. The average length for interviews lasted 100 minutes. The overall response rate was 80.6 %, with 80.4 % for African American youth and 83.5 % for Caribbean Black youth.

## Measures

The study included demographic factors, such as age, gender, and ethnicity. Data were also collected for socioeconomic factors, which was a poverty index, defined as the income-to-needs ratio from the 2001 United States Census. The poverty index was calculated by dividing household income by the poverty threshold (Proctor & Dalaker, 2002). Higher scores on the poverty index indicate relatively greater wealth.

### Religious Social Support

Religious social support was measured by four items. Respondents were asked "How often do the people in your church (1) make you feel loved and cared for, (2) listen to you talk about your private problems and concerns, (3) express interest and concern in your well-being, and (4) help you financially?" Response categories ranged from "very often" to "never." The first three items were used to assess emotional religious social support, while the last item was used to assess tangible religious social support. We calculated a sum score, where a higher value on these indices indicated higher levels of available support. Cronbach's alpha for the 3-item emotional support index is 0.72. (Assari, 2013; Chatters, Taylor, Lincoln, Nguyen, & Joe, 2011; Nguyen, Taylor, & Chatters, 2016).

### Discrimination

A 13-item modified version of the Everyday Discrimination Scale (EDS) was used to measure discrimination. These items assess chronic, routine, and less overt experiences of discrimination that occurred over the past year (Williams, Yu, Jackson & Anderson, 1997). Although the original EDS includes ten items, three items were added that reflect perceived teacher discrimination. Although the original EDS measure was developed and normed among adults, the measure similarly operates for adolescents (Krieger, Smith, Naishadham, Hartman & Barbeau, 2005; Seaton, Caldwell, Sellers, & Jackson 2010; Williams et al., 1997). All respondents were asked: "In your day-to-day, life how often have any of the following things happened to you?" Sample items include: "You are followed around in stores," "People act as if they think you are dishonest," "You receive poorer service than other people at restaurants," and "You are called names or insulted." The Likert response scale ($\alpha = .86$) for frequencies range from 1 (never) to 6 (almost everyday). A sum score was calculated, reflecting the frequency of discriminatory events that occurred in the previous year.

### Any Lifetime Psychiatric Disorder

Assessment for any lifetime psychiatric disorder was based on the Diagnostic and Statistical Manual, 4th Edition (DSM-IV-TR) criteria. We utilized the modified World Mental Health Composite International Diagnostic Interview (WMH-CIDI) for psychiatric evaluation. The WMH-CIDI is a comprehensive, fully-structured interview designed to be used by trained, lay interviewers. It is widely used in national and international epidemiological studies, as well as for clinical and research purposes, and has demonstrated satisfactory reliability and validity (Kessler & Ustun, 2004). Diagnosis of any non-psychotic psychiatric disorder included mood disorders (i.e., major depressive disorder, dysthymia, bipolar I and II disorders), anxiety disorders (i.e., generalized anxiety disorder, panic disorder, agoraphobia, social phobia, separation anxiety disorder, obsessive-compulsive disorder, posttraumatic stress disorder), substance use disorders (i.e. alcohol abuse, alcohol dependence, drug abuse, drug dependence), conduct disorder, attention deficit/hyperactivity disorder, oppositional defiant disorder, and eating disorders.

The CIDI evaluates a wide range of psychiatric disorders based on the DSM-IV-TR mental disorders. This interview schedule was originally developed for the World Mental Health project initiated in 2000 (Wittchen 2000). Clinical reappraisal studies among adults have

documented generally good concordance of CIDI diagnoses with blinded clinical diagnoses (Wittchen, 2000; Kessler, Wittchen, Abelson, McGonagle, Schwarz, Kendler, et al., 1998). CIDI versus SCID prevalence differences have been shown to be insignificant at the optimal CIDI-SC diagnostic thresholds. Individual-level diagnostic concordance at these thresholds is also substantial, with sensitivity of 68–80 % and of specificity 90–99 % (Kessler, Calabrese, Farley, Gruber, Jewell, Katon, et al., 2013). CIDI is believed to provide valid findings for Blacks and their ethnic groups (Assari, Lankarani, & Moazen, 2012; Assari, Moghani, & Lankarani, 2013; Jackson, Neighbors, Torres, Martin, Williams, & Baser, 2007; Neighbors, Caldwell, Williams, Nesse, Taylor, Bullard, et al., 2007; Williams, Haile, González, Neighbors, Baser, & Jackson, 2007; Woodward, Taylor, Abelson, & Matusko, 2013).

### Socio-demographics

Standard measures for age and gender were used. Ethnicity was assessed via the self-identified ethnicity of the family household during the sampling process based on the household in which the adolescent lived. Participants self-identified as either African Americans or Caribbean Blacks. African Americans were defined as Black without having ancestral ties to the Caribbean. Caribbean Black was defined as Blacks having ancestral ties to a country included on a list of Caribbean countries provided by the interviewer or that their parents or grandparents were born in a Caribbean country. The list of Caribbean countries included Cuba, Dominican Republic, Haiti, The Bahamas, Jamaica, Trinidad and Tobago, Dominica, Saint Lucia, Antigua and Barbuda, Barbados, Saint Vincent and the Grenadines, Grenada, and Saint Kitts and Nevis.

### Statistical Analysis

Stata 13.0 (Stata Corp., College Station, TX, USA) was used to apply the design variable to account for the complex design of the NSAL-A. Adjusted odds ratio (OR) and their 95 % confidence interval were reported. *P* values less than 0.05 were considered statistically significant. Missing data was not imputed. We used complete case analysis for our regression models.

We used the Taylor expansion approximation technique to re-calculate the complex design-based estimates of variance. Thus, all the standard errors and inferences in our analysis reflect the recalculation of variance using the weights due to the study's NSAL-A complex sampling design. All percentages reported in this study are weighted and are representative of the nation. The Caribbean Black sample is more clustered than the African American sample; therefore, the corrected standard errors are larger for Caribbean Black than that of the African American youth.

We used survey logistic regression for multivariable analysis. In our model, discrimination and religious social support were the main predictors, lifetime psychiatric disorders were the main outcome, and age, gender, ethnicity, and the poverty index were covariates. We fit multiple logistic regression models to determine the role of overall, emotional, and tangible support on the outcome. In the first step, the association of interest was tested in the pooled

sample, controlling for the main effects of gender and ethnicity. In the next step, we added the interaction terms (between religious social support and ethnicity or gender) to the model.

## Results

### Descriptive Statistics

The sample had an even distribution of boys ($n$ = 563, 48 %) and girls ($n$ = 605, 52 %). The mean age for both boys and girls was 15 years old (*SD = 1.42*). For the total sample, 40% were between the ages 13–14 ($n$ = 477), 41 % were between the ages 15–16 ($n$ = 441), and 19% were age 17 ($n$ = 252). Almost all (96 %) participants were in high school. Median family income ranged from 0 to US$520,000, with a median of US$28,000. Median income was considerably higher among Caribbean Blacks (US$32,250) than African Americans (US $26,000) ($p < 0.001$).

Caribbean Blacks were older than African Americans ($p<0.05$). Although African Americans and Caribbean Blacks reported similar levels of discrimination, boys reported significantly higher levels of discrimination than girls ($p < 0.05$). For both ethnic groups, boys and girls reported similar levels of overall, emotional, and tangible religious social support. Tangible religious social support-was lower for Caribbean Blacks than African Americans ($p < 0.05$) (Table 1).

Proportion of girls was slightly higher for Caribbean Blacks than African Americans ($p <0.1$). Lifetime psychiatric disorder was more common among Caribbean Blacks than among African Americans. With a marginally significant association, lifetime psychiatric disorder was more common among boys than girls ($p < 0.1$) (Table 2).

### Logistic Regression Models

Table 3 summarizes the results of four logistic regressions in the pooled sample, with lifetime psychiatric disorder as the outcome, discrimination and overall religious social support as predictors, and age, gender, ethnicity, and the poverty index as covariates. Model 1 only included main effects. More discrimination was associated with higher odds of lifetime psychiatric disorder, whereas more overall religious social support was associated with lower odds of lifetime psychiatric disorder, net of covariates. In Model 2, we included an interaction between ethnicity and overall religious social support, but this was not significant, suggesting that the protective effect of religious social support did not depend on ethnicity. An interaction between gender and religious social support was included in Model 3 was not significant, suggesting that the protective effect of religious social support is similar across gender groups. The final model, Model 4, included both interactions and showed similar findings (see Table 3).

Table 4 presents a summary of the results of two models with emotional religious social support and discrimination (Model 1) and instrumental religious social support and discrimination (Model 2) as predictors. As before, age, gender, ethnicity, and the poverty index are covariates and lifetime psychiatric disorder is the outcome. Based on these models, emotional religious social support and discrimination, but not instrumental religious social

support, were associated with lower odds of psychiatric disorder, net of covariates (see Table 4).

## Discussion

Using a risk and resilience model, the current study tested the effects of religious social support (i.e. resilience factor) in the presence of discrimination (i.e. risk factor) in a nationally representative sample of African American and Caribbean Black adolescents living in the United States. Findings suggest that, while discrimination increases the risk of psychiatric disorders, religious social support reduces such risk. The protective effect of religious social support was derived from emotional (but not tangible) religious social support, and this effect was universal, regardless of ethnicity and gender.

Although discrimination jeopardizes the mental health of adolescents (Pieterse et al., 2012) and adults (Krieger et al., 2005; Williams et al., 1997), previous work indicates that religious engagement has a protective effect both for adolescents (Hardie, Pearce, & Denton, 2016) and adults (Koenig, 2015). Among adolescents, religious engagement protects against a wide range of undesired outcomes such as high risk behaviors, substance use, and mental distress (Hardie, Pearce, & Denton, 2016; Kliewer, & Murrelle, 2007; Marsiglia, Kulis, Nieri, & Parsai, 2005; Yeung, Chan, & Lee, 2009; Wallace, Brown, Bachman, & LaVeist, 2003; Wallace, Delva, O'Malley, Bachman, Schulenberg, & Johnston, 2007). We stress that religious engagement (e.g., service attendance) is a separate construct from religious social support. However, there is little evidence as to whether religious social support is the actual component that accounts for the protective effect of religion and religious engagement on outcomes.

Most previous research on the effects of religious social support on mental health among Blacks is derived from studies on adults, for whom we know religious social support is protective in the presence of discrimination (Taylor, Chatters, & Nguyen, 2013). Krause and colleagues (2002, 2011) have conducted other serial studies that document the unique role of church-based social support for Blacks. Furthermore, religious social support has been identified as one of the main mechanisms through which religion functions protectively for individuals (Chatters, Taylor, Lincoln, Nguyen, & Joe, 2011; Chatters, Taylor, Woodward, & Nicklett, 2015), and has been conceptualized as a protective mechanism for health outcomes (Koenig, 2015). Further, Assari (2013) demonstrated that church-based social support fully mediated the effect of church attendance on mental health of Blacks, but not Whites. However, because almost all of the empirical and theoretical work is limited to Black adults, we know less about the role of religious social support for Black adolescents. Given this, the present study makes several unique contributions to the research literature.

Further, even fewer studies have explored the influence of religious social support on mental and psychiatric health outcomes in the presence of discrimination for Black adolescents, while simultaneously accounting for ethnic heterogeneity (e.g., African American and Caribbean Black). Our study examined the association between two types of religious social support (emotional and instrumental) and psychiatric health outcomes for African American and Caribbean Black youth within the context of discrimination. Using a compensatory risk

and resilience model, we predicted that religious social support would be associated with better psychiatric health for these youth in the presence of discrimination. Results were marginally consistent with this prediction. Religious social support was associated with a decreased chance of psychiatric disorder among both groups of Black youth. These results are consistent with previous findings that indicate religious engagement provides significant support for youth experiencing interpersonal challenges (Cole-Lewis et al., 2015). Furthermore, our findings suggest that religious engagement and supportive relationships are salubrious for Black adolescent psychiatric health outcomes.

Study findings of a positive role of emotional religious support for adolescent mental health may be especially useful for congregations that identify as predominantly Black. In addition to emotionally supportive relationships within predominantly Black congregations, Black adolescents may be also be exposed to messages and values within their faith communities that encourage racial and ethnic pride. Spencer, Dupree, Swanson, and Cunningham (1996) found that religious engagement and attendant factors were significant supports for the ethnic identity and self-efficacy processes of African American girls. Results from Gooden and McMahon (2016) suggest that religiosity, religious social support, and communalism were significantly associated with thriving outcomes for African American adolescents in predominantly Black churches. Similarly, Brown (2008) found positive associations between the resilience of African American undergraduates who reported receiving positive racial socialization messages and perceiving social support. Furthermore, ethnic identity development is a key marker of ethnic minority group adolescence (Phinney, 1990). Consequently, being a part of an emotionally supportive community that affirms both cultural and spiritual significance of adolescent personhood may bolster psychiatric well-being and self-concept processes. Predominantly Black congregations play significant cultural and civic roles in the Black community. Given this, emotional support within a culturally relevant context may be especially beneficial and protective for adolescents within these congregations. Understanding how emotional religious social support may be beneficial can empower leaders, community members, researchers, and other stakeholders to identify frameworks, resources, and opportunities to create new or strengthen existing outlets to serve Black adolescents within predominantly Black congregations. Given the past and current socio-political narratives and climate for Black youth development in the United States, access to culturally affirmative and emotionally supportive relationships is especially important.

In addition to exploring ethnic differences, this paper explores gender differences. Although youth may report differing levels of discrimination and religious engagement based on gender or ethnicity, our results did not yield significant differences between the effects of religious social support (of either type) for gender or ethnicity groups. Interestingly, this is in contrast to previous research suggesting that religious involvement is differentially protective for African American and Caribbean Black boys and girls (Butler-Barnes et al., 2016). Our findings suggest that the effects of religious social support for psychiatric health outcomes may be universal for Black youth in both ethnic groups at this life stage. Still, the varied narratives of native-born and immigrant youth in the United States strongly necessitate accounting for potential differences by gender and ethnicity, as they experience, respond to, and make meaning out of discrimination experiences.

## Limitations and Future Directions

These findings must be viewed within the limitations of this study. First, given that many adolescents are socialized into religious beliefs by their families, religious socialization may influence adolescent perceptions of religious social support. Religious engagement such as attending services or participating in religious community activities, are frequent experiences for many Black Americans and their families in the United States (Brody, Stoneman, Flor, & McCrary, 1994; Lincoln & Mamiya, 1990; Mattis, 2000). Consequently, our findings may also be explained by the positive influences of family support. However, we are not able to disaggregate the buffering effects of positive family support against poor mental health outcomes from the role of religious social support in this study. Future research might delineate ways to differentiate between these constructs to better understand the unique contributions of religious support.

Second, there was no available or accessible information about specific characteristics of the religious environments wherein religious social support was present. For example, congregational programming or supportive resources for youth may not be relevant to adolescent participants, or the beliefs, traditions, and resources of a religious community may not support opportunities for youth to become meaningfully engaged. Furthermore, religious social support may be available, but other individual-level and community-level factors may influence adolescents' perceptions of religious social support as available, effective, or desirable. Knowing which characteristics may be responsible for a detailed understanding of youths' environment can clarify how and where youth may receive religious support. This information can bolster the identification of effective and supportive environments, which in turn may strengthen the efforts of researchers and community stakeholders to work together to develop new or revamp existing interventions to support youth from marginalized groups.

Third, the measures used in the data set reflected a specific religious tradition for Black Americans, namely that of Judeo-Christian orientation. Black adolescents and their families ascribe to a wide range of religious and spiritual frameworks outside of Judeo-Christian beliefs, as well as denominational variation. Given our measures, we were not able to distinguish whether or not theological orientation differences in religious/spiritual beliefs, support, or engagement were significant for youth outcomes. Finally, this study did not account for either actual or perceived negatively valenced relationships and the associated religious social support. It is important to examine both positive and negative aspects of social support (Rook, 1984), especially as it pertains to religious settings (Krause, Chatters, Meltzer, & Morgan, 2000). Religious communities provide diverse experiences for participants, and not all of those experiences yield benefits or support thriving for adolescents. Although religious social support is often associated with positive outcomes, it may be only be beneficial for adolescents if that religious social support is linked to positively valenced relationships within that religious setting. Negative social interactions and relationships within religious settings can (and do) occur. In turn, these may adversely affect the quality, availability, and impact of religious social support (and any subsequent benefit) for youth. As such, more work is needed to ascertain the characteristics of religious communities that significantly promote or jeopardize positive outcomes for adolescents

within those contexts. Such information may facilitate more collaborative work between community leaders, lay members, and researchers dedicated to strengthen existing programs and outlets that serve and support youth.

Next steps should also examine whether or not African American and Caribbean Black adolescents in the United States experience changes in discrimination and religious social support over time. As youth navigate adolescence, they tend to gain more autonomy, prepare for post-secondary academic and vocational roles, and access and interact in a wide range of social networks (see Zarrett & Eccles, 2007). Reflective of these changes, their needs and desires for social support and religious engagement may also adjust. A lifespan approach may yield important information about how to support youth at various stages of development. Additionally, though some youth may attend congregations where relationships and participation are contingent on their meeting certain community standards and obligations, we did not have the information to explore the influences of those factors in this study. Further work might delineate how community definitions and expectations for adolescent participants affect the type and degree of religious social support received and expected.

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**Table 1:**

Descriptive Statistics of the sample overall, and based on ethnicity, gender, and their intersection

| | All | African Americans | Caribbean Blacks | Males | Females |
|---|---|---|---|---|---|
| | M (SE) | M (SE) | M (SE) | M (SE) | M (SE) |
| Age | 14.95 (0.06) | 14.92 (0.06)* | 15.27 (0.04) | 14.96 (0.06) | 14.93 (0.09) |
| Poverty Index | 4.05 (0.12) | 4.03 (0.13) | 4.25 (0.17) | 4.02 (0.18) | 4.07 (0.11) |
| Discrimination | 5.04 (0.22) | 5.04 (0.23) | 5.02 (0.40) | 5.31 (0.29)* | 4.78 (0.22) |
| Religious Support- Total | 2.98 (0.03) | 2.98 (0.03) | 2.96 (0.02) | 2.96 (0.06) | 3.00 (0.04) |
| Religious Support- Emotional | 5.93 (0.10) | 5.93 (0.10) | 5.88 (0.07) | 5.85 (0.18) | 6.01 (0.12) |
| Religious Support-Tangible | 0.75 (0.06) | 0.77 (0.06)* | 0.32 (0.11) | 0.85 (0.08) | 0.65 (0.08) |

* $p < 0.05$

M; Mean

SE; Standard Error

**Table 2:**

Descriptive Statistics of the sample overall, and based on ethnicity, gender, and their intersection

| | All | | African Americans | | Caribbean Blacks | | Males | | Females | |
|---|---|---|---|---|---|---|---|---|---|---|
| | % | 95% CI | % | 95% CI | % | 95% CI | % | 95% CI | % | 95% CI |
| Gender | | | | | | | | | | |
| Male | 50.05 | 46.51-53.59 | 50.42* | 46.59-54.25 | 44.78 | 39.98-49.68 | - | - | - | - |
| Female | 49.95 | 46.41-53.49 | 49.58 | 45.75-53.41 | 55.22 | 50.32-60.02 | - | - | - | - |
| Ethnicity | | | | | | | | | | |
| African Americans | 93.37 | 91.88-94.60 | - | - | - | - | 94.07* | 92.69-95.20 | 92.67 | 90.63-94.30 |
| Caribbean Blacks | 6.63 | 5.40-8.12 | - | - | - | - | 5.93 | 4.80-7.31 | 7.33 | 5.70-9.37 |
| Any Psychiatric Disorders | | | | | | | | | | |
| Yes | 36.12 | 32.06-40.40 | 35.93 | 31.63-40.46 | 38.92 | 26.24-53.29 | 38.79* | 33.02-44.89 | 33.45 | 29.28-37.90 |
| No | 63.88 | 59.60-67.94 | 64.07 | 59.54-68.37 | 61.08 | 46.71-73.76 | 61.21 | 55.11-66.98 | 66.55 | 62.10-70.72 |

* $p < 0.1$

M; Mean

SE; Standard Error

**Table 3:**

Summary of logistic regressions for the associations between overall social support and any lifetime psychiatric disorder in the sample overall

| | Model 1 | | Model 2 | | Model 3 | | Model 4 | |
|---|---|---|---|---|---|---|---|---|
| | **OR** | **95% CI** | **OR** | **95% CI** | **OR** | **95% CI** | **OR** | **95% CI** |
| Age | 1.16* | 1.01-1.34 | 1.16* | 1.01-1.34 | 1.16* | 1.01-1.34 | 1.16* | 1.01-1.34 |
| Poverty Index | 0.93 | 0.84-1.03 | 0.93 | 0.84-1.03 | 0.93 | 0.84-1.03 | 0.93 | 0.84-1.03 |
| Ethnicity (Caribbean Black) | 0.98 | 0.62-1.54 | 1.76 | 0.53-5.85 | 0.98 | 0.62-1.54 | 1.76 | 0.54-5.71 |
| Gender (Female) | 0.88 | 0.66-1.17 | 0.88 | 0.66-1.17 | 0.89 | 0.32-2.48 | 0.87 | 0.31-2.43 |
| Discrimination | 1.09** | 1.03-1.14 | 1.09** | 1.03-1.14 | 1.09** | 1.04-1.14 | 1.09** | 1.04-1.14 |
| Religious Support- Total | 0.82* | 0.68-0.98 | 0.83 | 0.68-1.01 | 0.82 | 0.65-1.05 | 0.83 | 0.65-1.06 |
| Religious Support × Ethnicity | - | - | 0.82 | 0.61-1.09 | - | - | 0.82 | 0.62-1.08 |
| Religious Support × Gender | - | - | - | - | 1.00 | 0.71-1.40 | 1.00 | 0.71-1.41 |
| Intercept | 0.11 | 0.01-1.21 | 0.10 | 0.01-1.19 | 0.11 | 0.01-1.33 | 0.11 | 0.01-1.32 |

* $p < 0.05$,

** $p < 0.001$

OR; Odds Ratio

SE; Standard Error

CI; Confidence Interval

**Table 4:**

Summary of logistic regressions for the associations between emotional and tangible social support and any lifetime psychiatric disorder in the sample overall

| | Model 5 | | Model 6 | |
|---|---|---|---|---|
| | **OR** | **95% CI** | **OR** | **95% CI** |
| Age | 1.16* | 1.01-1.34 | 1.17* | 1.01-1.35 |
| Poverty Index | 0.93 | 0.84-1.03 | 0.95 | 0.86-1.05 |
| Ethnicity (Caribbean Black) | 0.98 | 0.63-1.54 | 1.02 | 0.64-1.64 |
| Gender (Female) | 0.88 | 0.66-1.17 | 0.89 | 0.67-1.19 |
| Discrimination | 1.09** | 1.03-1.14 | 1.09** | 1.04-1.14 |
| Religious Support- Emotional | 0.94* | 0.88-1.00 | - | - |
| Religious Support- Tangible | - | - | 1.10 | 0.98-1.24 |
| Intercept | 0.09* | 0.01-0.93 | 0.05* | 0.00-0.49 |

* $p < 0.05$,

** $p < 0.001$

OR; Odds Ratio

SE; Standard Error

CI; Confidence Interval