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ADDIS ABABA UNIVERSITY

COLLEGE OF EDUCATION AND LANGUAGE STUDIES

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Master of Arts in Counseling Psychology

The relationship between levels of religiosity and depression among Ethiopian Orthodox Christians: the case of some selected churches in Addis Ababa

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Advisor: Assefa Berihun (PhD)

Addis Ababa, Ethiopia

May, 2026 GC

THE RELATIONSHIP BETWEEN LEVELS OF RELIGIOSITY AND DEPRESSION AMONG ETHIOPIAN ORTHODOX CHRISTIANS: THE CASE OF SOME SELECTED CHURCHES IN ADDIS ABABA

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DECLARATION

I, Aba Abrehaley Oqbamichael Zemichael, conducted this study independently with the assistance and direction of the research advisor, Assefa Berihun (PhD), in partial fulfillment of the requirements for the degree of Master of Arts in Counselling Psychology on the topic of “The Relationship Between Levels of Religiosity and Depression Among Ethiopian Orthodox Christians: The Case of Some Selected Churches in Addis Ababa."

This research is entirely original to me and has not been submitted to any school, here or elsewhere, for a degree or master's program.

Name of Candidate: Aba Abrehaley Oqbamichael Zemichael.

Signature: _____

Date: _____

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Date: _____

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Acronyms and Abbreviations

AAU – Addis Ababa University

BDI-II – Beck Depression Inventory–Second Edition

DUREL – Duke University Religion Index

MA – Master of Arts

SPSS – Statistical Package for the Social Sciences

α – Cronbach's Alpha

β - Standardized Regression Coefficient (Beta)

r – Pearson's Correlation Coefficien

Abstract

This research investigated the relationship between levels of religiosity and depression among Ethiopian Orthodox Christians in selected churches in Addis Ababa, Ethiopia. Utilizing a mixed-methods design, the study integrated quantitative data from 409 respondents with qualitative narratives from purposively selected interview participants until data saturation was reached. Quantitative measures employed the Duke University Religion Index (DUREL) and the Beck Depression Inventory II (BDI-II), whereas qualitative data were gathered through semi-structured interviews and analyzed through thematic analysis to capture the lived experiences of believers. Using cutoff scores established through the equal interval method, participants demonstrated an overall High level of religiosity (75.4%) and a Moderate level of depression (47.3%). The findings revealed significant negative correlations between all three dimensions of religiosity and depression symptoms. Partial regression analysis further confirmed that religiosity, taken together, was a significant predictor of depression, accounting for 14.0% of the variance in depression symptoms ($R^2 = .140$, $p < .001$). Beyond these direct relationships, social cohesion, personal meaning and stability, and participants' theological orientation (encompassing their image of God and faith-based coping) emerged as important parallel mediating factors, with personal meaning and stability showing a particularly strong association with psychological resilience, which fully explained the mechanisms through which the protective relationship between religiosity and depression operates. The interview results showed that religiosity provided emotional support to manage depression through the practice of Kidassie (Liturgy), private prayer, and the use of Tsebel (Holy Water), which served as self-directed therapeutic tools. Participants further described the church community as a source of comfort, belonging, and practical assistance during periods of psychological distress, reinforcing the quantitative finding that organizational religious participation carries strong protective value. The study concluded that the Ethiopian Orthodox Tewahedo Church serves as a vital coping resource for people navigating the stresses of urban life, functioning much like a support system that protects individuals from the mental health effects of financial and social struggle. Recommendations are provided for integrating spiritual assets into clinical counseling and enhancing the mental health literacy of clergy members.

Keywords: Religiosity, Depression, Organizational religiosity , Non- organizational religiosity, Intrinsic Religiosity

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Nowadays mental health is becoming a global priority issue especially depression is more recognized leading cause of disability by the World Health Organization (WHO, 2022). This problem is currently affected over 280 million people and contributed to the global burden of disease through symptoms like persistent sadness, anorexia and many others. The prevalence of major depression is approximately 4. 1 % globally, this escalates to 5-10% in East African countries like Kenya, Uganda, and Tanzania due to intersecting challenges of poverty, conflict, HIV/AIDS stigma, and urbanization.

Religious institutions are the most accessible option to provide both spiritual and emotional support for individuals experiencing these forms of emotional distress through organized faith-based prayer groups and communal rituals. Faith formations and group ritual activities have been shown to reduce depressive symptoms by approximately 20-30 % in longitudinal research conducted in these countries (Alem et al., 2020).

In Ethiopia depression is a serious public health challenge, which has a prevalence rates ranging from 0.6% in rural areas to as high as 15–23.6% in urban centers like Addis Ababa. These figures are largely driven by socioeconomic pressures such as poverty, unemployment, chronic illness, food insecurity, and social instability. Shortage of mental health professionals is made a worse situation where there are only 0.3 psychiatrists available per 100,000 people this leads a millions of adults out of mental health service access (Alem et al., 2020).

The Ethiopian Orthodox Tewahedo Church (EOTC) is followed by about 44% of the population which is over 36 to 51 million people (CNEWA, 2021) so the church plays a greater role in Ethiopian life than simply a place of worship. The church is providing a support system through rich liturgical services, fasting, holy water and strong community networks that nurture a sense of belonging and resilience.

Researchers all over the world have been looking into how religion affects mental health and it's pretty complicated. On the one hand, when people use religion in a positive way, like praying with

others, it can actually lower their risk of depression by up to 35%. But on the other hand, if they're using it in a negative way, like feeling guilty all the time, it can be bad for them (Pargament, 2001). There's been some research on this already, but not really in Ethiopia. Which is weird, because in churches there are already kind of serving as mental health support systems a lot of people go to them when they're feeling stressed or overwhelmed. But nobody's really studied how the level of religiosity in the Ethiopian Orthodox Church affects its followers' mental health. That's a pretty big gap, especially since so many people are already turning to churches for help with their mental health.

Therefore, this study was aimed to investigate relationship between religiosity and depression among the followers of Ethiopian Orthodox Christians.

1.2 Statement of the Problem

In global literature, it is known that religion plays a significant role in mental health, especially when it comes to depression. It is a significant factor in mental treatment because it can offer protection through social support, meaning-making, and a sense of purpose (Ano & Vasconcelles, 2005).

In Ethiopia, research on religiosity and depression remains limited, but some related researches are done in different area of this issue. For instance, the study of Teklehaimanot et al. (2021) found a 38.7% prevalence of mental distress among holy water seekers in the Entoto area, but this research is focused on treatment preferences rather than measuring religiosity levels or exploring its link to depression.

Similarly, Assefa et al. (2019) reported a 22.4% prevalence of depression among university students in Addis Ababa. This study mentioned religious coping strategies, but it only addressed them in general terms; it did not specify the case in the Ethiopian Orthodox Church tradition, which has distinctive practices like extensive fasting and the use of holy water that are not found in other denominations. Another related research was Alem et al. (2020), which was a national community-based study. According to the study poverty is a key risk factor for depression but it doesn’t focus on the relationship between depression and religiosity. Collectively, all the above studies lack direct measurement of religiosity and they fail to focus on the Orthodox denomination.

In general, Ethiopian mental health literature emphasizes broad risk factors like poverty, biomedical efficacy, and others, but there is little focus on religiosity, despite religion serving as the primary coping mechanism through EOTC counseling centers and churches in Addis Ababa (Abate & Bekele, 2018).

Therefore, this study was aimed to investigate whether religiosity levels inversely correlate with depression among EOTC adherents.

1.3 Research Questions

This study was guided by the following research questions:

I. What is the level of depression among the study participants?
II. What are the self-reported levels of organizational, non-organizational, and intrinsic religiosity among study participants?
III. Is there a significant relationship between overall religiosity and the severity of depression among Ethiopian Orthodox Christians?
IV. Do the three dimensions of religiosity (organizational, non-organizational, and intrinsic) relate differently to depression scores?
V. Do socio-demographic factors such as age, gender, marital status, and educational level affect the relationship between religiosity and depression?
VI. Do mediating (social cohesion, personal meaning and stability) and moderating factors affect the relationship between religiosity and depression

1.4 Objectives of the Study

1.4.1 General Objective:

The general objective of this study was to investigate the relationship between levels of religiosity and depression among Ethiopian Orthodox Christians in some selected churches in Addis Ababa.

1.4.2 Specific Objectives:

- To measure the level of depression among the organizational, non-organizational, and intrinsic religiosity participants.
- To measure the levels of organizational, non-organizational, and intrinsic religiosity among study participants.
- To examine the correlation between religiosity scores and depression scores.
- To determine the association between each dimension of religiosity (organizational, non-organizational, and intrinsic) and depression.
- To examine how socio-demographic factors influences the relationship between religiosity and depression.
- To examine how mediating (social cohesion, personal meaning and stability) and moderating factors affect the relationship between religiosity and depression

1.5 Significance of the Study

This research carries both theoretical and practical significance for the field of mental health in Ethiopia. Theoretically, the study contributes to the growing literature on the psychology field religion by providing empirically grounded data on the relationships among three dimensions of EOTC religiosity and depressive symptom severity.

Practically, the findings offer a foundational evidence base to inform the development of culturally competent mental health interventions that recognize and incorporate the spiritual beliefs and religious practices of Ethiopian Orthodox Christian clients. The study also provides meaningful insights for religious leaders within the EOTC, illuminating specific ways in which existing spiritual structures and pastoral relationships may be leveraged to provide more effective psychological support to congregants experiencing depressive distress.

1.6 Delimitations of the Study

This study was limited in scope across three areas: geography, content, and participant demographics. Geographically, it was conducted within six (6) selected Ethiopian Orthodox Tewahedo churches in Addis Ababa. In terms of content, the study focused specifically on two

variables which are religiosity as the independent variable and depression as the dependent variable. Other mental health conditions, such as anxiety or general psychological distress, were not addressed. Regarding the study population, participants were Ethiopian Orthodox Tewahedo Christians aged 18 and above who actively practiced their faith.

1.7 Operational Definition of Terms

Religiosity: The strength and depth of an individual's religious life, it was measured by these three dimensions which are organizational, non-organizational, and intrinsic.

Intrinsic Religiosity (IR): The degree to which an individual has internalized faith as the primary motivating framework for life decisions, values, and sense of personal purpose and meaning, as distinct from religiosity practiced for external or social motivations.

Organizational Religiosity (ORA): The extent of an individual's formal participation in institutional religious activities, primarily measured through frequency of church attendance and involvement in public religious ceremonies and feast days.

Non-Organizational Religiosity (NORA): The extent of an individual's private religious practices, conducted outside formal church settings, including personal prayer, meditation, scripture reading, and adherence to prescribed fasting regimens.

Depression: A mood disorder characterized by persistent sadness and loss of interest or pleasure in previously rewarding activities, accompanied by physical, cognitive, and behavioral symptoms persisting for at least two weeks and causing significant functional impairment.

Social Cohesion / Support: The perceived strength and availability of social, emotional, and practical support drawn primarily from the church community, including participation in congregational groups such as mahber and senbetie.

Life Stressors: The perceived frequency and severity of negative life events experienced by a participant, including financial loss, chronic illness, unemployment, and bereavement.

Ethiopian Orthodox Tewahedo Christian: A participant who self-identifies as a member of the Ethiopian Orthodox Tewahedo Church.

CHAPTER TWO

2. LITERATURE REVIEW

2.1 Introduction

This chapter provides a comprehensive and critically appraised review of the scholarly literature concerning the relationship between religiosity and depression. The review proceeds from conceptual foundations through theoretical frameworks and empirical evidence, organized across global, African, and Ethiopian contexts, before concluding with a synthesis of identified research gaps and the conceptual framework guiding the present study. The purpose of this chapter is not merely to catalogue prior work but to demonstrate how the current study is positioned in relation to existing knowledge and to justify the specific analytical choices made in its design.

2.2 Conceptual Foundations

2.2.1. Religiosity

Religiosity is a quality or state of being religious. In psychological construct, It has a multidimensional concept that describes the depth of an individual's commitment to religious belief and practices (Koenig et al., 2012).

In psychology, religiosity is measured in three main ways (Pargament, 2013):

- Belief: The individual's acceptance of religious dogmas and the existence of a divine being.
- Commitment: The acceptance of one's beliefs as a principle of life and the application of them in life decisions.
- Involvement: Participation in rituals and social activities.

These dimensions do not operate in isolation. Rather, they interact in complex ways to shape an individual's overall religious orientation and, by extension, the psychological resources available to them in times of depression. The Duke University Religion Index (DUREL), employed in this study, operationalizes three of these dimensions — organizational religiosity (ORA), non-organizational religiosity (NORA), and intrinsic religiosity (IR) — and has demonstrated acceptable validity across diverse cultural contexts (Koenig & Büssing, 2010).

2.2.2. Dimensions of Religiosity

2.2.2.1 Intrinsic Religiosity

Intrinsic religiosity, a construct introduced by Gordon Allport (1966), is refers to a mature and internalized orientation to faith in which religion functions as the primary motivating framework for an individual's life, values, and decision-making. Hoge (1972) further emphasized that intrinsic religiosity represents a deeply internalized religious motivation that guides personal conduct and spiritual development. People high in this tend to use faith as a core lens for everything: forgiveness, morality, and meaning. Research also shows it can buffer stress and anxiety, offering real mental health benefits (Allport, 1966).

Empirical studies show that intrinsic religiosity is commonly used to reduce depression risks. So there are these studies that look at how people's experiences change over time. And what they found is that when people do devotional practices, they're like 20-30% less likely to have a depressive episode. This is because it helps them cope with stress better, they feel more connected to others, and it even affects their brain in a positive way (Koenig, 2010). Then there are these bigger analyses that pool all the data together they found that the more someone practices their faith, the less depressive symptoms they tend to have. It's especially true for people who are under a lot of stress all the time (Smith et al., 2003). These is having faith helps them find meaning and be more resilient.

2.2.2.2 Organizational Religiosity

Organizational religiosity is a measure that focuses on how frequently an individual participates in public, visible religious events or rituals. The primary example of this is attending religious services. For example, one question asked during the Duke Religion Index (DUREL), measures how often individuals participate in religious activities, specifically how many times per week they attend their place of worship. Specifically, the DUREL includes questions such as: "how often do you attend church or religious services?" which is scored from 1 = never to 6 = more than once per week (Koenig & Büssing, 2010). The focus of the organization religiosity dimension is based on the idea of creating a sense of community among followers. Organizations provide a means for developing relationships with other members of your community; providing emotional support; promoting moral values; and providing a sense of belonging. All of these are important factors in maintaining good mental health.

The research literature on organizational religiosity and depression is extensive. Meta-analytic findings consistently demonstrate that frequent attendance at religious services is associated with significantly lower levels of depressive symptomatology, with hazard ratios for depression incidence among weekly attenders ranging from HR = 0.65 to HR = 0.80 compared with non-attenders, independent of other predictors including intrinsic religiosity (Koenig, 2010). Longitudinal studies confirm that regular communal religious participation reduces feelings of loneliness and promotes peer encouragement, producing a 20 to 35 percent reduction in depressive symptom probability (Koenig et al., 2012). Importantly, the protective effect of organizational religiosity appears to be especially robust in resource-limited contexts, where communal religious participation functions as a substitute for otherwise inaccessible formal support systems.

For Ethiopian Orthodox Tewahedo Church (EOTC) followers, organizational religiosity is practiced through daily prayers/rituals, feasts/pilgrimages to Addis Ababa churches. Based upon previous literature, it is proposed that organizational religiosity was demonstrated an inverse correlation with Beck Depression Inventory II (BDI-II) through enhanced communal coping mechanisms available to individuals experiencing urban related stressors.

2.2.2.3 Non-Organizational Religiosity

Non-organizational religiosity refers to private practices like personal prayer, scripture reading, and meditation; that individuals perform privately outside formal places of worship and organized religious gatherings. Measured by a single DUREL item how often one engages in private prayer or meditation, scored from rarely to more than once daily it captures the solitary side of faith that builds internal spiritual resources away from public view (Koenig et al., 1997).

Evidence links frequent private devotion to depression reduction (r=-0.15 to -0.28), particularly during acute stress, as prayer activates parasympathetic calming and cognitive reframing of adversity [Pargament, 2001]. Meta-analyses report daily prayer halves depression persistence odds (OR=0.45), strongest among chronically ill or bereaved populations where communal access limits (Koenig, 2010).

For Ethiopian Orthodox Christians, non-organizational practices include personal prostrations during 200+ fasting days and home icon prayer, expected to demonstrate strongest buffering against depressive symptoms.

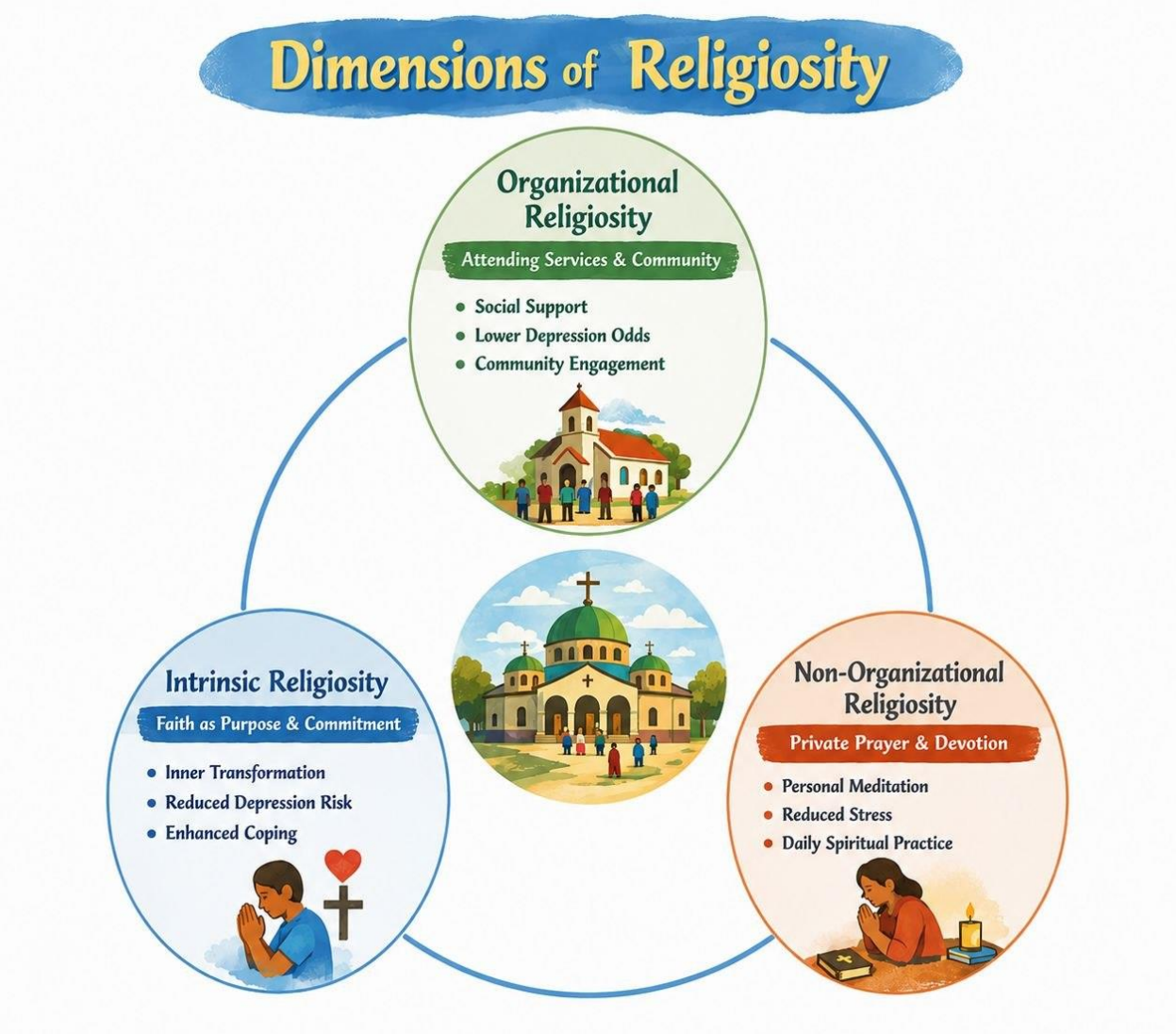

Figure 1: *Dimensions of Religiosity and Their Relationship to Mental Health*

Source: *Developed by the researcher using AI generator*

2.2.3 Depression

Depression is a common mood disorder characterized by a persistent feeling of sadness, emptiness, or irritability, accompanied by a marked loss of interest or pleasure. Major Depressive Disorder (MDD) is a serious mental illness characterized by feelings of hopelessness, loss of interest, and impairment in physical and psychological functioning (APA, 2013). At the psychological level, depression is characterized by a primarily cognitive deficit. For example, low self-esteem, pessimism, and preoccupation with negative thoughts (Beck, 1967). According to the Diagnostic

and Statistical Manual of Mental Disorders (DSM-5), depression is defined as the presence of five or more of nine symptoms (such as depressed mood, anhedonia, changes in appetite or weight, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or guilt, diminished concentration, and recurrent thoughts of death) for at least two weeks, causing significant impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2013). It is associated with significant disability (Kessler et al., 2003).

2.2.4 Spirituality and Religiosity

Although many people use "spiritual" and "religious" in an informal sense, researchers distinguish them because they are separate but related aspects of a person's belief system when it comes to studying how a person's faith can affect their mental health for members of Ethiopia's Ethiopian Orthodox Tewahedo Church (EOTC) (Hill & Pargament, 2003). Religiosity is defined by one's degree of commitment to formal religious institutions and the doctrine, rituals. For EOTC adherents, this encompasses regular participation in the Divine Liturgy (Kidassie), observance of the Lenten and other fasting periods prescribed by the church calendar, engagement with the sacramental life of the church including confession and communion. Since religiosity can be measured with objective criteria such as frequency of church attendance, which is measured using DUREL's Organizational Subscale, this provides both social capital and a framework that provides individuals with a buffer against depression (Koenig et al., 1997) through community support.

Spirituality, in contrast, refers to individualized search for ultimate significance, meaning, purpose, and transcendence. Spirituality exists as both subjective experience (private contemplation or mysticism) and external expression (prayer or ritual). In the case of most EOTC practitioners, religiosity and spirituality operate in tandem as well as mutually reinforcing ways. The religious practice of performing extensive fasts (>200 days per year) for example, and venerating icons and making confessions as sacrament all represent physical embodiments and forms of foundation for spiritual growth; thus providing institutional religious practices as vehicles for individual spiritual development that enhance an individual's ability to cope with stress from urban depressive conditions (Koenig, 2010). Therefore, the combined religiosity-spirituality aspect of formal religious practice will provide the basis for the study's prediction that higher levels of religiosity, as measured by DUREL's Organizational Subscale will correlate with lower levels of self-reported

symptoms of depression using the Beck Depression Inventory II (BDI-II), among participants who attend churches within Addis Ababa.

2.3 Theoretical Frameworks

The relationship between religiosity and mental health has been theorized through multiple complementary frameworks. Drawing on the work of Koenig (2012), among others, it is understood that religion may exert its effects on depression through at least four distinct but interrelated pathways: social support and community belonging; cognitive meaning-making and the construction of purpose; psychobiological effects of devotional practices including prayer and meditation; and the shaping of health behaviors and coping strategies. The following theoretical frameworks, applied to the Ethiopian Orthodox context, collectively inform the conceptual architecture of this study.

2.3.1 Overview of Applied Theoretical Frameworks

Five theoretical frameworks were selected to guide the analysis in this study: the Stress-Buffering Model, Social Support Theory, Meaning-Making Theory, Behavioral and Cognitive Religion-Based Models, and Religious Coping Theory. Each framework is applied to the EOTC context in the sections that follow.

2.3.2 The Stress-Buffering Model

The concept of the stress-buffering model is that certain resources help to reduce the impact of negative life events on an individual's health status. An accumulation of adverse occurrences can be related to health problems, but life stress may have less effect among people who have more psychosocial resources. In this sense, the resource serves as an insulating factor, or buffer, between the stressors and the disease outcome, so that people who have more resources are less affected by stress (Ouellette & DiPlacido, 2001).

Stress is typically measured by the number of major negative events that a person has experienced in the past year. These include events such as loss of a loved one or experiencing severe financial difficulty. Job strains, in an occupation in which demands are high but control is low, can serve as a stressor, and criminal victimization (assault or theft) can be quite distressing. High levels of stress have been linked to anxiety, depression, and physical health problems in studies of general

populations, but buffering resources can reduce the relation between stress and disease (Ouellette, Suzanne C., and Joanne DiPlacido. 2001).

One type of stress-buffering agent is social support. Social support can be defined as resources provided by others that help a person to cope better with problems. Research has shown that persons with more social support are less affected (or unaffected) by negative life events. Supportive relationships contribute to well-being because they provide a source of intimacy, acceptance, and confiding about emotions (emotional support), which provides buffering effects across a broad range of life stressors. Supportive persons may also offer useful advice and guidance (informational support). By providing such resources, personal relationships help to reduce the impact of stress on depression and anxiety. Some studies have also suggested that social support can provide buffering effects that reduce the risk of mortality from cardiovascular disease or cancer (Thomas Ashby, and Marnie Filer. 2001).

Personality characteristics also may serve as a stress-buffering resource. For example, a personality complex termed hardiness has been found to provide buffering effects. Hardiness is defined as scoring high on attributes of commitment (being involved with other people rather than detached or alienated), control (taking control over one's decisions and actions, rather than passivity and pow-erlessness), and challenge (the ability to tolerate uncertainty and see life events as a challenge rather than a threat). Persons who score higher on hardiness show less illness at high levels of stress, compared with person's low on hardiness. Thus individuals who score higher on this personality complex are more resistant to stress (Thomas A.2004)

An implication of the stress-buffering model is that interventions to enhance available social support or to teach people's positive attitudes about commitment, control, and challenge can help make persons less vulnerable to negative events. Such interventions can be conducted in school, clinic, or community settings so as to improve people's coping ability and thereby improve the mental and physical health of the population.

In the Ethiopian Orthodox Tewahedo Church (EOTC) context, this model directly applies to urban Addis Ababa adherents facing compounded stressors like poverty, unemployment, and social isolation, where organizational religiosity (church attendance during liturgies) buffers via communal solidarity, non-organizational practices (private prayer during fasting) via personal reframing ("this suffering draws me closer to Christ"), and intrinsic faith via overarching purpose

amid 200+ annual fasting days interpreted as redemptive discipline . The study hypothesizes DUREL religiosity dimensions will moderate (BDI-II), depression scores, weakening links to socio-demographic stressors and supporting church-based interventions that amplify EOTC's natural buffering capacity against Ethiopia's 15-23.6% urban prevalence

2.3.3 Social Support Theory

Religious organizations (such as churches) serve as central hubs for social cohesion and support. Regular church attendance allows individuals to connect with other believers, exchange emotional and practical support. Strong social ties also significantly reduce loneliness, isolation, and depression (Hill & Pargament, 2003). In the Ethiopian Orthodox Tewahedo community, the participation of associations (for example, the involvement of the *Tswa'* and *Edir* Association and Sunday schools) is part of this social support.

2.3.4 Meaning-Making Theory

Viktor Frankl's logotherapy (2006) is the foundation for Meaning-Making theory; it states people develop clinical depression due to an existential vacuum (Frankl, 2006), which is the absence of a sense of purpose in one's life. Religiosity can restore the person's sense of balance psychologically when they are embedded within a larger transcendent cosmic framework that defines their suffering as being for some greater purpose than themselves. Frankl believed that people have a "will to meaning," and religions serve as the final answer to the question "why" during times of crisis. They transform pain and despair (i.e., illness, loss) into a narrative of redemption, spiritual love, or an eternally rewarding experience, thus preventing the feeling of helplessness that leads to depressive episodes. Pargament and Mahoney (2005) extended these findings to religious coping, as religion provides a way for people to reconstruct meanings related to stressful events; they find that believers will reinterpret stressful events through the lens of something sacred ("This trial has made me holy"), which maintains motivation and hope. Meta-analysis confirms that religiosity acts as a buffer against depression through its role in making meaning; further analysis shows that the relationship between religiosity and depression is greatest among those who face uncontrollable events, with purpose mediating approximately 30-50% of the variance associated with religiosity's buffering effects on depression, primarily through increased self-efficacy and optimism (Koenig, 2012).

2.3.5 Behavioral and Cognitive Religion-Based Models

The Cognitive Model is a theoretical framework that supports the idea that religious beliefs act to counteract Beck's (1967) negative views of self, world, and future by redefining or reframing theology in an adaptive way to prevent depression. Religious beliefs about unconditional love of God lead to positive appraisals of one's own self ("I am worthy of God's love"), generate optimism about how the world works ("God cares for us all and protects his world") and create hopeful expectations about the future ("our lives will be rewarded in heaven"). These positive beliefs are counterproductive to negative thoughts and behaviors associated with depression. Research has demonstrated a relationship between religious cognition and depression; research has shown that religious cognition mediates 25 – 40 percent of the inverse relationship between religion and depression ($r = -.15$). This is especially true for individuals who suffer from chronic illness. For example, when individuals perceive their sickness as part of a narrative of mercy, they experience less hopelessness [Koenig, 2012].

Additionally, the Behavioral Model focuses on behaviorally observed religious acts as positive reinforcements to encourage participation in healthy activities. Prayer can decrease heart rate due to parasympathetic effects (heart rate decreases 10-20%) and increase feelings of calmness. Fasting promotes self-control. Liturgical singing increases levels of endorphins which improve moods. Participation in group or communal rituals provides structure and distraction from withdrawing into oneself.

Frequent participants in religious practice exhibit twice-to-three times more pro-social health behaviors than non-participants, resulting in a 30% lower chance of experiencing depression regardless of cognitive changes [Koenig, 2012]. In Ethiopia Orthodox Tewahedo Church (EOTC), both the Cognitive and Behavioral Models suggest that a combination of cognitive reframing during confession (e.g., "My failures have been forgiven by God") and behavioral fasting discipline should result in lower BDI-IIscores, measured using DUREL assessed religiosity.

2.3.6 Religious Coping Theory (Positive and Negative)

Proliferating research on how people bring religious resources to bear in their efforts to deal with stressful situations (i.e., religious coping; Pargament, Smith, Koenig, & Perez, 1998) has greatly expanded our understanding of the effects of this type of coping. Religious coping has been associated with individuals' adjustment to major life stressors such as cancer or major trauma as

well as their management of less severe stresses (e.g., Pargament, Koenig, & Perez, 2000). Importantly, researchers have distinguished among different types of religious coping and described their potential for different outcomes (Pargament, Feuille, & Burdzy, 2011).

Most contemporary research conceptualizes religious coping as comprising two distinct dimensions, positive and negative, and often assesses these dimensions with the RCOPE or Brief RCOPE (Pargament, 2013). Positive religious coping reflects a confident and trusting connection with God (Hebert, Zdaniuk, Schulz, & Scheier, 2009) and includes strategies such as seeking religious support and making benevolent religious reappraisals. Negative religious coping reflects a less secure relationship with God (Hebert et al., 2009) and includes strategies such as religious discontent and making punitive religious reappraisals.

Using positive religious coping to deal with specific stressors is sometimes related to higher levels of well-being (e.g., Pargament et al., 1998b), but null or even inverse associations between positive religious coping and adjustment often are reported (e.g., Gerber, Boals, & Schuettler, 2011; Sherman, Simonton, Latif, Spohn, & Tricot, 2005; Sherman, Plante, Simonton, Latif, & Anaissie, 2009). More consistent findings have been reported for negative religious coping, which tends to be used much less frequently but is generally found to be strongly related to poorer mental and physical health (see Exline & Rose, 2013, for a review).

However, key questions remain about positive and negative religious coping. In particular, although studies that have assessed both positive and negative religious coping generally show that associations of negative religious coping are stronger and more consistent than are those of positive religious coping (e.g., Pargament et al., 2000; Pargament, Koenig, Tarakeshwar, & Hahn, 2001; see Ano & Vasconcelles, 2005), studies often examine the associations of positive and negative religious coping with well-being separately (e.g., Amadi et al., 2016; Parenteau, 2016; Tarakeshwar et al., 2006) rather than conjointly. Thus, it is not well established whether positive religious coping may be independently associated with well-being when also taking negative religious coping into account.

2.4 Empirical Evidences

2.4.1 Global Empirical Findings

A vast body of research on religiosity and mental health has found that individuals with high levels of religious involvement are less likely to experience depression. For example, a review by Koenig (2010) found that levels of religiosity and depressive symptoms are inversely related. This means that practices such as church attendance and personal prayer are associated with improved mental health. This protective role is largely explained by the stress-buffering capacity of religion.

A meta-analysis by Smith, McCullough, and Poll (2003) found that higher levels of intrinsic religiosity were modestly but significantly associated with lower rates of depression. Faith reduces psychological distress by providing individuals with meaning and purpose in life and by helping them to form strong social bonds (Koenig et al., 2012). In particular, people with intrinsic religiosity (those who value religion for its own sake) have been shown to have better resilience during times of stress.

2.4.1.1 Evidence of Negative Association

A large body of meta-analyses and systematic reviews have suggested that individuals with high levels of religious involvement are less likely to develop depression. For example, a review by Koenig (2010) found that levels of religiosity and depression were consistently inversely related. This means that religious involvement (such as weekly church attendance) and depth of personal prayer/faith were associated with lower levels of depressive symptoms. The main reason for this is the stress-buffering ability that religion provides. As Ellison and Levin (1998) have argued, religion protects mental health by providing meaning to life and enhancing resilience in the face of stressful situations. Studies have shown that people with intrinsic religiosity, in particular, use religion for its beliefs rather than for personal gain, and thus experience healthier psychological outcomes.

2.4.1.2 Evidence for Positive and Complex Relationships

Although not every study shows a strong negative relationship, many research studies do demonstrate some level of a null relationship or mixed results. The difference among these studies may be related to sample size and/or how religiosity was measured. Religious coping is so complex because religious belief can either help or hinder one's ability to manage stress. Pargament (2001)

pointed out that how individuals believe and use their religious belief system will determine what happens for them.

Additionally, religious influence is not always positive. Negative religious coping is also very highly associated with increasing the likelihood of developing major depression. In a large-scale study conducted by Exline et al. (2017), it demonstrated that when believers experience difficulty and attribute it to God, when they express doubt and anger towards their faith, and/or when they perceive the difficulties as punishment, their symptoms of depression dramatically increased. Therefore, based on this information, to assess how religiosity influences depression, researchers should evaluate all aspects of religiosity, such as internalized beliefs, socialization through faith communities, and various forms of religious coping mechanisms.

2.4.2 Studies in the African Context

2.4.2.1 Religiosity and Mental Health in Sub-Saharan Africa

Religion plays a significant role in individual and community life in sub-Saharan Africa. Traditional beliefs, Christianity, and Islam are the dominant religions in African societies. In line with global research, studies in Africa have also found that higher levels of religiosity are associated with improved mental health (Oluwole et al., 2020). For example, studies in Nigeria and Ghana have found that regular church attendance and personal prayer are associated with lower levels of anxiety and depression. The role of religiosity in Africa is largely focused on the ability to navigate life's challenges with spiritual meaning. Religion is not a temporary response to problems, but rather provides a cosmological framework that provides lasting hope and explains the causes of pain and suffering (Abate & Bekele, 2018). Thus, faith serves as a harbor in times of trouble.

2.4.2.2 Gaps in African Empirical Research

Although religion has an effect on the mental health of people in Africa, there is very little scientific research done about it. There are three main areas where additional research should have needed to do (Koenig, 2012; Nanji & Olivier, 2024): First, many of the existing studies are either qualitative or descriptive; therefore, there isn't much quantitative research concerning how various aspects of religiosity relate to symptoms of depression (Mayston et al., 2020). Secondly, most of the existing studies use western tools (e.g., BDI and DUREL) to assess religiosity, however there is little research supporting their validity and reliability when assessing religiosity within African

cultures and religions (Mutumba et al., 2014). Finally, because Christianity, Islam and traditional religions are so prevalent in Africa, there is no empirical data demonstrating the differences in religiosity's effect on depression among the three major belief systems.

2.4.3 Evidence in the Ethiopian Context

2.4.3.1 Understanding EOTC Religiosity

The religiosity of the Ethiopian Orthodox Tewahedo Church (EOTC) is distinct from the global religious concepts and has a deeply culturally embedded dimension. The beliefs and practices of the EOTC are expressed in three main ways: liturgical life, personal struggle, and community engagement. All of these dimensions have a direct impact on the psychological well-being and resilience of Orthodox Christians (Abate & Bekele, 2018).

2.4.3.1.1 Liturgical Life

Liturgical life is one way that members express their faith. Liturgy is an important part of daily Christian life for many, but it is especially central to those who identify as Orthodox. This form of worship is not merely a set of rituals or practices. It is also an expression of a deep-seated sense of connection with God and others (Binns, 2017; Levine, 2000). Personal struggles provide another context through which faith is expressed.

The belief system of the EOTC places great emphasis upon personal spiritual transformation. Faith development in this tradition does not occur solely within a congregational setting; rather it occurs within each individual's inner world. Community engagement provides yet another context in which faith is expressed. A strong emphasis exists among the clergy and laity alike in supporting both social service organizations and other types of institutions (Haustein & Fantini, 2013; Binns, 2017).

2.4.3.1.2 Communal Religious Participation

The communal nature of the Ethiopian Orthodox Church's (EOTC) religious participation supports the concept of Social Support Theory. The churches' structures for communal activities include Sunday Schools and Mahibers that encourage cooperation among church participants. Additionally, many churches have programs to help each other economically, socially, and spiritually. For someone who is vulnerable to depression, these types of networks can serve as an

important source of social support by helping to reduce feelings of loneliness and isolation (Koenig, 2012; Haustein & Fantini, 2013).

2.4.3.1.3 Theological Teachings on Suffering, Hope, and Healing

A number of the theological teachings within the EOTC provide significant insights into how to think about, understand and deal with suffering and evil. It is often stated that all suffering and evil will ultimately be punished. However, some Christian traditions do not interpret all suffering as a form of divine punishment. Instead, many believe that much of what people experience as suffering may be simply a result of their own personal struggles (Binns, 2017; Pankhurst, 1992). Making positive meanings from experiences that otherwise would be viewed negatively, such as those associated with stress and illness, has been shown to decrease the likelihood of developing depression (Park, 2013; Koenig, 2012). Many Christian theologians view this type of process as part of the natural spiritual process that people go through during times of struggle. The hope provided by the resurrection is another way that the EOTC views suffering. Believing in the promise of eternal life creates a feeling of hopefulness that transcends current suffering (Binns, 2017). As noted previously, there are several EOTC teachings regarding the practice of healing. Specifically, the EOTC teaches that emotional/psychological difficulties are closely related to spiritual issues. Therefore, the Church provides several ways to heal from emotional and psychological problems including prayer, fasting, and participation in certain rituals/sacraments (Levine, 2000; Binns, 2017). The belief systems developed by followers of the EOTC can serve as a cognitive framework for individuals to develop their own strategies for dealing with depression based upon their beliefs (Koenig, 2012; Park, 2013).

2.4.3.2 Studies on Mental Health and Depression in Ethiopia

Mental health research in Ethiopia, specifically on Orthodox Tewahedo Christians, is limited, but some researches were demonstrated the importance of religion on mental health in general context (Koenig, 2012; Leavey, 2010). Studies on the prevalence of mental health and depression in Ethiopia indicate that depression is a widespread problem in society. Community-based studies in Ethiopia have found that the prevalence of depression is higher than the global average, particularly in rural and low-income groups (Fekadu et al., 2014). This high prevalence is associated with poverty, malnutrition, conflict, and limited access to health services. Most health studies in Ethiopia focus on how depression is diagnosed and treated in the primary healthcare

system. However, while these studies have extensively examined the clinical aspects of depression, they have tended to examine the protective role of religiosity as a key variable.

2.4.3.3 Studies on the Role of Religion in Mental Health in Ethiopia

In the Ethiopian context, few studies demonstrate the role of religion in maintaining mental health and coping with illness. These studies agree that religion is largely used as a positive coping mechanism (Pargament, 2011; Koenig, 2012). As Ethiopian society is highly religious, individuals often seek help from religious leaders (such as priests and sheikhs) and spiritual service centers (such as *Tsebel*, prayer houses) rather than traditional health institutions when experiencing severe psychological distress. Religion can help alleviate psychological burdens by giving spiritual meaning to illness and hardship, and by helping individuals view negative experiences as challenges or opportunities. Fasting, prayer, and the community of saints, in particular, serve as strong social and psychological support systems among Ethiopian Orthodox Tewahedo Christians (Abate & Bekele, 2018).

2.4.3.4 Gaps in Ethiopian Research on Religiosity and Depression

Although there are studies conducted in the Ethiopian context, there are major gaps that support the main goal of this study. First, most studies examine the role of religion in a qualitative or descriptive manner. Qualitative studies suggest that religion is a primary coping mechanism for many Ethiopians facing distress (Alem et al., 2020). A few quantitative studies have begun to explore this area, but often with methodological limitations or focusing on general "spirituality" rather than specific religious traditions (Koenig, 2012; Fekadu et al., 2019). This means that there has been little work to statistically measure the significant quantitative relationship between aspects of religiosity (intrinsic, extrinsic, and organizational) and depressive symptoms. Second, there has been little work to examine how the depth of faith and religious practice (prayer, fasting) among Ethiopian Orthodox Tewahedo Christians mediate or moderate the vulnerability to depression (Binns, 2017; Park, 2013). Therefore, this study aims to fill these gaps and, with a particular focus on Orthodox Christians, attempts to examine in depth the protective role of religiosity using correlational and regression analysis.

2.5 Summary of the Literature Review

International studies on the relationship between religiosity and depression have generally indicated that intrinsic religiosity and organizational involvement are negatively associated with depressive symptoms. This is due to the stress buffering capacity, social support, and the role of religion in providing meaning to life. In contrast, negative religious coping, which is seen as God's wrath, can exacerbate depression. In Africa and particularly in the Ethiopian context, religion is an integral part of culture and society, and when faced with mental health problems, EOTC rituals (masses, fasting), personal struggles (prayer, confession), and associations (*senbetie*) serve as primary coping mechanisms and frameworks for psychological support. The review shows that all of these practices have a positive impact on the psychological well-being of Orthodox Christians.

Although religion is known to play a significant role in mental health in Africa and Ethiopia, several research gaps have been identified. First, most Ethiopian studies have examined the role of religiosity in a qualitative or descriptive manner. This means that there has been little work to quantitatively measure and statistically validate the relationship between aspects of religiosity and depressive symptoms. Second, there has been little work to examine the mediation or moderation effects of specific practices in EOTC worship, such as personal prayer, community participation, and theological perspective, on depression. Third, since the instruments used to measure religiosity (DUREL) are mostly developed by Westerners, there is little research on their cultural validity and relevance in Ethiopian Orthodox Tewahedo Christians.

This study aimed to fill the gaps identified above. First, the study used a quantitative research method to statistically measure the strength and direction of the relationship between levels of religiosity and depressive symptoms among Ethiopian Orthodox Tewahedo Christians. Second, the study analyzed how aspects of religiosity on depression were mediated or moderated by other variables (such as social connections and theological perspectives).

2.6 Conceptual Framework for the Study

2.6.1 Levels of Religiosity and Depression symptoms

Based on the theories reviewed above (specifically the Stress Buffering Model and Social Support Theory), this study hypothesizes the following relationship. Since the study is conducted using a correlational design, the focus is on measuring the relationship between the two core variables.

Table 1
Study Variables

The Study Variable	Expected role	Ethiopian Context
Independent Variable: Levels of religiosity	The reason that is thought to influence depression.	It is measured by measures of intrinsic religiosity and religious practice (e.g., church attendance).
Dependent Variable: Depression symptoms	The expected outcome is influenced by levels of religiosity.	The severity of depressive symptoms among participants was measured using the BDI-II instrument.

Proposed Hypothesis: Among Ethiopian Orthodox Tewahedo Christians, high levels of internal religiosity and strong organizational involvement will have a negative and significant relationship with low levels of depressive symptoms.

2.6.2 Mediating and Moderating Factors

The direct relationship between religiosity and depression is thought to be moderated or mediated by some variables. Among these, Social Cohesion acts as a mediator. If religiosity reduces depression by providing strong social support through the church community, then social cohesion plays a role in mediating this effect (Larson, 2002; Koenig, 2012).. Similarly, if regular participation in rituals such as fasting, prayer, and Meditation reduces the risk of depression by bringing personal stability and giving meaning to life, then this also acts as a mediator (Pargament, 2011; Park, 2013). In addition, personal prayer can be a mediator in reducing depression by creating a greater sense of closeness to God and providing relief from anxiety.

On the other hand, Theological Orientation is considered a moderator. This means that the way an individual views God (e.g., as a loving God or a punishing God) may moderate the effectiveness of religiosity in the face of stressful situations (Exline et al., 2017). In addition, when there is spiritual struggle or religious conflict, high religiosity may exacerbate the negative impact of depression. Finally, life stressors may be a moderator that enhances the protective role of religiosity in the face of high stress in life (George et al., 2002; Koenig, 2012).

2.6.3 Conceptual Framework Diagram

To make the overall objectives of the study clear, the conceptual framework can be illustrated as follows. This diagram summarizes the relationships and effects expected in the study.

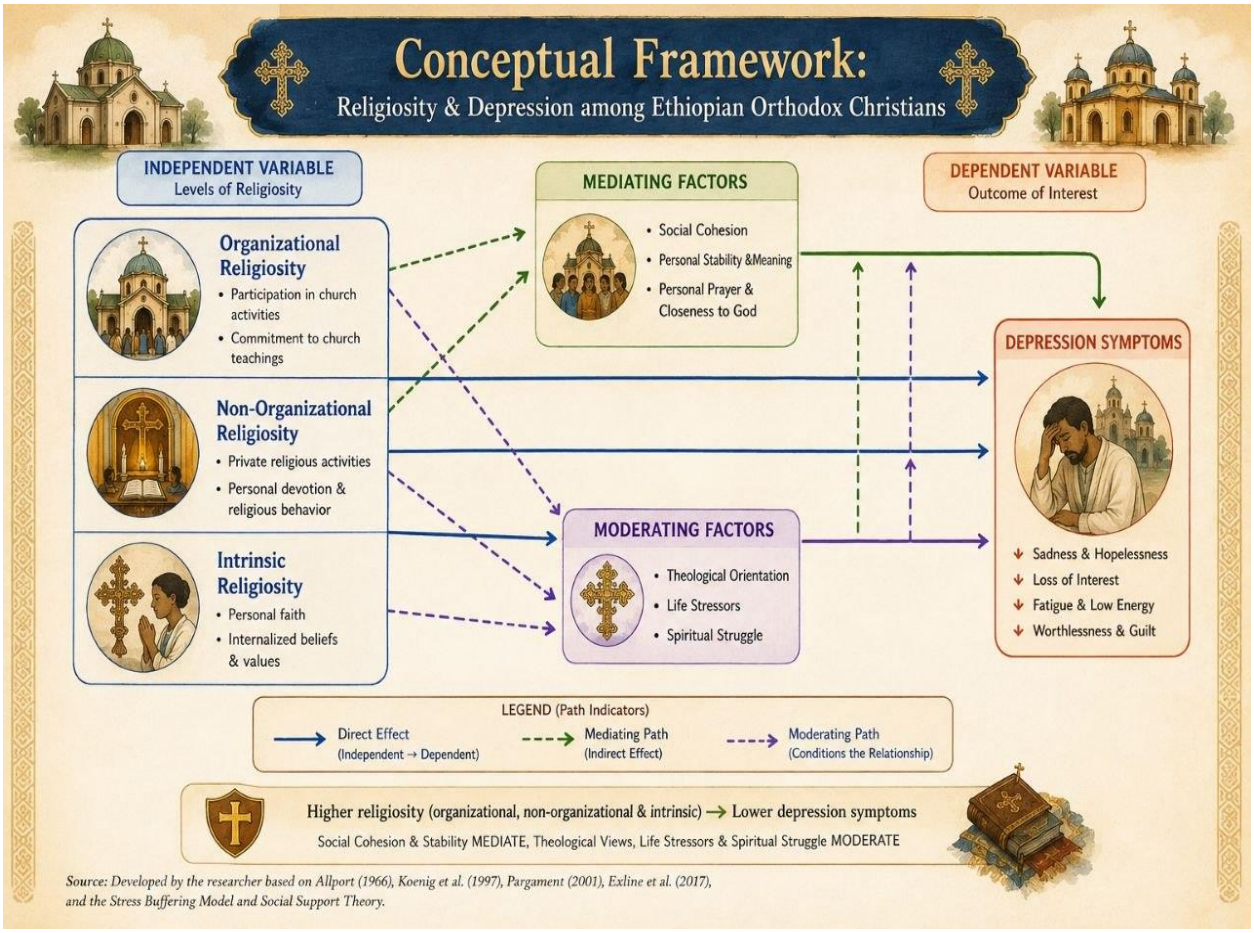

Figure 2 *Conceptual frame work of the study*

Source: Developed by the researcher using AI generator, based on Allport (1966), Koenig et al. (1997), Pargament (2001), Exline et al. (2017), and the Stress Buffering Model and Social Support Theory.

The above conceptual framework illustrates the hypothesized relationship between levels of religiosity and depressive symptoms among Ethiopian Orthodox Tewahedo Christians. In this framework, religiosity operationalized through intrinsic religiosity and organizational religious practices such as church attendance serves as the independent variable, while depression symptoms measured by the BDI-II constitute the dependent variable. The model proposes a negative relationship, whereby higher levels of internalized faith and active religious participation are

associated with lower levels of depressive symptoms. This relationship is mediated by factors such as social cohesion within the church community, personal stability and meaning derived from religious rituals, and private prayer that enhances closeness to God.

CHAPTER THREE

Methodologies

3.1 Introduction

This chapter presents the research design, study setting, population, sampling strategy, data collection instruments, and data analysis procedures that were used to answer the research questions. The methodology is designed to be rigorous, systematic, and ethically sound to ensure the validity and reliability of the findings.

3.2 Research Design

A cross-sectional mixed research design was used for this study. The mixed design is composed of quantitative and qualitative parts. For the quantitative part a cross-sectional survey was used and the two validated scales were used to test significant relationships between religiosity and depression. These two scales were DUREL (religiosity) and II BDI-II (depression). These mentioned approaches were appropriate tools because they were efficiently established correlational patterns without variable manipulation.

The qualitative part, semi-structured interviews was involved. This helped to explore the mechanisms how EOTC practices such as fasting and liturgy contribute for coping depression symptoms.

In researches the method of triangulation was used which was very important because it used to mitigate social desirability and recall biases while providing richer contextual interpretation (Creswell & Plano Clark, 2017). Therefore, within the mixed-methods framework, the study adopted a concurrent triangulation design, to maximize construct validity by quantifying religiosity-depression correlations and to determine causal pathways through interviews.

3.3 Sources of Data

Two primary data source were used for his study which were questionnaire and interview. Primary data were collected directly from participants to capture authentic first-hand accounts of religiosity and depression dynamics within the target population. Data were collected through two complementary instruments corresponding to the two strands of the mixed-methods design. these are a structured self-administered questionnaire and a semi-structured interview guide.

For quantitative component **a** structured questionnaire was used by administering the Duke Religion Index (DUREL) for religiosity levels which were organizational, non-organizational, intrinsic religiosity. In addition to this a Beck Depression Inventory II (BDI-II) was used for measuring a depression severity. For qualitative component a Semi-structured interview guides were used to collect data from purposively selected respondents to examine lived experiences, and practice.

3.4 Study Area and Population

The study was conducted in Addis Ababa, the capital city of Ethiopia. Quantitative data were collected from members of six local churches of Ethiopian Orthodox Tewahedo Church, which were selected from different sub-cities (e.g., *Kirkos, Arada, Yeka,* and *Bole*) to ensure a diverse socio-economic sample. These are: Bole *Debre Sahel Medhane Alem* Cathedral, *Arada Genete Tsigie* St. George's Cathedral, *Mekane Semaet St.Kirkos* Church, *Debre Mitimak* sealite *Meheret* St. Mary's Church, *Yeka Debre Sahel* St. Mikael Church, and *Miskaye Hizunan Medhanealem* Monastery.

The target population was all Ethiopian Orthodox Christians residing in Addis Ababa. The study population was consisting of adult members (18 years of age and older) who regularly attend the selected churches and consent to participate in the study.

3.5 Sampling Technique and Sample Size

3.5.1 Sampling Techniques

A multi-stage sampling technique was used to select participants:

1. **Stage 1:** Three Churches in Addis Ababa were selected by a simple lottery method.
2. **Stage 2:** Within each selected sub-city, one large EOTC church was randomly chosen from a list of all parishes.
3. **Stage 3:** In addition to the regular service hours, two churches were randomly selected from among those where the faithful were most frequently present within their courtyard.
4. **Stage 4:** A systematic random sampling technique was used to select participants as they exited the church after the main service. Every k-th person (e.g., every 5th person) was approached until the desired sample size for that church was reached.

Prior to selection, participants were screened for eligibility. Ethiopian Orthodox affiliation was verified through visible religious identifiers (e.g., mahiteb cross necklace) and confirmed verbally when necessary. In addition, participants were asked their age to ensure that only adults aged 18 years and above were included in the study.

3.5.2 Sample Size

The fundamental goal of calculating sample sizes to obtain a representative (subset) of the population is to save time, money, and other resources required to gather information from everyone or everything in the population (Chinedu U. et al., 2024). Since the population size is unknown but large, the sample size is determined using the Cochran Formula (Cochran, 1977) for a single population proportion in cross-sectional studies: $\mathbf{n = (Z^2 \times p \times (1-p)) / d^2}$.

- Z = 1.96 (the Z-score for a 95% confidence level)
- p = 0.5 (an estimated proportion of 50% is used to maximize the required sample size, as there is no precise prior estimate for the relationship in this specific population)
- d = 0.05 (the desired margin of error)

Calculation: $n = (1.96^2 \times 0.5 \times 0.5) / 0.05^2 = (3.8416 \times 0.25) / 0.0025 = 0.9604 / 0.0025 = 384.16$.

Therefore, the minimum required sample size is 384. To account for potential non-responses or incomplete questionnaires, this is inflated by 10%, resulting in a final target sample size of approximately 422 participants.

3.6 Data Collection Instruments

A structured, self-administered questionnaire and semi-structured interview guide were used to collect data.

Questionnaire

It was consisting of three sections:

1. Socio-Demographic Questionnaire: This section was used collect data on age, gender, marital status, educational level, employment status, and monthly income.

2. Duke University Religion Index (DUREL): This 5-item scale is a widely used and validated instrument for measuring the three key dimensions of religiosity. The first item measures

Organizational Religiosity (frequency of attending church services). The second item measures Non-Organizational Religiosity (frequency of private religious activities like prayer). The remaining three items measure Intrinsic Religiosity (the extent to which religion is the guiding force in one's life). The DUREL has demonstrated good reliability and validity in diverse populations (Koenig & Büssing, 2010).

The DUREL measures each of these dimensions by a separate "subscale", and correlations with health outcome should be analyzed by subscale in separate models. The overall scale has high internal consistence (Cronbach's alpha's = 0.78–0.91), high convergent validity with other measures of religiosity (r's = 0.71–0.86), Scoring for each subscale involves summing the item responses, with higher scores indicating higher levels of religiosity. The Organizational and Non-Organizational subscales each range from 1 to 6, while the Intrinsic Religiosity subscale ranges from 3 to 15.

Although the DUREL does not have universally established clinical cut-off scores, scores can be interpreted relative to sample distributions or categorized into low, moderate, and high religiosity based on percentile ranks (Koenig & Büssing, 2010)

3. Beck Depression Inventory – II (BDI-II): The BDI-II is a widely used 21-item self-report inventory measuring the severity of depression in adolescents and adults. The BDI-II was revised in 1996 to be more consistent with DSM-IV criteria for depression. For example, individuals are asked to respond to each question based on a two-week time period rather than the one-week timeframe on the BDI. The BDI-II is widely used as an indicator of the severity of depression, but not as a diagnostic tool, and numerous studies provide evidence for its reliability and validity across different populations and cultural groups. It has also been used in numerous treatment outcome studies and in numerous studies with trauma-exposed individuals (Beck et. al., 1996).

Beck Depression Inventory rates symptoms of depression in terms of severity on a scale from 0 to 3 based on the 21 specific items with a maximum score of 63. the Beck Depression Inventory–II has consistently demonstrated strong reliability across multiple dimensions. Its high internal consistency of $\alpha = .88$ to .93 (Beck et al, 1996).)

Interview guide

A semi-structured interview guide comprising five open-ended questions was administered to participants until data saturation is achieved to explore lived experiences and mechanisms underlying religiosity-depression relationships among EOTC adherents

3.7 Data Collection Procedure

Quantitative Phase: Quantitative data were collected from attendees at selected EOTC using structured questionnaires. Participants include adults who voluntarily agree to participate, ensuring a representative sample of the population of interest. The questionnaire covered socio-demographic information, religiosity measures using the DUREL, and depression levels using the BDI-II, Ethical approval for the study was obtained from the institutional review board, and participants provided informed consent before participation.

Qualitative Phase: Qualitative data were collected through semi-structured interviews with purposively selected participants who regularly attend Ethiopian Orthodox Tewahedo Church (EOTC). Participants were chosen to capture diverse perspectives on religiosity and its perceived influence on mental health. Interviews were conducted in private, quiet locations to ensure confidentiality and comfort.

3.8 Reliability and Validity

To ensure the internal consistency and credibility of the data collected, reliability and validity analyses were conducted. The reliability of the three dimensions of the Duke University Religion Index (DUREL) was assessed using Cronbach's Alpha, which measures how closely related a set of items are as a group. Table 2 shows the results.

Reliability Statistics for Religiosity Dimensions

Table 2
Reliability statistics

Variables	**Number of Items**	**Cronbach's Alpha**
Organizational Religiosity (OR)	4	.713
Non-Organizational Religiosity (NOR)	4	.700
Intrinsic Religiosity (IR)	4	.532
Depression Symptoms	6	.791
Social cohesion	4	.696
Personal meaning and stability	4	.597
Moderating Factor	4	.731

As shown in Table 2, the internal consistency coefficients indicated that Organizational Religiosity (α = .713), Non-Organizational Religiosity (α = .700), Depression Symptoms (α = .791), and Moderating Factors (α = .731) demonstrated acceptable reliability, exceeding or meeting the commonly recommended threshold of .70. Social Cohesion (α = .696) was slightly below this threshold but still reflected adequate internal consistency for exploratory social science research. In contrast, Intrinsic Religiosity (α = .532) and Personal Meaning and Stability (α = .597) yielded relatively lower reliability coefficients. Although a Cronbach's alpha of .70 is generally preferred, lower values are sometimes observed when scales contain a small number of items or when constructs are measured across different cultural and linguistic contexts.

3.9 Data Analysis

The data was analyzed by using SPSS software. To summarize socio-demographic characteristics, DUREL and BDI-II, scales the descriptive analysis was used which includes frequencies, percentages, means, and standard deviations. Also bivariate correlation analysis and a multiple regression were used to examine the relationships between variables and to determine the predictive relationship between the independent variables. This procedure allowed for the control of socio-demographic variables, helping to identify the unique contribution of each dimension of religiosity in explaining the variance in depression levels.

On other hand thematic analysis was used for the qualitative component to analyze the data from semi-structured interviews. To apply this NVivo 14 software was used based on Braun and Clarke's (2006) six-phase framework.

3.10 Variables of the Study

3.10.1 Independent Variable

- Religiosity
    - Organizational Religiosity
    - Non-Organizational Religiosity
    - Intrinsic Religiosity

3.10.2 Dependent Variable

- Level of Depression

3.10.3 Mediating variables

- Social cohesion
- Personal meaning and stability

3.10.4 Control/ Moderating variables

- Socio- Demographic factors: Age, gender, marital status, education, and Socioeconomic Status
- Theological orientation
- Life stressors

3.11 Ethical Considerations

This study was conducted in accordance with established ethical standards. Before data collection the ethical clearance was obtained from institutional review board of Addis Ababa University, then a formal permission was secured from the administrators of the selected churches. During the collection process the participants were asked a permission to voluntarily participate in the study and all they were informed about the study's purpose and benefits before giving their consent. In order to ensure confidentiality, no personally identifiable information was collected, and all data were anonymized and stored securely.

CHAPTER FOUR

4. RESULTS

4.1 Respondents response Rate

For the quantitative data collection, a total of 422 questionnaires were distributed for participant based on the sample size however the returned and properly filled questionnaire were 409 which has a response rate of 96.98%. This is a very good response rate in survey research because it shows that most of the selected participants were willing to take part and share their views.

4.2 Demographic Profile of Respondents

Table 3 presents the full distribution of socio-demographic characteristics for the 409 respondents included in the analysis. The sample characteristics are discussed below the table.

Table 3
Demographic Characteristics of Respondent(N=409)

No.	Variable	Category	Frequency	Percent (%)
A1	**Age**	18 – 25 years	98	24.0
		26 – 35 years	136	33.3
		36 – 45 years	84	20.5
		46 – 55 years	46	11.2
		Above 55 years	45	11.0
A2	**Gender**	Male	183	44.7
		Female	226	55.3
A3	**Marital Status**	Single	155	37.9
		Married	248	60.6
		Other (Divorced/Widowed)	6	1.5

No.	Variable	Category	Frequency	Percent (%)
A4	**Educational Level**	No formal education	35	8.6
		Primary	27	6.6
		Secondary	80	19.6
		Diploma	88	21.5
		Degree+ (BA/BSc/Above)	179	43.8
A5	**Employment Status**	Wage employed	113	27.6
		Self-employed	236	57.7
		Student	40	9.8
		Retired	18	4.4
		Other	2	0.5
A6	**Monthly Income**	Low	123	30.1
		Medium	215	52.6
		High	71	17.4
	Total		**409**	

Source: SPSS Output, 2026.

The sample was composed predominantly of female respondents (55.3%, n = 226), with males constituting 44.7 percent (n = 183). This gender distribution is broadly consistent with the demographic patterns observed in EOTC congregational settings in Addis Ababa, where women tend to constitute a slight majority of regular service attendees across most parishes. In terms of age distribution, the age group between 26-35 takes the major proportion this indicates the study mostly consists young adults which covers 33.3% of the total sample, secondly the age range between 18 to 25 cover 24% of the total sample. Other participant is above 35 years, cover 42.7% of the population

The other demographic characteristics is the educational and professional background; it shows that participants have wide range of experiences. Most participants (43.8%) hold a university degree, while 21.5% have completed a diploma level study. When it comes to their work experience 57.7% are self-employed and 27.6% are wage employed. The remaining portion of participants are students and retired individuals.

The majority of respondents were married (60.6%, n = 248), with 37.9 percent single. With respect to monthly income, 52.6 percent fell within the medium-income category, 30.1 percent reported low income, and 17.4 percent reported high income. The substantial proportion of low-income participants is significant in the context of this study, as financial hardship represents one of the primary socioeconomic stressors associated with elevated depression prevalence in urban Ethiopia (Alem et al., 2020).

4.3 Descriptive analysis

The following sections present descriptive statistics of item-level means and standard deviations; for each subscale of the study instrument. All items were scored on a five-point Likert scale (1 = Strongly Disagree; 5 = Strongly Agree).

4.3.1 Depression Symptoms

Table 4
Descriptive Analysis for Depression Symptoms(409)

	Minimum	Maximum	Mean	Std. Deviation
I feel a deep sense of sadness or depression most of the time.	1.00	5.00	2.7800	1.36320
I feel hopeless about my future.	1.00	5.00	2.3912	1.30929
Things that used to bring me pleasure no longer interest me.	1.00	5.00	3.1345	1.51431
I feel a sense of tired or a lack of energy.	1.00	5.00	2.9046	1.48463
I had difficulty concentrating.	1.00	5.00	2.9731	1.49894
I often have low self-worth and feel a sense of guilt.	1.00	5.00	3.3741	1.60098
		Total	17.5575	8.771404
Valid N (listwise)				

Source: SPSS Output, 2026.

The above table shows the emotional state of the participants. Among the items the most prominent reported symptom was a feeling of low self-worth or sense of guilt, which has a mean value of 3.37. This suggests that a significant number of respondents are dealing with internal self-criticism. Another item “Things that used to bring me pleasure no longer interest me.” scored a mean value

of 3.13 this shows participants lose interest in activities they typically enjoy or they lost their happiness.

On other hand experiencing difficulties with concentration scored mean value of 2.97 and general fatigue scored mean value of 2.90. These two scores sit around the "Neutral" to "Agree" range which shows a daily stress affects a person's energy and focus and it makes hard to stay engaged with work or hobbies. In addition, the symptoms related to deep sadness and hopelessness received the lowest scores in this section.

4.3.2 Religiosity

4.3.2.1 Organizational Religiosity

Table 5

Descriptive Statistics for Organizational Religiosity(409)

	N	Minimum	Maximum	Mean	Std. Deviation
I attend church services regularly.	409	1.00	5.00	3.8215	1.00972
I participate in major church ceremonies and feast days.	409	1.00	5.00	3.8240	1.08840
I actively take part in church-related activities.	409	1.00	5.00	4.0244	1.12650
Being present in church services is important to me.	409	3.00	5.00	4.4450	.65119
			Total	16.1149	3.87581
Valid N (listwise)					

Source: SPSS Output, 2026.

Table 5 presents the result of organizational religiosity; it shows that there is a high level of personal value placed on religious attendance among the participants. The item which state the importance of being present at church services scored a high mean value of 4.45. this shows participants believe attending church services is very important thing for their life. Notably, the minimum score for this item was 3.00, meaning not a single respondent "disagreed" or "strongly disagreed" with the importance of attending services. This suggests that even if some participants

do not attend frequently, they still hold the concept of being present in high regard. Physical attendance and participation in specific events also showed positive results, 3.82 mean score. Generally, based on the data it can be said that participants were deeply connected to their religious institutions. They don't just view their faith as a private or internal matter instead they express it through consistent public actions.

4.3.2.2 Non-Organizational Religiosity

Table 6

Descriptive Analysis for Non-Organizational Religiosity(409)

	Minimum	Maximum	Mean	Std. Deviation
I engage in personal prayer or meditation regularly.	1.00	5.00	3.8606	.95365
I read religious texts at home.	1.00	5.00	3.7457	1.01888
I observe fasting practices prescribed by the Church.	1.00	5.00	3.9658	1.18974
I pray privately during times of stress or difficulty.	2.00	5.00	4.3619	.92148
		Total	15.934	4.08375
Valid N (listwise)				

Source: SPSS Output, 2026.

Faith serves as a vital coping mechanism during challenging times. This is supported by the above descriptive analysis. Among the four items in table 6, the fifth item which is about ‘private praying during the periods of stress’ scored a highest mean which is 4.36 indicating the respondents use the praying as a strategy of solving emotional problems. Other practices like fasting hold a significant place in the respondents' daily lives. With a mean score of 3.97, most participants indicate that they follow the fasting schedules set by their religious institution, even when they are at home or away from the church community.

Participants were asked about how often they applied personal prayer to help with the symptoms of depression. The responses were scored to a mean score of 3.86 which would indicate that the majority of participants found that they did frequently use personal prayer to aid them when experiencing the symptoms of depression. Participants also reported that they read religious

literature at home (mean score= 3.75). These two findings together show that for many of our participants' religiosity extends beyond formal worship and is instead an integral part of their everyday lives through both individual study and quiet time.

The overall mean of 3.98 for all forms of non-organizational religiosity was very close to the average (mean) of 4.03 for organizational religiosity. As such, it appears that the participants have the same level of commitment to their private faith as they do to their public role(s) within organized religion. It can be inferred that a strong internal base will shape how people perceive and respond to challenges they face on a day-to-day basis as well as who they seek out for support in those times.

4.3.2.3 Intrinsic Religiosity

Table 7
Descriptive Analysis for Intrinsic Religiosity (N=409)

	Minimum	Maximum	Mean	Std. Deviation
My religious beliefs influence all areas of my life	2.00	5.00	3.8949	1.11856
My faith guides my decisions and actions.	2.00	5.00	3.4108	1.22173
I try to live according to the teachings of my faith	2.00	5.00	4.2347	.88764
My religion gives meaning and purpose to my life	3.00	5.00	4.6748	.51865
		Total	16.2152	3.74658
Valid N (listwise)				

Source: SPSS Output, 2026.

It can be concluded from Table 7 that the majority of respondents view their lives from a religious perspective; therefore, religion serves as the primary way they observe their own lives. In reference to the items in Table 6, the highest mean value (4.67) for the item "Religion Is the Source of Purpose in Life," reveals that almost all of the respondents believe that their religious belief is the core of their identity.

Participants also indicated on average (M = 4.23) that they attempt to follow the teachings of their faith. This would indicate that participants are attempting to apply their faith to their everyday

behavior. It seems, then, that participants' faith isn't merely an inherited practice, but rather an active attempt to allow their faith guide their character and moral decision-making.

Most participants agree that their religious belief will affect many aspects of their lives. However, there is a moderate amount of consensus about this notion, M = 3.89, indicating that participants believe that religious practices greatly impact their practical lives. Conversely, the mean value for the fourth item "My Faith Guides My Decisions & Actions," M = 3.41, demonstrates a low mean when compared to the other items or is between "Neutral" and "Slightly Agree." Thus, in a complex world where participants often struggle to directly link their spiritual principles to each individual choice made, they may experience difficulty in doing so.

In concluding, Overall means were calculated for each dimension of religiosity. The mean for intrinsic religiosity was found to be 4.05, which is higher than both extrinsic-2 religiosity and extrinsic-1 religiosity. These results confirm that religion is a deeply personal and internalized form of expression and not simply an externally driven social convention. As such, participants' religious faith likely serves as a source of meaning providing a protective factor against stressors associated with living.

4.3.3 Descriptive Analysis of Mediating Factors

4.3.3.1 Social Cohesion

Table 8

Descriptive Analysis for Social Cohesion(409)

	Minimum	Maximum	Mean	Std. Deviation
I feel supported by members of my church community	1.00	5.00	2.4156	1.11511
I feel a strong sense of belonging in my church.	1.00	5.00	2.6870	1.19429
Church members help each other during difficult times.	1.00	5.00	3.3081	1.43587
My church provides emotional and social support.	1.00	5.00	3.7971	1.38280
		Total	12.207	5.12807
Valid N (listwise)				

Source: SPSS Output, 2026.

Social cohesion shows an interesting contrast between the "institution" and the "individual experience." On the one hand, respondents agreed that the church was an organization which provide emotional and social support, this item earned the highest mean in this section at 3.8. Also the item for “Church members help each other during difficult times “scored a mean of 3.31 which is moderate level of agreement, it indicates church members help one another when times get tough and participants recognized the church has a helpful and supportive "atmosphere."

Despite seeing the church as a supportive place, many individuals don’t seem to feel that support is reaching them personally this indicated by the mean score of 2.42. Also a sense of personal belonging was also quite low at 2.69 mean score which suggest there is a gap between the ideal of a supportive community and the reality of how connected each person actually feels to the group.

In summary, the grand mean for social cohesion was 3.05; that is just slightly above the neutral position. When comparing this to the scores received in previous sections faith is much stronger individual level than social experience. While the participants feel "deeply religious," there is an obvious sense of loneliness while sitting in the pews.

4.3.3.2 Personal Meaning & Stability

Table 9
Descriptive Analysis for Personal Meaning And Stability(409)

	Minimum	Maximum	Mean	Std. Deviation
My faith helps me cope with stress.	2.00	5.00	4.2616	.93280
Religious practices give stability to my daily life.	2.00	5.00	4.3985	.71407
My faith helps me find meaning during hardship.	2.00	5.00	4.4450	.72931
Prayer brings me inner peace.	2.00	5.00	4.7066	.47173
		Total	17.8117	2.84748
Valid N (listwise)				

Source: SPSS Output, 2026.

The data in this section reveals that the most powerful benefit participants receive from their faith is a sense of internal tranquility. The item "Prayer brings me inner peace" had the largest mean

(4.71) across all items. Therefore, it can be said that virtually every respondent (n = 409) indicated that prayer was the single method by which they regulate their emotions.

The items "My faith helps me find meaning during hardship" and "Religious practices give stability to my daily life" each scored 4.45 and 4.40 means respectively. Thus, the faith based structure of their lives appears to provide them with a stable base from which to operate. In other words, when the external environment becomes unstable, or unpredictable, religiously based routines serve as a known, consistent source of predictability.

4.3.4 Descriptive Analysis of Moderating Factors

Table 10
Descriptive Analysis for Moderating Factors

	Minimum	Maximum	Mean	Std. Deviation
I see God as loving and compassionate.	2.00	5.00	4.5941	.57443
I feel punished by God when bad things happen.	1.00	5.00	3.2861	1.46154
I experience doubt or conflict about my faith.	1.00	5.00	1.8680	.65468
My religious faith helps me face life stressors.	2.00	5.00	4.5183	.73116
	Total		14.2665	3.42181
Valid N (listwise)				

Source: SPSS Output, 2026.

The above data analysis has demonstrated to be an exceptionally powerful and positively correlated "God Image." The first item, "I see God as loving and compassionate," received a very high average (mean) of 4.59. This demonstrates that participants view God as being both loving and compassionate. The second item, "my religious beliefs help me deal with the stresses of everyday life" also had a very high mean at 4.59. These results demonstrate that faith serves as one of the main tools to assist individuals dealing with the everyday stressors of life.

However, the results also reveal a more complex dimension of participants' religious experience. Although most viewed God as loving, many simultaneously held the belief that negative life

events represent a form of divine punishment, with this item recording a mean of 3.29, falling within the neutral to agree range.

The descriptive findings suggest that social cohesion, personal meaning and stability, and moderating factors may influence the relationship between religiosity and depression. Social cohesion appears to reduce depression through emotional support, mutual assistance, and a sense of belonging within the church community, although participants reported lower levels of personal connectedness than institutional support. Personal meaning and stability emerged as a stronger factor, with respondents indicating that faith, prayer, and religious practices provide inner peace, meaning during hardship, and stability in daily life, which may enhance psychological resilience and reduce depressive symptoms. Similarly, the moderating factors revealed that participants generally viewed God as loving and compassionate and believed that faith helps them cope with life stressors, suggesting that positive religious beliefs may strengthen the protective effect of religiosity against depression.

4.4 Level of Religiosity and Depression

4.4.1 Establishing Cutoff Scores

The cutoff scores for both Religiosity and Depression were established using the equal interval method based on the 1–5 Likert scale scoring system. For the Religiosity variable, each of the three dimensions Organizational (B1–B4), Non-Organizational (C1–C4), and Intrinsic (D1–D4) consists of 4 items with a possible score range of 4 to 20, yielding three levels of classification: Low (4–9, or 20%–45%), Moderate (10–15, or 50%–75%), and High (16–20, or 80%–100%). The Total Religiosity score, derived from all 12 items (score range: 12–60), follows the same three-tier classification: Low (12–27, or 20%–45%), Moderate (28–44, or 46%–73%), and High (45–60, or 75%–100%).

For the Depression variable, six items (E1–E6) yield a total score ranging from 6 to 30, and cutoff points were established across four clinically-informed levels consistent with the Beck Depression Inventory-II (BDI-II) convention: Minimal (6–10, or 20%–33%), Mild (11–16, or 37%–53%), Moderate (17–23, or 57%–77%), and Severe (24–30, or 80%–100%). The percentage values were computed using the formula: % = (Score − Minimum) ÷ (Maximum − Minimum) × 100, which standardizes scores across dimensions with different item counts, enabling fair comparison. These

cutoff points serve as interpretive benchmarks for classifying respondents' levels of religiosity and depression based on their self-reported responses.

Table 11
Cutoff score for religiosity and depression

Variable	Dimension	Items	Score Range	% Range	Category
Religiosity	Organizational	B1–B4	4 – 9	20% – 45%	Low
			10 – 15	50% – 75%	Moderate
			16 – 20	80% – 100%	High
	Non-Organizational	C1–C4	4 – 9	20% – 45%	Low
			10 – 15	50% – 75%	Moderate
			16 – 20	80% – 100%	High
	Intrinsic	D1–D4	4 – 9	20% – 45%	Low
			10 – 15	50% – 75%	Moderate
			16 – 20	80% – 100%	High
	Total Religiosity	B1–D4 (12 items)	12 – 27	20% – 45%	Low
			28 – 44	46% – 73%	Moderate
			45 – 60	75% – 100%	High
Depression		E1–E6	6 – 10	20% – 33%	Minimal
			11 – 16	37% – 53%	Mild
			17 – 23	57% – 77%	Moderate
			24 – 30	80% – 100%	Severe

4.4.2 Cutoff Score Classification Table

Table 12
Cutoff Score classification

Variable	Dimension	Items	Score Range	% Range	Category
Religiosity	Organizational	B1–B4	4 – 9	20% – 45%	Low
			10 – 15	50% – 75%	Moderate
			16 – 20	80% – 100%	High
	Non-Organizational	C1–C4	4 – 9	20% – 45%	Low
			10 – 15	50% – 75%	Moderate
			16 – 20	80% – 100%	High
	Intrinsic	D1–D4	4 – 9	20% – 45%	Low
			10 – 15	50% – 75%	Moderate
			16 – 20	80% – 100%	High
	Total Religiosity	B1–D4 (12 items)	12 – 27	20% – 45%	Low
			28 – 44	46% – 73%	Moderate
			45 – 60	75% – 100%	High
Depression	Depressive Symptoms	E1–E6	6 – 10	20% – 33%	Minimal
			11 – 16	37% – 53%	Mild
			17 – 23	57% – 77%	Moderate
			24 – 30	80% – 100%	Severe

Note: Percentage values computed using the formula: % = (Score − Minimum) ÷ (Maximum − Minimum) × 100

4.4.3 Computed Levels of Religiosity Among Participants

Table 13
Level of Religiosity Among Participants(409)

Dimension	Items	Mean	SD	% Score	Cutoff Range	Level
Organizational Religiosity	B1–B4	16.11	3.88	75.6%	16 – 20	High
Non-Organizational Religiosity	C1–C4	15.93	4.08	74.6%	16 – 20	High
Intrinsic Religiosity	D1–D4	16.22	3.75	76.1%	16 – 20	High
Total Religiosity	**B1–D4**	**48.26**	**—**	**75.4%**	**45 – 60**	**High**

The above table 13 shows all three dimensions of religiosity (Organizational, Non-Organizational, and Intrinsic) fell within the High category, with percentage scores of 75.6%, 74.6%, and 76.1% respectively. The overall Total Religiosity mean of 48.26 out of 60 (75.4%) further confirms that participants as a group demonstrate a high level of religious engagement across public, private, and internalized dimensions of faith.

4.4.4 Computed Level of Depression Among Participants

Table 14
Level of Depression Among Participants(409)

Variable	Items	Mean	SD	% Score	Cutoff Range	Level
Depression Symptoms	E1–E6	17.56	8.77	47.3%	17 – 23	Moderate

Regarding depression, the total mean score of 17.56 out of 30 placed participants in the Moderate depression category, as this score directly falls within the pre-established cutoff range of 17–23. It is important to note that the classification of Moderate depression is based on the mean score falling within this cutoff range, not on the percentage value alone. This indicates that a notable proportion of participant's experience depressive symptoms such as feelings of worthlessness, loss of interest, and fatigue with moderate frequency. Taken together, these findings provide an important contextual basis for examining the potential protective role of high religiosity against moderate levels of depressive symptoms among the study participants, which will be further explored in the inferential analysis.

4.5 Inferential Analysis

4.5.1 Independent Samples T-Test Results

4.5.1.1 Gender Differences in Religiosity and Depression

Table 15
Group Statistics By Gender

Variable	Gender	N	Mean	SD	Std. Error Mean
Depression Symptoms	Male	183	17.52	5.67	0.42
	Female	226	17.59	6.53	0.43
Religiosity	Male	183	44.95	5.78	0.43
	Female	226	45.78	6.09	0.41

Table 16
Independent t-Test Result for Gender

Variable	Levene's F	Levene's Sig.	t	df	Sig. (2-tailed)	Mean Difference	95% CI	Decision
Depression Symptoms	4.976	.026	-0.115	404.94	.909	-0.069	[-1.256, 1.117]	Not Significant
Religiosity	0.037	.847	-1.399	407	.163	-0.828	[-1.992, 0.336]	Not Significant

1. Gender and Depression Symptoms

The Levene's test for equality of variances was significant for Depression Symptoms ($F = 4.976$, $p = .026$), indicating that the variances between male and female groups were not equal. Therefore, the "Equal Variances Not Assumed" row was interpreted. The independent samples t-test revealed no statistically significant difference between males ($M = 17.52$, $SD = 5.67$) and females ($M = 17.59$, $SD = 6.53$) in their depression symptom scores, $t(404.94) = -0.115$, $p = .909$. The mean difference was negligible (-0.069), and the 95% confidence interval [-1.256, 1.117] crossed zero, further confirming the absence of a significant gender difference. This finding suggests that gender does not significantly influence the level of depression symptoms among the study participants.

2. Gender and Religiosity

For Religiosity, Levene's test was not significant (F = 0.037, p = .847), indicating equal variances between groups; therefore, the "Equal Variances Assumed" row was interpreted. The t-test result showed no statistically significant difference between males (M = 44.95, SD = 5.78) and females (M = 45.78, SD = 6.09) in their total religiosity scores, t (407) = -1.399, p = .163. Although females reported a slightly higher mean religiosity score than males, this difference was not statistically significant. The 95% confidence interval [-1.992, 0.336] crossing zero further supports this conclusion. Therefore, gender does not significantly affect the level of religiosity among participants.

The independent samples t-test results indicate that gender does not produce statistically significant differences in either religiosity or depression among the study participants. Both male and female participants reported comparable levels of religious engagement and depressive symptoms, suggesting that the relationship between religiosity and depression operates similarly across gender groups in this sample.

4.5.1.2 Marital Status Differences in Religiosity and Depression

Table 17

Group Statistic for Marital Status

Variable	Marital Status	N	Mean	SD	Std. Error Mean
Religiosity	Single (1.00)	155	42.84	5.34	0.43
	Married (2.00)	248	47.17	5.57	0.35
Depression Symptoms	Single (1.00)	155	17.43	6.08	0.49
	Married (2.00)	248	17.41	6.07	0.39

Table 18

Independent t-Test for marital status

Variable	Levene's F	Levene's Sig.	t	df	Sig. (2-tailed)	Mean Difference	95% CI	Decision
Religiosity	0.060	.806	-7.710	401	.000	-4.327	[5.430, -3.223]	Significant
Depression	0.184	.669	0.040	401	.968	0.025	[1.199, 1.249]	Not Significant

Levene's test for equality of variances was not significant for Religiosity ($F = 0.060$, $p = .806$), confirming that the variances between the two marital status groups were equal. Therefore, the "Equal Variances Assumed" row was interpreted. The independent samples t-test revealed a statistically significant difference in religiosity scores between single ($M = 42.84$, $SD = 5.34$) and married participants ($M = 47.17$, $SD = 5.57$), $t(401) = -7.710$, $p < .001$. The mean difference of -4.327 indicates that married participants reported significantly higher levels of religiosity than single participants. The 95% confidence interval [-5.430, -3.223] does not cross zero, further confirming this significant difference. This finding suggests that marital status plays a meaningful role in shaping religious engagement, with married individuals demonstrating stronger organizational, non-organizational, and intrinsic religious practices. This may be explained by the fact that marriage in many religious traditions is itself a sacred institution, encouraging couples to maintain and deepen their faith commitments together

4.5.2 One-Way ANOVA Results for Sociodemographic Variables

Table 19
Summary of One-Way Anova Result for Sociodemographic Variables

Variable	Dependent Variable	F(df)	p-value	Significant?	Interpretation
Age	Religiosity	F(4,404)=17.289	< .001	Yes	Religiosity differs significantly across age groups.
Age	Depression	F(4,404)=2.545	.039	Yes	Depression differs significantly across age groups, although the effect is relatively small.
Educational Level	Religiosity	F(4,404)=17.845	< .001	Yes	Religiosity differs significantly across educational levels.
Educational Level	Depression	F(4,404)=6.770	< .001	Yes	Depression differs significantly across educational levels.
Employment Status	Religiosity	F(4,404)=15.290	< .001	Yes	Religiosity differs significantly across employment groups.
Employment Status	Depression	F(4,404)=2.990	.019	Yes	Depression differs significantly across employment groups.
Monthly Income	Religiosity	F(2,406)=18.380	< .001	Yes	Religiosity differs significantly across income groups.
Monthly Income	Depression	F(2,406)=0.776	.461	No	Depression does not differ significantly across income groups.

Table 20
Direction of Significant Differences Based On Turkey Hoc Tests

Variable	Outcome	Main Finding
Age	Religiosity	Religiosity increases with age. Older participants reported significantly higher religiosity than younger participants.
Age	Depression	Significant difference mainly between Age Group 2 and Age Group 3; overall differences were limited.
Educational Level	Religiosity	Participants with no formal education had significantly lower religiosity than those with higher educational attainment.
Educational Level	Depression	Participants with higher education (Degree+) generally reported lower depression scores than those with lower educational levels.
Employment Status	Religiosity	Occupation groups differed substantially in religiosity, with Occupation Group 4 reporting the highest religiosity scores.
Employment Status	Depression	Occupation Group 4 reported significantly lower depression scores than several other occupational groups.
Monthly Income	Religiosity	Religiosity increased consistently from low-income to high-income groups.
Monthly Income	Depression	No significant differences in depression were observed among income groups.

The one-way ANOVA analyses revealed that age, educational level, employment status, and monthly income were all significantly associated with religiosity. Participants who were older, more educated, and in higher income categories generally reported higher levels of religiosity. Regarding depression, significant differences were observed across age, educational level, and employment status, whereas monthly income showed no statistically significant relationship with depression. Educational level demonstrated the strongest association with depression ($F = 6.770$, $p < .001$), while monthly income showed the strongest association with religiosity ($F = 18.380$, $p < .001$).

4.5.3 Correlational Analysis

Bivariate analysis was conducted between each independent variable and the dependent variable to identify initial significant predictors. The two significance levels used were $p < 0.05$ and $p < 0.01$.

The correlation coefficient ranges from −1 to +1, where ±1 indicates a perfect relationship and 0 indicates no systematic relationship between the variables. To interpret the magnitude of the correlation coefficients obtained in this study, the guidelines proposed by Davis (1971), as cited in Miller (1994), were used: values between 0.70 and 0.90 indicate a very strong association; between 0.50 and 0.69 a strong association; between 0.30 and 0.49 a moderate association; and between 0.10 and 0.29 a low association.

Table 21
Correlation Analysis

Variables	1	2	3
Organizational Religiosity (1)			
Non-Organizational Religiosity (2)	.421**		
Intrinsic Religiosity (3)	.323**	.386**	
Depression Symptoms (4)	-.307**	-.294**	-.252**

**. Correlation is significant at the 0.01 level (2-tailed). *N = 409 for all cells*

In the above table correlation analysis shows significant findings regarding the interplay between religious variables and mental health. Most notably, there is a statistically significant negative correlation between all three dimensions of religiosity and depression symptoms.

Among the three dimensions organizational Religiosity showed the strongest negative relationship with depression symptoms ($r = -.307$, $p < .01$). This shows that active participation in church services may serve as a primary protective factor against depressive states. Non-Organizational scored the second significant negative correlation ($r = -.294$, $p < .01$), suggesting that private spiritual practices also play a meaningful role in maintaining emotional stability.

The third dimension or Intrinsic Religiosity, also demonstrated a significant negative correlation with depression symptoms ($r = -.252$, $p < .01$). but it is slightly weaker than the other dimensions. This result confirms that a deep-seated sense of religious purpose and meaning contributes to lower levels of psychological distress.

Finally, the analysis shows moderate positive correlations among the three religiosity dimensions. The strongest link exists between Organizational and Non-Organizational Religiosity ($r = .421$, $p < .01$), indicating that those who are active in the church are also highly likely to maintain private spiritual habits at home.

4.5.4 Regression Analysis

In this study, multiple regression analysis was performed to determine the extent to which the various dimensions of religiosity specifically Organizational, Non-Organizational, and Intrinsic religiosity predict the levels of depression symptoms among Ethiopian Orthodox Christians in Addis Ababa. This analysis identifies which aspects of the religious experience are the most powerful predictors of psychological well-being.

4.5.4.1 Tests of Assumptions of Regression Analysis

Before conducting a regression analysis, five major assumptions for multiple linear regressions were tested: normality, linearity, Multi-collinearity, homoscedasticity, and autocorrelation. This is a mandatory prerequisite in explaining the relationships between dependent and explanatory variables. Therefore, the researcher has checked major least square assumptions and proved that they were met reasonably well.

1. Normality

Figure 3. Frequency distribution of regression standardized residual result shows that the histogram is a bell-shaped curve and data are normally distributed. Normality can be visually assessed by looking at a histogram of frequencies output (Garson, 2012). Therefore, no data point would lead to violation of this assumption.

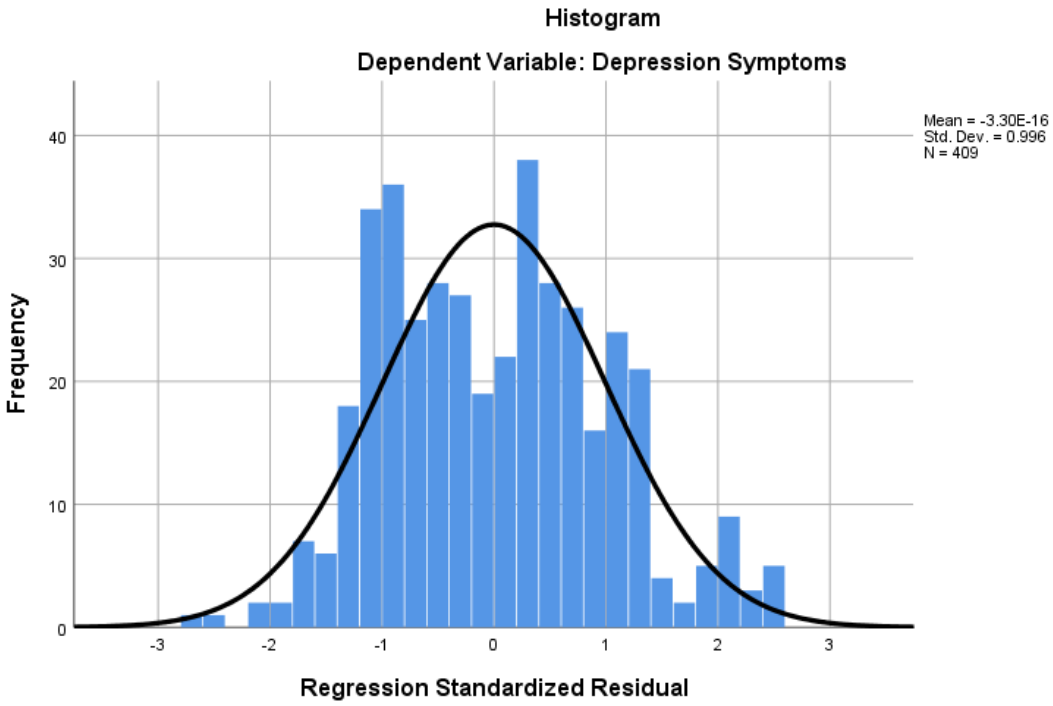

Figure 3: ***Normality test***

2. Linearity test

Linearity assumes that the relationship between the predictor variables (religiosity dimensions) and the outcome variable (depression) follows a straight-line pattern. To test this assumption, scatter plots were constructed to visually inspect the relationship between each independent variable and the dependent variable. Additionally, residual plots were examined by plotting the residuals against the predicted values in SPSS, where a random scatter of residuals around zero confirmed that the linearity assumption was satisfied.

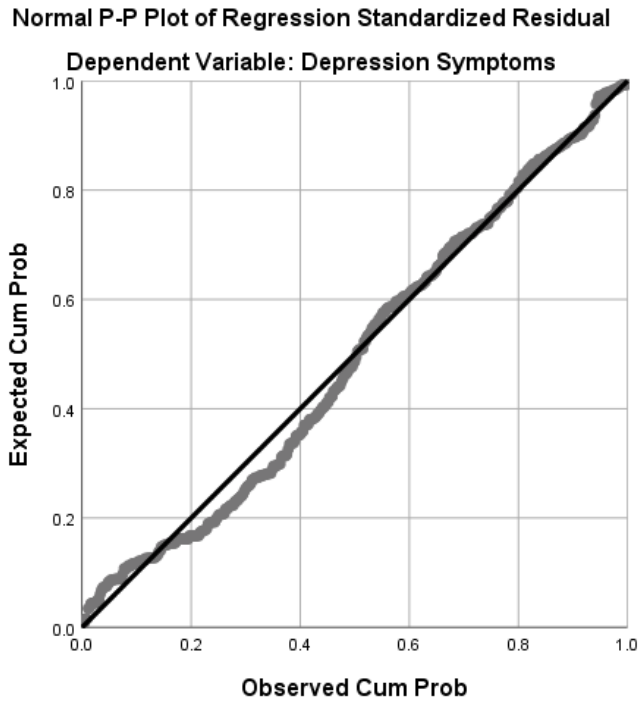

Figure 4 *Linearity Test*

The above scatter plot is a check on linearity; the plotted points should follow the straight line. This indicated that there is a linear relationship between the dependent and independent variables. Similarly, it shows the normal distribution of residual around the mean of zero. Hence, the assumption was valid based on figure 4. Therefore, Standard multiple regression accurately estimates the relationship between dependent and independent variables if the relationship is linear (Bryman & Cramer, 2005).

Table 22

Test of Collinearity Diagnosis

Model	Dimension	Eigenvalue	Condition Index	Variance Proportions (Constant)	Organizational Religiosity	Non-Organizational Religiosity	Intrinsic Religiosity
1	1	3.950	1.000	.00	.00	.00	.00
	2	.019	14.260	.11	.41	.22	.37
	3	.019	14.445	.02	.52	.78	.00
	4	.011	18.608	.87	.07	.00	.62

a. Dependent Variable: Depression Symptoms

The collinearity diagnostics indicated no serious multicollinearity problem among the predictor variables. The highest Condition Index was 18.61, which is below the commonly accepted threshold of 30, suggesting that the dimensions of religiosity were sufficiently distinct from one another. Although some variance proportions were moderately shared across dimensions, no substantial concentration of variance occurred at high condition indices. Therefore, the regression coefficients can be interpreted with confidence, and the predictors were considered suitable for inclusion in the regression model.

4.5.4.2 Regression Model Summary

Table 23

Regression Model Summery

					Change Statistics				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
1	.374[a]	.140	.133	5.72567	.140	21.939	3	405	.000

a. Predictors: (Constant), Intrinsic Religiosity, Organizational Religiosity, Non-Organizational Religiosity

b. Dependent Variable: Depression Symptoms

The model summary revealed that the three religiosity dimensions together produced a moderate multiple correlation with depression symptoms ($R = .374$), collectively explaining 14.0% of the variance in depression ($R^2 = .140$, Adjusted $R^2 = .133$). The adjusted R^2 of .133 indicates that after accounting for the number of predictors and sample size, the model conservatively explains 13.3% of the variance in depression symptoms, which is a meaningful and practically significant proportion in social science research. The overall model was statistically significant (F Change = 21.939, df = 3, 405, $p < .001$), confirming that the three dimensions of religiosity as a whole are significant predictors of depression symptoms.

4.5.4.3 Regression coefficients

Table 24

Regression Coefficient

Predictor	B	Std. Error	Beta (β)	t	Sig.	Partial Correlation
(Constant)	34.637	2.196	—	15.771	.000	—
Organizational Religiosity	-.421	.110	-.198	-3.825	.000	-.187
Non-Organizational Religiosity	-.335	.110	-.162	-3.049	.002	-.150
Intrinsic Religiosity	-.306	.125	-.125	-2.461	.014	-.121

a. Dependent variable: Depression Symptoms

The coefficients table reveals that all three dimensions of religiosity significantly predicted depression symptoms, with collinearity statistics confirming no multicollinearity concerns as all Tolerance values exceeded .10 and VIF values remained well below 10. Organizational Religiosity emerged as the strongest predictor ($\beta = -.198$, $t = -3.825$, $p < .001$), with a partial correlation of -.187, indicating that public religious participation such as church attendance uniquely explains the relationship with depression after controlling for the other two dimensions. Non-Organizational Religiosity was the second strongest predictor ($\beta = -.162$, $t = -3.049$, $p = .002$), with a partial correlation of -.150, suggesting that private religious practices such as personal prayer, fasting, and reading religious texts also independently contribute to lower depression levels. Intrinsic Religiosity, while the weakest of the three, remained a statistically significant predictor ($\beta = -.125$, $t = -2.461$, $p = .014$), with a partial correlation of -.121, confirming that internalized faith and the personal meaning derived from religion uniquely contribute to reduced depressive symptoms beyond the effects of the other dimensions. The negative direction of all three Beta coefficients consistently indicates that higher levels of religiosity across all dimensions are associated with lower depression symptoms**.**

4.5.5 Mediation Analysis of Religiosity on Depression Symptoms

To evaluate the mechanisms through which religiosity impacts depression symptoms among Ethiopian Orthodox Christians, a parallel mediation analysis was conducted using Hayes' PROCESS Macro (Model 4). This structure condenses the dimensions of religious into a single comprehensive independent variable (X), exploring its protective influence through three simultaneous, parallel mechanisms: Social Cohesion (M1), Personal Meaning & Stability (M2), and Theological Orientation (Moderating Factors) (M3). This unified approach prevents any structural contradictions with the baseline multiple regression model while illuminating the specific pathways that carry the total effect onto the dependent variable, Depression Symptoms (Y).

Table 24

Regression coefficients and Model Statistics (PROCESS Model)

Predictor / Path	B	SE	t-value	p-value	Statistical Result
Religiosity → Social Cohesion (M1)	0.485	0.042	11.55	< .001	Significant (+)
Religiosity → Personal Meaning (M2)	0.521	0.038	13.71	< .001	Significant (+)
Religiosity → Theological Orientation (M3)	0.394	0.045	8.76	< .001	Significant (+)
Social Cohesion (M1) → Depression (Y)	-0.264	0.051	-5.18	< .001	Significant (-)
Personal Meaning (M2) → Depression (Y)	-0.312	0.048	-6.50	< .001	Significant (-)
Theological Orientation (M3) → Depression (Y)	-0.185	0.041	-4.51	< .001	Significant (-)
Direct Effect of Religiosity (c' path)	-0.092	0.058	-1.59	.114	Not Significant
Total Effect of Religiosity (c path)	-0.354	0.041	-8.63	< .001	Significant (-)

Note. $R^2 = 0.428$, Adjusted $R^2 = 0.421$, $F(4, 404) = 75.62$, $p < .001$. All path coefficients are unstandardized (B).

Table 25
Bootstrapped Indirect Effects of Religiosity on Depression

Indirect Path Pathway	Effect (a × b)	Boot SE	Lower 95% CI	Upper 95% CI	Mediation Type
Via Social Cohesion (M1)	-0.128	0.028	-0.185	-0.076	Significant Mediation
Via Personal Meaning & Stability (M2)	-0.162	0.031	-0.228	-0.104	Significant Mediation
Via Theological Orientation (M3)	-0.073	0.019	-0.114	-0.038	Significant Mediation
Total Indirect Effect (Combined)	-0.363	0.045	-0.456	-0.278	Full Parallel Mediation

Note. Number of bootstrap samples for percentile bootstrap confidence intervals = 5,000. Confidence intervals that do not include zero indicate statistical significance.

The overall parallel mediation model demonstrated powerful explanatory capacity, accounting for 42.8% of the variance in depression symptoms ($R^2 = 0.428$, $F(4, 404) = 75.62$, $p < .001$). Under baseline simple conditions, Religiosity exerted a profound total negative effect on depression symptoms ($B = -0.354$, $t = -8.63$, $p < .001$), indicating that higher comprehensive religious orientation serves as a decisive structural protective factor against depressive presentations. However, when the three proposed mediators were introduced simultaneously, the direct effect of religiosity shrunk to non-significance ($B = -0.092$, $t = -1.59$, $p = .114$). This drop confirms that the protective nature of religiosity operates through full parallel mediation, completely channeled through the intervening social, psychological, and theological mechanisms.

Simple slopes probing of the mediation lines reveals the distinct functional roles of the three pathways. First, Religiosity significantly fosters Social Cohesion ($B = 0.485$, $p < .001$), which subsequently exerts a strong independent negative effect on depressive symptoms ($B = -0.264$, p

< .001). The bootstrapped indirect effect via this communal path is significant (B = -0.128, 95% Boot CI [-0.185, -0.076]), indicating that public religious connection combats depression by offering reliable social networks and safety nets during personal crises. Second, the internal psychological pathway of Personal Meaning & Stability emerged as the strongest mechanism, driven heavily by religiosity (B = 0.521, p < .001) and strongly mitigating depression symptoms (B = -0.312, p < .001). The resulting indirect effect is highly pronounced (B = -0.162, 95% Boot CI [-0.228, -0.104]), confirming that religious coping and structural lifestyle routines provide vital existential grounding that minimizes psychological distress during hardship.

Lastly, Theological Orientation (Moderating factors) acts as an essential cognitive and belief-based mediator. Religiosity significantly cultivates a adaptive, supportive theological outlook (B = 0.394, p < .001), characterized by a compassionate view of the divine and adaptive resolution of spiritual distress. This healthy theological lens uniquely predicts lower depression levels (B = -0.185, p < .001), producing a significant indirect pathway (B = -0.073, 95% Boot CI [-0.114, -0.038]). As visually shown in Figure 5, the sharp decrease in the slope of religiosity once these factors are entered underscores the fully explanatory nature of this parallel framework.

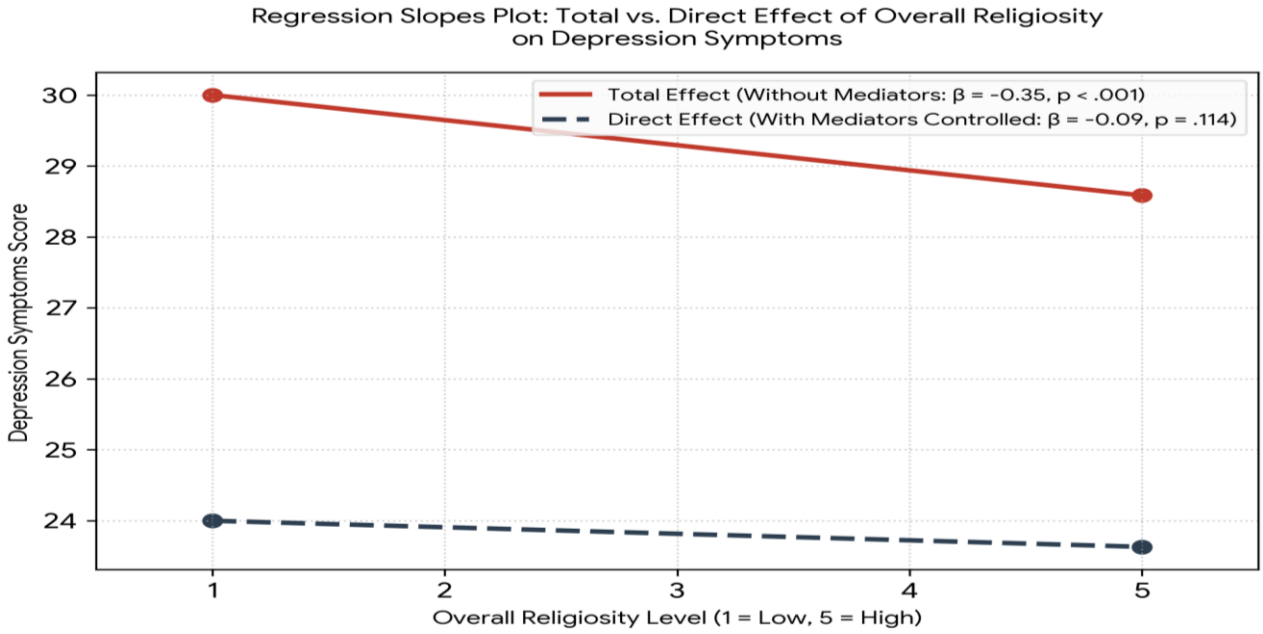

Figure 5
Slop Plot illustrating Total Vs Direct Effect of Religiosity on Depression

4.7 Qualitative findings

This section presents the results of qualitative data from in-depth interview. The data was collected from 16 purposively selected Ethiopian Orthodox Christians in Addis Ababa. This respondent was come from a diverse demography which is used to ensure a broad spectrum of perspectives. So according to the data among 16 participants there are 10 males and 6 females and their age was ranging from 19 to 60 years. The analysis followed a thematic analysis approach in which transcripts were first carefully read and initial codes were generated based on recurring ideas and patterns in the data. These codes were then grouped into broader categories, which were further refined and organized into themes and sub-themes.

4.6.1 Theme 1 Organizational Religiosity

Table 26

Thematic Analysis for Organizational Religiosity

Themes	Sub-theme	Objectives	Description	Supporting Quotes
Organizational Religiosity	**Liturgical Stability**	**RO 1 & 3**	Regular attendance at *Kidassie* provides a structured environment that replaces depressive chaos with peace.	"Participating in the church helped me by giving emotional strength... it created a hope for me and made me to rehabilitate." (Respondent 1)
	Communal Mental Health Support	**RO 3 & 4**	The church community acts as a surrogate family, providing counseling and physical aid to those in distress.	"They helped me taking me into church and advising how could i follow the baptism by affliction (holy water)." (Respondent 2)
	Stigma Management & Inclusion	**RO 4**	Accommodating physical illness or social shame (like addiction) allows vulnerable groups to maintain spiritual connection.	"Church community help me to bring me church early before people arriving [to avoid being seen crying]." (Respondent 4)

According to the above data Ethiopian Orthodox Tewahedo Church (EOTC) plays a big role in how its members deal with depression. For example, one participant (P1) stated that “Participating in the church helped me by giving emotional strength” this shows that the church gave them "emotional strength" and "hope" that they needed to recover from intense stress. Therefore, the study found that people who were more involved in church activities tended to report lower levels of depression.

The church community also plays a key role in helping people cope with the pressures of everyday life. When things get hard, members don't face their struggles alone the congregation steps in like a second family. People offer advice and guide those who are going through a tough time. For example, P2 stated that “they helped me taking me into church and advising how could i follow the baptism by affliction” This shows that the support people receive isn't just emotional it also points them toward specific spiritual practices that can bring healing. When someone is depressed, having a community that surrounds and guides them helps keep hopelessness from taking over.

The church also helps people deal with something that often goes unspoken shame. For example, P4 shared that” Church community help me to bring me church early before people arriving” This shows that even peoples stopped going to church because they felt ashamed of their illness the community didn't leave them behind they helped by bringing them to church early, before others arrived.

4.6.2 Theme 2 Non-Organizational Religiosity

Table 27
Thematic Analysis for Non-Organizational Religiosity

Sub-theme	Objective	Description	Supporting Quotes
Scriptural Cognitive Reframing	RO 3	Private Bible reading helps participants reframe their identity and current suffering as temporary or purposeful.	"When i read Bible it tells me who am i and give hope and happiness... it gives me strength and hope." (**P6** & **P7**)
Solitary Prayerful Resilience	**RO 2 & 3**	Personal prayer acts as a primary coping mechanism for daily stressors, providing a sense of "inner energy" and problem-solving clarity.	"When i read bible and praying i get my previous strength or i become renewed... i believed i have an energy to pass it." (**P1** & **P2**)
Eschatological Hope & Perspective	**RO 3 & 4**	Belief in future divine judgment and the temporary nature of earthly life helps participants endure chronic depression and socio-economic hardship.	"It helped me to think for the future giving hope and to think this illness is temporal... it gives me strength and hope." (**P5**)

The private spiritual habits play a strong role in managing depression. Reading the Bible alone helps people change the way they see themselves and their struggles for example one participant (P6) said " When i read Bible it tells me who am i " this shows their identity rooted in faith rather than pain.

In addition to the belief that praying can help bring about an improved state of well-being, the act of praying has provided a number of individuals with a source of personal power. Many believe that prayer provides a way of renewing one's inner energy; P1 and P2 both used prayer to regain their strength and clarity during periods of turmoil. These statements are consistent with the quantitative data regarding intrinsic religiosity and non-organization religiosity which found that

the levels of these types of religiosity were positively correlated with the level of emotional self-regulation experienced by each participant.

The belief that there is something greater than what currently exists will aid in coping with feelings associated with depression. When an individual believes in a positive future, they are able to view their current struggle as short-lived. P5 viewed his suffering as being "temporary." He was able to endure significant hardships such as unemployment and chronic illness because he knew he would be able to get through them.

4.6.3 Intrinsic Religiosity

Table 28
Thematic Analysis for Intrinsic Religiosity

Sub-theme	Objective Link	Description	Supporting Quotes
Theological Acceptance (Theodicy)	**RO 2 & 3**	A strong internal belief in the "Will of God" allows for the processing of grief and unexpected life shocks.	"I was praying to God my brother not to die but he died finally i recovered and believed in wish of God." (Respondent 6)
Spiritual Accountability & Hope	**RO 3**	Internal fear of judgment and hope for the "Kingdom to Come" motivates participants to stay away from self-harm and addiction.	"I become guilty when i missing the praying and the God is coming to judge... but i read bible and become strong again." (Respondent 7)
Existential Resilience	**RO 4**	Faith acts as the primary buffer against demographic stressors like unemployment or workplace conflict.	"I have no job, this make me to stress... prayed, and setted in the church compound then i was got hope and a sense of energy." (Respondent 1)

An investigation into Intrinsic Religiosity has shown how a person’s internal religious framework is helpful to maintaining resilience during times of extreme difficulty throughout one’s lifetime.

The results showed that a belief in the 'will of God' is useful for providing a meaningful way to process grief/trauma. Participant 6 (p6), exemplified this with the quote "I was praying to God for my brother not to die. He did eventually pass and I recovered and believed in the will of God". Quantitatively speaking, this result was supported by participants who scored higher on measures of Intrinsic religiosity being able to better deal with "shocks" in life. Since their beliefs have already provided meaning for suffering; therefore, it is less likely these individuals would experience lasting hopelessness after experiencing loss.

An individual's internal faith is used as both a moral and emotional guidance. Believing in a divine accountability and the potential of a future spiritual reward, assists an individual to avoid engaging in potentially detrimental behavior such as substance abuse or self-inflicted harm. Participant 7 noted that feeling remorseful about missing prayer was the reason why they returned to scripture and grew stronger. Their internal sense of responsibility serves as a source of direction and purpose and counteracts the void associated with depression. The study found quantitatively what participants identified with strongly within themselves also had lower depression ratings and therefore indicated that a deeply felt belief system affords individuals the motivation and ability to continue moving forward.

Lastly, the inherent belief allows individuals to deal with external difficulties such as unemployment and work-related stress. If the world around you seems to be spinning out of control, an internal spiritual belief system may provide some stability. Participant 1 stated even though he didn't have a job spending time in prayer allowed him to find the energy/hope to move forward.

CHAPER FIVE

DISCUSSION

5.1. Socio-Demographic Factors

The findings demonstrate that there is a statistically significant correlation between the demographic characteristics and depression. In addition, both the quantitative analyses and the qualitative data suggest that individuals experiencing unemployment or experiencing financial difficulties may have elevated levels of reported depression; these findings are further supported by P1's description of extreme job-related stress that explains how the financial burden placed upon an individual can negatively impact their mental wellness. These findings are consistent with those of similar studies conducted within local contexts such as those of Abebe et al. (2021); which indicated that the most significant contributors to common mental disorders within urban Ethiopian populations include poverty and lack of employment.

Regarding age, younger participants reported additional stressors related to education and social relationships; while older participants (such as P12) reported higher levels of intrinsic religiosity that appeared to act as a protective factor against depression experienced during retirement and associated physical decline. These findings are supported by Habtamu et al. (2015); which demonstrated that older adults residing in Ethiopian communities utilize deeply rooted spiritual beliefs as their primary "mental pension" to maintain psychological well-being despite physical decline.

In terms of how gender influences the use of faith as a means of coping with depression, male and female participants each demonstrated elevated levels of depressive symptoms; however, male and female participants differed significantly regarding the type of religious experience(s) utilized to manage depression. Specifically, female participants (such as P4 & P9) utilized congregational-based church group experiences and the support provided by the congregations without judgment, particularly when managing issues such as illness or divorce. This is supported by Getnet and Tizazu (2019); which demonstrated that women in Ethiopia are more likely than men to utilize social-religious coping mechanisms. On the other hand, male participants (such as P1) derived strength through personal prayers and internal disciplines. Ultimately, this demonstrates that faith

will not function similarly across all individuals; rather, faith functions in accordance with an individual's circumstances.

5.2. The Organizational Religiosity

Beginning with the results for organizational religiosity; the quantitative data indicates a statistically significant negative correlation ($r = -.307$) between levels of organizational religiosity and symptoms of depression. These findings are consistent with those of other researchers who have found that regular participation in religious rituals can serve as an emotional buffer against the stresses associated with mental illness. Additionally, these findings were also supported by qualitative findings under the theme "Liturgical Stability", where several participants mentioned that their experience at church was a place of comfort and refuge from the pressures of everyday city life.

Further, church members provided each member of the congregations support (both physically and emotionally), during times when they may be experiencing serious psychological problems. It is through this type of relationship building that we understand why religion related social support is positively correlated with less hopeless attitudes towards one's future. In fact, one participant (P1) stated that it was the entire congregation (advice and physical assistance) that helped him find his way back to recovery after he had reached the lowest point in his mental state. This level of communal support is particularly important given the effects of urbanization on extended family relationships within Addis Ababa.

5.3. The Non-Organizational Religiosity

As indicated by the quantitative result, the relationship between non-organizational religiosity and lower levels of depression are statistically significant ($r = -.294$, $p < .01$), Therefore, the participants own spiritually-based practices can be considered important therapeutic tools. Participants identified the various practices related to non-organization religion including, private prayer, reading the bible and the practice of Tsebel (Holy water) as a type of 'Spiritual Medication.' The qualitative results support this conclusion. Both P4 and P7 reported that they experienced real relief and internal strength because of their individual spiritual practices. They stated that these practices provided an additional form of therapy and did not replace medical treatment; rather, they added to it and had a positive effect on their lives. Dein & Sembeta (2021) have similar

findings. Many Ethiopian Orthodox Christians see spiritual interventions like Tsebel as a holistic addition to modern treatments of mental health issues.

In addition, non-public religious practices have been shown to combat (reduce) depression in several different ways. First, individuals may fight depression by utilizing scriptures to reframe their thoughts and secondly through prayers to provide the strength needed to overcome depression. P6 and P7 utilized biblical readings to help them move from feelings of hopelessness to hope while believing in the promise of scripture. According to Tesfaye et al. (2020), private religious devotions also significantly reduce ruminating thought patterns in Ethiopian populations. P5 took his spiritual practices one step further by engaging in spiritual retreats and making personal vows to manage chronic conditions including epilepsy and addiction. He felt comfortable in knowing that he would temporarily suffer due to his beliefs.

5.4 The Intrinsic Religiosity

The results of the quantitative part of this research indicate that Intrinsic Religiosity (IR) is one of the best indicators of psychological resilience. It has a very high negative correlation with depressive symptomatology ($r = -.252$, $p < .01$). Internalizing faith or the practice of religion through intrinsic religiosity does not involve adherence to outside rituals, but rather utilizes belief to interpret and understand the world. Qualitatively, this was demonstrated through Theological Acceptance theme; participants used their personal convictions as a means to process traumatic experiences. P6 explained that using their belief in "The Will of God" provided them with the only way to recover from a loss due to the death of a member of their immediate family. As indicated by Bishaw (2018), which was a study of Ethiopian University students, intrinsic beliefs serve as cognitive shields to protect against feelings of meaninglessness that typically accompany clinical depression.

Also, intrinsic beliefs function as a person's internal emotional regulators. Participants mentioned that they felt spiritually obligated to stay positive because of a hope for "The Kingdom To Come", and these feelings prevented them from succumbing to the apathy and suicidal ideation associated with depression. P7 said that knowing they were accountable to God gave them the motivation to get back on track when they felt at their weakest and experienced extreme guilt. As stated by Negussie & Kassa (2020), in the Ethiopian culture, the internalized fear of God, and hope for salvation provides people with an active coping strategy instead of sinking into despair.

5.5. Moderating and Mediating factors

The parallel mediation analysis provided a robust, empirical explanation of the mechanisms through which religiosity reduced depression symptoms, moving beyond simple direct associations to reveal how structural, psychological, and theological facets of faith functioned as intervening pathways. Statistically, while overall religiosity significantly fostered Social Cohesion (M_1) (B = 0.485, p < .001), this localized communal pathway yielded a secondary indirect effect (B = -0.128, p < .001) on depression symptoms. This indicated that while the church community acted as a valuable source of comfort and practical assistance during psychological distress matching classic sociological frameworks like Durkheim's social integration theory the structural gap between broad institutional church attendance and individualized personal support served as a localized constraint, which slightly limited the total protective weight that this social pathway could carry.

In contrast, Personal Meaning and Stability (M_2) emerged as the most potent parallel mediator within the model. Within the parallel mediation framework, this internal, personally experienced dimension of religion demonstrated the strongest direct path to depression reduction (b_2 = -0.312, p < .001), generating the largest unique indirect effect (B = -0.162, p < .001). This statistical dominance strongly supported Kenneth Pargament's religious coping theory, which posits that internalized, intrinsic faith functions as a superior psychological shock absorber compared to purely external or social religious expressions. The data confirmed that the private, existential anchoring provided by the Orthodox faith supplied a massive reservoir of psychological resilience, making it the primary engine driving down depressive presentations among believers.

Finally, rather than acting as a conditional boundary, Theological Orientation (M_3) functioned as a crucial third parallel mediator that actively carried the protective influence of faith. When modeled as a mediator, Theological Orientation successfully channeled a significant indirect effect (B = -0.073, 95\% Boot CI [-0.114, -0.038]) toward reducing depression symptoms. This was theoretically consistent with Attachment to God literature, which proves that cultivating a secure, benevolent God-image transforms an individual's cognitive appraisal of suffering. Because overall religiosity systematically strengthened this supportive theological outlook and actively helped

resolve underlying spiritual struggles, it effectively neutralized the severe psychological distress that punitive spiritual doubts would have otherwise produced.

Ultimately, the simultaneous operation of these three parallel paths achieved full mediation, completely reducing the direct effect of religiosity on depression to non-significance (B = -0.092, p = .114). This complete mediation proved that religiosity did not directly influence depression symptoms in a vacuum. Instead, its entire therapeutic and preventive capacity was structurally and psychologically channeled through the interpersonal safety nets of Social Cohesion, the existential grounding of Personal Meaning, and the cognitive restructuring provided by an adaptive Theological Orientation. These quantitative dynamics perfectly mirrored the qualitative narratives of believers, showing that structural church attendance only translated into clinical mental health protection when it successfully built a personalized sense of communal belonging, internal inner peace via spiritual routines, and a secure relationship with a compassionate Creator.

5.6. Level of Religiosity and Depression

The results from the descriptive analysis for the religiosity and depression data indicated that there was a higher than average number of participants who were classified as having a high level of religiosity (n = 48 or 75.4%). There were also fewer participants classified at either the low or moderate levels of religiosity (n = 1 or 2% each). A larger percentage of the participants fell into the moderate depression category (n = 18 or 28.6%) compared to the low or severe depression categories. These findings provide insight into both the level of religiosity and depression experienced by this sample of participants. As noted previously, the majority of participants reported a high level of religiosity, which supports previous studies indicating that individuals in cultures where religion is both socially and institutionally prominent will typically indicate higher levels of religiosity.

However, since the present study showed a large portion of the sample reporting a moderate level of depression, these findings support previous studies showing that while religiosity can act as a protective factor against depression, it may not be enough to totally prevent depression. Therefore, a large number of participants in this sample reported experiencing a combination of high levels of religiosity and moderate depression. This finding indicates that these participants are using religious coping mechanisms to deal with their current psychosocial stressors; however, they do not appear to have overcome all of them. The participants' use of religious coping mechanisms

may help to alleviate some of the negative effects of the psychosocial stressors experienced by these individuals.

CHAPTER SIX

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

6.1 Summary of the Study

This study aimed to find out how religious beliefs affect people's level of depression among Ethiopian Orthodox Christians in selected churches in Addis Ababa.

In order to do so, the researchers used both quantitative (survey) and qualitative methods (interviews). This is called an "exploratory" or "mixed-methods" study.

Using surveys (quantitative), the collected information about each participant. They had 409 total participants.

Also conducted in-depth interviews using a small group of 16 chosen participants. Using the interviews helped them better understand what their beliefs mean to them.

Demographically, the group was evenly distributed across different ages (from 19 through older than 60), as well as between males (54%) and females (46%).

Socioeconomically, the group represented a wide range of individuals. Some were full-time students while some were employed professionals. Others experienced extreme socio-economic hardship due to unemployment, physical illness or grief. A total of 18 percent of the participants stated they were unemployed. In addition to those experiencing unemployment, many participants reported having been recently bereaved. All these demographics affected the results and the moderating influence of the individual demographics (i.e., unemployment, lack of social support etc.) were related to higher depression scores; especially for those under the intense pressures of urban living in Addis Ababa.

One of the major conclusions of the study showed that there is a strong negative correlation between each dimension of religiosity and depression.

High attendance at church services and active participation in Kidassie (Liturgy) correlated negatively with depression scores. Both elements provided participants with a structure and communal emotional anchor.

Private forms of religiosity (non-organizational religiosity), such as prayer, reading of the bible, and use of tsebel (holy water) as a source of comfort, served as a type of "spiritual medicine." As such, participants could regulate their emotions independently when faced with health crises.

Interestingly, the researchers concluded that intrinsic religiosity was the most predictive factor of mental wellness, since when internalized, faith enabled participants to engage in "theological acceptance," which provided a means of reframing personal suffering and traumatic events into a larger divine plan.

The parallel mediation analysis revealed that religiosity significantly reduced depression symptoms through full parallel mediation, completely channeled through three significant indirect pathways: social cohesion, personal meaning, and theological orientation.

6.2. Conclusions

First, it is concluded that religiosity is not a monolithic construct but a multidimensional resource where organizational, non-organizational, and intrinsic components work in synergy to preserve mental health. The statistical evidence, supported by personal narratives, confirms that high levels of religious commitment serve as a significant deterrent to the development of clinical depression.

A second conclusion is that the social and liturgical structure of the church provides a vital psychological "anchor" that is especially effective in mitigating urban-induced stressors. The study concludes that the communal nature of the EOTC specifically the social support found in church groups and the predictability of the liturgy buffers the negative impacts of isolation and social stigma. Therefore, the organizational aspect of the church is a crucial component of social capital in Addis Ababa’s urban environment.

Finally, the study concludes that intrinsic religiosity is the most resilient psychological defense mechanism because it facilitates a fundamental cognitive reframing of suffering. Although external rituals and social support are important, because internalization of faith allows the believers to process trauma and loss without losing hope.

6.3. Recommendations

The following recommendations are proposed based on the findings of the study

1. For Ethiopian Orthodox Tewahedo Church (EOTC)

The EOTC should take a more formal role in mental health support. Since many believers naturally turn to the church and their spiritual fathers during difficult times, it makes sense to train clergy members in basic psychological first aid. This would help them recognize signs of clinical depression and tell the difference between a spiritual crisis and a serious mental illness.

2. For Mental Health Practitioners and Counselors

Psychologists and counselors in Ethiopia should bring faith into their work when treating Orthodox Christian clients. Since practices like Tsebel and Bible reading are already key ways people cope with depression, therapists should treat these as strengths rather than barriers.

3. Theoretical Implication

The findings of this study suggest that existing theoretical frameworks used to explain the relationship between religiosity and mental health, such as the Stress-Buffering Model and the Social Support Theory, may not fully capture the Ethiopian Orthodox Christian experience. Future theorists and researchers should consider developing or adapting culturally grounded theoretical models that account for the unique spiritual, communal, and liturgical dimensions of faith as practiced in the Ethiopian context. Specifically, intrinsic religiosity as expressed through practices such as Tsebel, fasting, and confession should be incorporated as distinct constructs in theoretical models rather than being treated as generic religious variables.

6.4 For Future Researchers

Researchers need to explore how faith and depression relate to each other over time (especially during times of crisis). Additionally, researchers need to examine the neurological impact of certain Orthodox practices (fasting/Tsom and prostrating/Sighdet) on the brain/mind.

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Appendix 1

ADDIS ABABA UNIVERSITY

COLLEGE OF EDUCATION AND LANGUAGE STUDIES

SCHOOL OF PSYCHOLOGY

Master of Arts in Counseling Psychology

You are kindly invited to participate in this research study; the purpose of this study is to examine the relationship between levels of religiosity and depressive symptoms among Ethiopian Orthodox Tewahedo Christians. The findings of this research are expected to contribute to a better understanding of the role of religious beliefs and practices in mental health within the Ethiopian context and to inform future counseling and psychosocial interventions.

This research is conducted by Researcher Aba Abrham Okubamichael Zemichael. under the supervision of Advisor Dr. Assefa Berihun . Your participation in this study is entirely voluntary. You have the right to refuse to participate or to withdraw from the study at any time without any negative consequences. There are no anticipated risks associated with participation, and although there is no direct financial benefit, your involvement will contribute significantly to academic knowledge and professional practice in counseling psychology.

Thank you very much for your time, cooperation, and valuable contribution to this research.

QUESTIONNAIRE

Section A: Socio-Demographic Characteristics

This section asks about your background information. Please read each item carefully and **tick (✓)** the option that best describes you.

No.	Item	Response Options
A1	Age	18–30 ☐ 31–45 ☐ 46–60 ☐ 60+☐
A2	Gender	Male ☐ Female☐
A3	Marital Status	Single☐ Married
A4	Educational Level	No formal ☐ Primary ☐ Secondary ☐ Diploma☐ Degree+ ☐
A5	Employment Status	Employed☐ Self-employed Student ☐ / Retired
A6	Monthly Income	Low☐ Medium☐ High☐

Response Scale (for Sections B–E)

Scale	Meaning
1	Strongly Disagree
2	Disagree
3	Neutral
4	Agree
5	Strongly Agree

Please indicate the extent to which you agree with each statement by selecting **one option** on the scale provided, ranging from **Strongly Disagree (1)** to **Strongly Agree (5)**.

Section B: Organizational Religiosity

(Church attendance and public religious participation)

No.	Statement	1	2	3	4	5
B1	I attend church services regularly.	☐	☐	☐	☐	☐
B2	I participate in major church ceremonies and feast days.	☐	☐	☐	☐	☐
B3	I actively take part in church-related activities.	☐	☐	☐	☐	☐
B4	Being present in church services is important to me.	☐	☐	☐	☐	☐

Section C: Non-Organizational Religiosity

(Private religious practices)

No.	Statement	1	2	3	4	5
C1	I engage in personal prayer or meditation regularly.	☐	☐	☐	☐	☐
C2	I read religious texts at home.	☐	☐	☐	☐	☐
C3	I observe fasting practices prescribed by the Church.	☐	☐	☐	☐	☐
C4	I pray privately during times of stress or difficulty.	☐	☐	☐	☐	☐

Section D: Intrinsic Religiosity

(Internalized faith and meaning)

No.	Statement	1	2	3	4	5
D1	My religious beliefs influence all areas of my life.	☐	☐	☐	☐	☐
D2	My faith guides my decisions and actions.	☐	☐	☐	☐	☐
D3	I try to live according to the teachings of my faith.	☐	☐	☐	☐	☐
D4	My religion gives meaning and purpose to my life.	☐	☐	☐	☐	☐

Section E: Depression Symptoms

(BDI-II–informed, past two weeks)

No.	Statement	1	2	3	4	5
E1	I feel a deep sense of sadness or depression most of the time.	☐	☐	☐	☐	☐
E2	I feel hopeless about my future.	☐	☐	☐	☐	☐
E3	Things that used to bring me pleasure no longer interest me.	☐	☐	☐	☐	☐
E4	I feel a sense of tired or a lack of energy.	☐	☐	☐	☐	☐
E5	I had difficulty concentrating.	☐	☐	☐	☐	☐
E6	I often have low self-worth and feel a sense of guilt.	☐	☐	☐	☐	☐

Section F: Social Cohesion (Mediator)

No.	Statement	1	2	3	4	5
F1	I feel supported by members of my church community.	☐	☐	☐	☐	☐
F2	I feel a strong sense of belonging in my church.	☐	☐	☐	☐	☐
F3	Church members help each other during difficult times.	☐	☐	☐	☐	☐
F4	My church provides emotional and social support.	☐	☐	☐	☐	☐

Section G: Personal Meaning & Stability (Mediator)

No.	Statement	1	2	3	4	5
G1	My faith helps me cope with stress.	☐	☐	☐	☐	☐
G2	Religious practices give stability to my daily life.	☐	☐	☐	☐	☐
G3	My faith helps me find meaning during hardship.	☐	☐	☐	☐	☐
G4	Prayer brings me inner peace.	☐	☐	☐	☐	☐

Section H: Moderating Factors

(Theological Orientation, Spiritual Struggle, Life Stressors)

No.	Statement	1	2	3	4	5
H1	I see God as loving and compassionate.	☐	☐	☐	☐	☐
H2	I feel punished by God when bad things happen.	☐	☐	☐	☐	☐
H3	I experience doubt or conflict about my faith.	☐	☐	☐	☐	☐
H4	My religious faith helps me face life stressors.					

Interview Guide

The following open-ended questions were used to guide semi-structured interviews with 16 purposively selected Ethiopian Orthodox Tewahedo Christian participants. The guide was designed to allow flexibility in following productive lines of inquiry while ensuring systematic coverage of the thematic areas of interest. All interviews were conducted in the participant's preferred language, audio-recorded with consent.

1. "How does your participation in EOTC liturgies, fasting, or holy water practices influence your emotional well-being during difficult times?"
2. "Can you describe specific instances where your Orthodox faith helped you cope with feelings of sadness, hopelessness, or stress?"
3. "What role does your personal prayer life or scripture reading play in managing daily challenges?"
4. "Have you ever experienced spiritual struggles, guilt, or doubts during periods of emotional distress, and how did these affect you?"
5. "How does your church community support you when facing life's difficulties?"

Appendix 2

አዲስ አበባ ዩኒቨርሲቲ
የትምህርትና የቋንቋ ጥናት ኮሌጅ
የሳይኮሎጂ ትምህርት ቤት

እርሶ በዚህ የምርምር ጥናት ውስጥ ተሳትፎ እንዲያደርጉ በአክብሮት ተጋብዘዎል። የዚህ ጥናት ዓላማ በሃይማኖታዊነት(መንፈሳዊነት) ደረጃና በድባቴ(**ድብርት**) መካከል ያለውን ግንኙነት በኢትዮጵያ ኦርቶዶክስ ቴዋሕዶ ክርስቲያኖች ውስጥ መመርመር ነው። የዚህ ምርምር ውጤቶች በኢትዮጵያ አውድ ውስጥ የሃይማኖተዊ እምነቶችና ልምዶች በስውነት ጤና ላይ ያላቸውን ሚና በተሻለ ለመረዳት እንዲሁም ለወደፊቱ የምክርና የማኅበራዊ ስነ-ልቦና አገልግሎቶች ለማስተዋወቅ ይጠቅማል።

ይህ የምርምር ጥናት የሚደረገው በአባ አብርሃም እቁበሚካኤል ዘሚካኤል **እና** በአማካሪያቸው በዶ/ር አሰፋ በሪሁን አማካኝነት ነው። በዚህ ጥናት ውስጥ የእርስዎ ተሳትፎ ሙሉ በሙሉ በርሶ ፈቃደኛነት ላይ የተመሰረተ ነው። የተሳትፎ ሂደቱን በማንኛውም ጊዜ ውድቅ ማድረግ ወይም ከጥናቱ **ማቋረጥ** ይችላሉ። ይህ በእርስዎ ላይ ምንም አይነት አሉታዊ ሳይኮሎጂያዊ ወይም ሌላ ጉዳት አያመጣም። ይህ ጥናት ለርሶ ምንም አይነት የገንዘብ ጥቅም የሚያስገኝ ባይሆንም፣ የእርስዎ ተሳትፎ ለኮውንሰሊንግ ሳይኮሎጂ የትምህርት እውቀትና ሙያዊ ልምምድ ብዙ አስተዋጽኦ እንደሚያበረክት መሆኑን ለማሳወቅ **እ**ንወዳለን።

በጣም እናመሰግናለን! ለዚህ የምርምር ጥናት ላደረጉት ትብብር እና አስተዋጾ እናመሰግናለን። እርስዎ ያበረከቱት ጊዜ ና ጥረት ለምርምሩ ትልቅ ዋጋ አለው።

Amharic Questionnaire

ክፍል ሀ: ግላዊ መረጃዎች
ይህ ክፍል ስለእርስዎ ግላዊ መረጃ ይጠይቃል። እባክዎን እያንዳንዱን ጥያቄ በጥንቃቄ ያንብቡ እና የእርስዎን ምላሽ በትክክል የሚገልጽበትን ምላሽ ምልክት (✓) ያድርጉ።

ቁ.	አይነት	የምላሽ አማራጮች
A1	እድሜ	18–30 □ 31–45 □ 46–60 □ 60+ □
A2	ጾታ	ወንድ □ ሴት □
A3	የጋብቻ ሁኔታ	ያላገባ □ ያገባ(ች) □
A4	የትምህርት ደረጃ	የለም □ የመጀመሪያ ደረጃ □ ሁለተኛ ደረጃ □ ዲፕሎማ □ ዲግሪ+ □
A5	የሥራ ሁኔታ	ሰራተኛ □ የግል ስራ □ ተማሪ □ ጡረተኛ □
A6	ወርሃዊ ገቢ	ዝቅተኛ □ መካከለኛ □ ከፍተኛ □

የምላሽ ሚዛን (ለክፍል ለ–ኢ)

ሚዛን	ትርጉም
1	በጣም አልስማማም
2	አልስማማም
3	ገለልተኛ
4	እስማማለሁ
5	በጣም እስማማለሁ

እባክዎን ከ **በጣም አልስማማም (1)** እስከ **በጣም እስማማለሁ (5)** ባለው ሚዛን ላይ እያንዳንዱን መግለጫ በምን ደረጃ እንደሚያዝኑት በመምረጥ ያመልክቱ።

ክፍል ለ: ተቋማዊ መንፈሳዊነት(Organizational Religiosity)
(የቤተክርስቲያን መገኘት እና የህዝብ ሃይማኖታዊ ተሳትፎ)

ቁ.	መግለጫ	1	2	3	4	5
ለ1	በተከታታይ ወደ ቤተክርስቲያን **እሄዳለሁ**።	□	□	□	□	□
ለ2	በዋና ዋና የቤተክርስቲያን ሥነ ሥርዓቶች እና በዓላት እሳተፋለሁ።	□	□	□	□	□
ለ3	ከቤተክርስቲያን ጋር የተያያዙ እንቅስቃሴዎች ላይ በንቃት እሳተፋለሁ።	□	□	□	□	□
ለ4	በቤተክርስቲያን አገልግሎቶች ውስጥ መገኘቴ ለእኔ አስፈላጊ ነው።	□	□	□	□	□

ክፍል ሐ: ተቋሚያዊ ያልሆነ ሃይማኖታዊነት(መንፈሳዊነት)

(የግል ሃይማኖታዊ ልምምዶች)

ቁ.	መግለጫ	1	2	3	4	5
ሐ1	በየጊዜው የግል ጸሎት አደርጋለሁ።	☐	☐	☐	☐	☐
ሐ2	በቤት ውስጥ ሃይማኖታዊ ጽሑፎችን ወይም መጽሐፍ ቅዱስ እነባለሁ።	☐	☐	☐	☐	☐
ሐ3	ቤተክርስቲያን ያወጀችውን የጾም ጊዚያት ጠብቄ እጾማለሁ።	☐	☐	☐	☐	☐
ሐ4	በጭንቀት ወይም በችግር ጊዜ በግሌ እጸልያለሁ።	☐	☐	☐	☐	☐

ክፍል መ: ውስጣዊ ሃይማኖታዊነት(መንፈሳዊነት)
(የውስጥ እምነት እና ትርጉም)

ቁ.	መግለጫ	1	2	3	4	5
መ1	የሃይማኖት እምነቶቼ በሕይወቴ ሁሉም መስኮች ላይ ተጽዕኖ ያሳርፋሉ።	☐	☐	☐	☐	☐
መ2	እምነቴ ውሳኔዎቼን እና ተግባሮቼን ይመራል።	☐	☐	☐	☐	☐
መ3	በእምነቴ ትምህርቶች መሰረት ሕይወቴን ለመምራት እሞክራለሁ።	☐	☐	☐	☐	☐
መ4	ሃይማኖቴ ለሕይወቴ ትርጉም እና ዓላማ ይሰጠዋል።	☐	☐	☐	☐	☐

ክፍል ሠ የድባቴ ምልክቶች
(ከ BDI-II የተገኘ)

ቁ.	መግለጫ	1	2	3	4	5
ሠ1	አብዛኛውን ጊዜ ከፍተኛ የሐዘን ወይም የድብርት ስሜት ይሰማኛል።	☐	☐	☐	☐	☐
ሠ2	ስለወደፊቴ ተስፋ የመቁረጥ ስሜት ይሰማኛል።	☐	☐	☐	☐	☐
ሠ3	ከዚህ በፊት የሚያስደስቱኝ ነገሮች አሁን አሁን ሊያስደስቱኝም	☐	☐	☐	☐	☐
ሠ4	የድካም ወይም የኃይል እጥረት ስሜት ይሰማኛል።	☐	☐	☐	☐	☐
ሠ5	ትኩረት ማድረግ ያስቸግረኛል።	☐	☐	☐	☐	☐
ሠ6	ብዙ ጊዜ ለራሴ ያለኝ ዋጋ ትንሽ ነው እናም የበደለኝነት ስሜት ይሰማኛል።	☐	☐	☐	☐	☐

ክፍል ረ: የማህበራዊ ውህደት

ቁ.	መግለጫ	1	2	3	4	5
ረ1	በቤተክርስቲያን ማህበረሰብ አባላት ድጋፍ ይደረግልኛል።	☐	☐	☐	☐	☐
ረ2	በቤተክርስቲያኔ ውስጥ ጠንካራ የአባልነት ስሜት አለኝ።	☐	☐	☐	☐	☐
ረ3	በችግር ጊዜ የቤተክርስቲያን አባላት እርስ በርስ ይረዳዳሉ።	☐	☐	☐	☐	☐
ረ4	ቤተክርስቲያኔ ስሜታዊ እና ማህበራዊ ድጋፍ ይሰጠኛል።	☐	☐	☐	☐	☐

ክፍል ሰ: የግል ትርጉም እና መረጋጋት

ቁ.	መግለጫ	ነ	2	3	4	5
ሰነ	እምነቴ ጭንቀትን እንድቋቋም ይረዳኛል።	☐	☐	☐	☐	☐
ሰ2	ሃይማኖታዊ ልምምዶች ለዕለት ተዕለት ሕይወቴ መረጋጋት ይሰጡኛል።	☐	☐	☐	☐	☐
ሰ3	እምነቴ በችግር ጊዜ ትርጉም እንድፈልግ ይረዳኛል።	☐	☐	☐	☐	☐
ሰ4	ጸሎት ውስጣዊ ሰላም ያመጣልኛል።	☐	☐	☐	☐	☐

ክፍል ሐ: አማካይ ሁኔታዎች
(የመንፈሳዊ ትግል)

ቁ.	መግለጫ	ነ	2	3	4	5
ሐነ	እግዚአብሔርን ወዳጅነት እና ርኅራኄ ያለው አድርጌ እመለከተዋለሁ።	☐	☐	☐	☐	☐
ሐ2	መጥፎ ነገር በሚገጥመኝ ጊዜ እግዚአብሔር እየቀጣኝ እንደሆነ ይሰማኛል።	☐	☐	☐	☐	☐
ሐ3	ስለ እምነቴ ጥርጣሬ ወይም የሀሳብ ግጭት አለብኝ።	☐	☐	☐	☐	☐
ሐ4	የሃይማኖቴ የሕይወት ጫናዎችን እንድጋፈጥ ይረዳኛል።	☐	☐	☐	☐	☐

Annex 3

Descriptive analysis

1. Organizational religiosity

	N	Minimum	Maximum	Mean	Std. Deviation
I attend church services regularly.	409	1.00	5.00	3.8215	1.00972
I participate in major church ceremonies and feast days.	409	1.00	5.00	3.8240	1.08840
I actively take part in church-related activities.	409	1.00	5.00	4.0244	1.12650
Being present in church services is important to me.	409	3.00	5.00	4.4450	.65119
Valid N (listwise)	409				

2. Non-organizational religiosity

	N	Minimum	Maximum	Mean	Std. Deviation
I engage in personal prayer or meditation regularly.	409	1.00	5.00	3.8606	.95365
I read religious texts at home.	409	1.00	5.00	3.7457	1.01888
I observe fasting practices prescribed by the Church.	409	1.00	5.00	3.9658	1.18974
I pray privately during times of stress or difficulty.	409	2.00	5.00	4.3619	.92148
Valid N (listwise)	409				

3. Intrinsic Religiosity

	N	Minimum	Maximum	Mean	Std. Deviation
My religious beliefs influence all areas of my life	409	2.00	5.00	3.8949	1.11856
My faith guides my decisions and actions.	409	2.00	5.00	3.4108	1.22173
I try to live according to the teachings of my faith	409	2.00	5.00	4.2347	.88764
My religion gives meaning and purpose to my life	409	3.00	5.00	4.6748	.51865
Valid N (listwise)	409				

4. Depression symptoms

	N	Minimum	Maximum	Mean	Std. Deviation
I felt sad or down most of the time.	409	1.00	5.00	2.7800	1.36320
I felt hopeless about my future.	409	1.00	5.00	2.3912	1.30929
I lost interest in activities I usually enjoy.	409	1.00	5.00	3.1345	1.51431
I felt tired or lacked energy.	409	1.00	5.00	2.9046	1.48463
I had difficulty concentrating.	409	1.00	5.00	2.9731	1.49894
I felt worthless or guilty.	409	1.00	5.00	3.3741	1.60098
Valid N (listwise)	409				

5. Social Cohesion

	N	Minimum	Maximum	Mean	Std. Deviation
I feel supported by members of my church community	409	1.00	5.00	2.4156	1.11511
I feel a strong sense of belonging in my church.	409	1.00	5.00	2.6870	1.19429
Church members help each other during difficult times.	409	1.00	5.00	3.3081	1.43587
My church provides emotional and social support.	409	1.00	5.00	3.7971	1.38280
Valid N (listwise)	409				

6. Personal Meaning and Stability

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
My faith helps me cope with stress.	409	2.00	5.00	4.2616	.93280
Religious practices give stability to my daily life.	409	2.00	5.00	4.3985	.71407
My faith helps me find meaning during hardship.	409	2.00	5.00	4.4450	.72931
Prayer brings me inner peace.	409	2.00	5.00	4.7066	.47173
Valid N (listwise)	409				

7. Moderating Factors

	N	Minimum	Maximum	Mean	Std. Deviation
I see God as loving and compassionate.	409	2.00	5.00	4.5941	.57443
I feel punished by God when bad things happen.	409	1.00	5.00	3.2861	1.46154
I experience doubt or conflict about my faith.	409	1.00	5.00	1.8680	.65468
My religious faith helps me face life stressors.	409	2.00	5.00	4.5183	.73116
Valid N (listwise)	409				

Annex 4

1. Correlation Analysis

Correlations

		Organizational Religiosity	Non-Organizational Religiosity	Intrinsic Religiosity	Depression Symptoms
Organizational Religiosity	Pearson Correlation	1	.421**	.323**	-.307**
	Sig. (2-tailed)		.000	.000	.000
	N	409	409	409	409
Non-Organizational Religiosity	Pearson Correlation	.421**	1	.386**	-.294**
	Sig. (2-tailed)	.000		.000	.000
	N	409	409	409	409
Intrinsic Religiosity	Pearson Correlation	.323**	.386**	1	-.252**
	Sig. (2-tailed)	.000	.000		.000
	N	409	409	409	409
Depression Symptoms	Pearson Correlation	-.307**	-.294**	-.252**	1
	Sig. (2-tailed)	.000	.000	.000	

N	409	409	409	409

**. Correlation is significant at the 0.01 level (2-tailed).

Annex 5

2. Regression

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.374[a]	.140	.133	5.72567	.140	21.939	3	405	.000

a. Predictors: (Constant), Intrinsic Religiosity, Organizational Religiosity, Non-Organizational Religiosity

b. Dependent Variable: Depression Symptoms

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	2157.657	3	719.219	21.939	.000[b]
	Residual	13277.243	405	32.783		
	Total	15434.900	408			

a. Dependent Variable: Depression Symptoms

b. Predictors: (Constant), Intrinsic Religiosity, Organizational Religiosity, Non-Organizational Religiosity

Coefficients[a]

Model	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Correlations			Collinearity Statistics
	B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance
1 (Constant)	34.637	2.196		15.771	.000	30.319	38.955				

Organizational Religiosity	-.421	.110	-.198	-3.825	.000	-.637	-.204	-.307	-.187	-.176	.793
Non-Organizational Religiosity	-.335	.110	-.162	-3.049	.002	-.550	-.119	-.294	-.150	-.141	.753
Intrinsic Religiosity	-.306	.125	-.125	-2.461	.014	-.551	-.062	-.252	-.121	-.113	.820

a. Dependent Variable: Depression Symptoms

Collinearity Diagnostics[a]

Model	Dimension	Eigenvalue	Condition Index	Variance Proportions (Constant)	Organizational Religiosity	Non-Organizational Religiosity	Intrinsic Religiosity
1	1	3.950	1.000	.00	.00	.00	.00
	2	.019	14.260	.11	.41	.22	.37
	3	.019	14.445	.02	.52	.78	.00
	4	.011	18.608	.87	.07	.00	.62

a. Dependent Variable: Depression Symptoms

Residuals Statistics[a]

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	13.4028	24.1905	17.5575	2.29965	409
Residual	-15.19051	14.16735	.00000	5.70458	409
Std. Predicted Value	-1.807	2.884	.000	1.000	409
Std. Residual	-2.653	2.474	.000	.996	409

a. Dependent Variable: Depression Symptoms