ROLE OF RELIGIOSITY ON HOPELESSNESS, LIFE SATISFACTION, RESILIENCE AND DEPRESSION AMONG HIGH SCHOOL STUDENTS

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CERTIFICATE

This is to certify that the present research work titled, "**Role of Religiosity on Hopelessness, Life Satisfaction, Resilience and Depression among High School Students**", is the original research work carried out by Ms.Margaret LalruatfeliFanai under my Supervision. The work done is being submitted for the Award of the degree of Doctor of Philosophy in Psychology of the Mizoram University.

This is to further certify that the research conducted by Ms. Margaret LalruatfeliFanai has not been submitted in support of an application to this or any other University or an Institute of Learning.

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DECLARATION

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I **MARGARET LALRUATFELI FANAI**, hereby declared that the subject matter of this thesis is the record of work done by me, that the contents of this thesis did not form basis of the award of any previous degree to me or to do the best of my knowledge to anybody else, and that the thesis has not been submitted by me for any research degree in any other University/ Institution.

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Chapter- 1

INTRODUCTION

Youth is a period of major physical, physiological, psychological and behavioural changes with changing patterns of social interactions and relationships areconsidered one of the most critical phases of life. Youth representing a crucial period of opportunity that lays the foundation for a healthy and productive adulthood, helping to minimize the risk of health issues in later life. During puberty, numerous biological transformations take place, such as growth in height and weight, the completion of skeletal development with a rise in bone mass, sexual maturation, and alterations in body composition. The succession of these events during puberty is generally consistent among adolescents which are influenced by age of onset, gender, duration, and individual variations. These changes in adolescents are often accompanied by significant stress on young people and those around them while influencing and affecting their relationships with their peers and adults. The increase in impulsivity during adolescenceis accompanied by vulnerability which is mostly influenced by peer groups and media that result in changes in perception and practice and is characterized by decision-making skills and abilities along with the acquisition of new emotional, cognitive and social skills.

Adolescence Period with Storm and Stress

'The term '*adolescenc*e' comes from the Latin word '*adolescere*,' meaning "to grow into maturity," and refers to the transitional phase of development between childhood and adulthood (Darley et al., 1988), it is the period where an individual is biologically adult but emotionally not fully matured. This phase spans from age eleven to twenty, covering the teenage years (Mahale, 1987). Hall (1904) describes adolescence as the age range from 12 to 23 years, characterizing it as a time of turbulence and stress. Hall (1904) further asserted that environmental factors play a greater role in shaping adolescent development compared to earlier stages of life. United Nations defines 'Adolescents' as individuals in the 10-19 years age group and 'Youth' as the 15–24-year age group (UNO, 2024).Adolescence is a period of transformation, vibrant exploration, and youthful curiosity. In modern times,

adolescents face various challenges and concerns. It can aptly be described as “both the best and worst of times” (Coon, 1992).

Dogra (2007) described adolescence as the stage bridging childhood and adulthood. Biologically, it marks sexual maturation and the end of physical growth. It is both a biological and psychosocial phase, transitioning from childhood dependency to functional independence in adulthood.

Chaube (2002) described adolescence as a life stage marked by significant physical, emotional, mental, and social transformations that profoundly reshape an individual’s perspective. These changes often lead to conflicts with parents, elders, and teachers who are unwilling to loosen their strict control. Adolescents seek recognition as independent individuals with unique personalities and feel compelled to voice their opinions, even when not asked. However, their views are often dismissed as immature, as they are still perceived as children lacking an understanding of their environment. Elders, aiming to shape adolescents’ futures according to their preferences, often face resistance from adolescents, who strongly oppose such interference.

According to Chaube (2002), adolescents strive to make independent decisions in various situations, but these efforts are often viewed as misconduct or indiscipline. Over time, they learn to regulate their desires based on societal norms and begin to understand their social responsibilities. Failure to meet these expectations can lead to personality issues. As a result, adolescents often feel the urge to break free from the restrictions imposed by elders, causing significant stress and tension as they attempt to live according to their preferences and beliefs.

Pajares and Urdan (2004) highlighted that modern adolescents must acquire greater skills and knowledge to compete in the expanding global marketplace. In postindustrial societies, entry-level jobs for individuals with limited education have become scarce. Additionally, adolescents must navigate and adapt to cultural and social changes brought about by globalization, integrating these into their worldviews. Therefore, it is crucial to understand their educational needs and challenges and implement suitable programs and interventions within school

environments. During adolescence, reality takes precedence over fantasy. Many of their activities build on the tasks they began in childhood and preadolescence. Some adolescents are still mastering consistent self-care, completing chores, and forming new habits (Powell, 1983).

Erikson (1968) defined adolescence as spanning from ages ten to twenty and characterized it as a stage of identity versus role confusion. He described this period as marked by uncertainty, exploration, experimentation, and struggles with identity. Erikson proposed that many adolescents go through a psychological moratorium, during which they delay committing to a specific identity while exploring various possibilities.

Adolescence is recognized as both a cultural and social phenomenon, making its boundaries difficult to define and not strictly linked to physical milestones. While biological factors, such as puberty, contribute to this phase, the transition to adulthood is equally shaped by the attainment of social and emotional maturity. Consequently, the duration and endpoints of adolescence vary significantly across cultures and individuals. According to Coleman and Roker (1998), the defining characteristic of adolescence is the development of decision-making abilities. This period is marked by multiple transitions, including shifts in education, training, employment, unemployment, and living arrangements, underscoring its complexity.

Adolescence is often characterized by increased independence granted by parents or legal guardians and reduced supervision compared to preadolescence. The transition from adolescence to adulthood is a complex process that varies widely across cultures and legal systems. The age at which an individual is deemed chronologically and legally mature enough to take on specific societal responsibilities differs by country and context. These responsibilities include milestones such as obtaining a driver’s license, serving in the military or on a jury, consuming alcohol, engaging in legal sexual activity, voting, signing contracts, completing certain educational levels, and marriage.

Adolescence is often characterized as a stage of life that begins with biological changes and concludes within a societal framework (Sharma, 1996). This phase commences with puberty, a biological process, and encompasses various social, emotional, and cognitive developments that prepare individuals for adult roles. The conclusion of adolescence is typically defined by the attainment of cultural and societal milestones, which differ significantly across cultures and legal systems. While physical and biological changes during this stage are universal and driven by maturation, the psychosocial and behavioural responses to these changes are shaped by the cultural context. Consequently, the experiences of adolescents during their teenage years vary greatly depending on the cultural and social values embedded within their network of social identities. During adolescence, individuals explore various roles while attempting to integrate identities formed in earlier stages. According to Friedman and Schustack (2004), failure to navigate this process successfully can lead to a persistent identity crisis, which disrupts aspects of development. Erikson's theory of psychosocial development highlights adolescence as a pivotal stage where individuals must establish a cohesive sense of self. Difficulty in resolving this challenge can result in prolonged identity struggles, affecting the ability to form stable relationships and achieve a clear sense of purpose. Such identity crises may manifest as uncertainty regarding personal values, career choices, and life goals, ultimately hindering emotional stability, social interactions, and professional growth.

Adolescents experience significant stress stemming from various aspects of their lives (Lock & Steiner, 1999), including parental expectations for academic success, family relocations, exposure to drugs, and peer influences, all of which can contribute to depression (Capuzzi, 1994). Stress is defined as a condition or event that may be physical, social, or psychological, triggering a stress response (Ragheb & McKinney, 1993). Additionally, individual perceptions play a crucial role in determining how events, often considered objectively stressful, are experienced (Lazarus, 1966 & 1977).

Adolescents today face greater challenges and life difficulties compared to previous generations, yet they receive less guidance and support for their personal growth (Pajares &Urdan, 2004). Research (Aldwin & Greenberger, 1987; Bonner & Rich, 1987 & 1988; Wilburn & Smith, 2005) indicates that the stress experienced by adolescents and college students is linked to negative outcomes such as anxiety, depression, and suicidal thoughts. Conversely, effectively managing stress contributes to improved well-being among adolescents.

Adolescence is often a period of both exploration and uncertainty. This transitional stage can prompt questions about identity and independence, as adolescents develop their sense of self. During this time, they may encounter challenging decisions related to academics, friendships, sexuality, gender identity, and the use of substances such as drugs and alcohol.

Reasons for storm and stress in adolescence

The term "storm and stress" describes a phase of adolescence where teenagers may experience conflicts with parents, moodiness, and engagement in risky behaviours. While not all adolescents go through this stage, it is more common during adolescence than in childhood or adulthood. Research suggests that storms and stress tend to be less intense in traditional cultures and more pronounced in Western societies. However, as globalization progresses, the prevalence of this phenomenon is expected to rise (Hall, 1904). Many still view adolescence as a turbulent period, often dismissing the concerns of teenagers as merely a phase. In some cases, parents may anticipate negative behaviours from their teenagers, potentially creating tension regardless of the child's temperament. This highlights the importance of educating parents and caregivers about mental health and its impact on adolescents to foster better understanding and support.

Storm and stress in teenagers can arise from a variety of factors, including hormonal fluctuations, adjustments in school and personal life, brain development, a growing desire for independence, and added pressures about the future. Common causes of adolescent turbulence include:

(i) Physical changes during the adolescence period

During the transition from childhood to adulthood, adolescents undergo numerous physical changes as their bodies develop. These changes include the formation of new neural connections in the brain, particularly in the prefrontal cortex, alongside elevated hormone levels that contribute to mental and physical maturation. A key aspect of brain development during this stage is synaptic pruning, a natural process where weaker or unused neural connections are eliminated, while frequently used connections are strengthened and reinforced. This process enhances the efficiency of neural pathways, supporting optimal brain function and enabling the acquisition of new skills and abilities through experience.

(ii) Environmental changes

Today's youth are exposed to significant environmental changes (Faustini, 2014). Adolescents encounter many first-time experiences, such as tackling challenging coursework, forming new social connections, taking on greater responsibilities, and managing increasingly busy schedules, all while undergoing physical and mental development. Their surrounding environments play a crucial role in shaping their health and well-being, both directly and indirectly. Adolescents may form close-knit social groups, explore romantic relationships, and face intense pressure to excel academically, athletically, or in other pursuits. Additionally, they are often required to take on new responsibilities, such as working part-time, caring for family members, or contributing to household finances. This phase of life can amplify existing stressors, including financial struggles, social anxiety, or toxic relationships, often placing significant burdens on adolescents before they have fully matured.

(iii) Increased independence

As adolescents transition from childhood to adulthood, they develop new perspectives and ideas about the world, often accompanied by an increase in risk-taking behaviours. While they are more advanced physically, cognitively, and socio-

emotionally than children, their actions may still conflict with adult values and norms. During this stage, adolescents begin to establish their preferences, desires, and aspirations, which may clash with the expectations and needs of family and friends. This growing independence frequently leads to conflicts, especially when it directly opposes the desires of those around them.

(iv) Gender identity

An increasing number of adolescents report having gender identities or expressions that differ from those assigned at birth or societal and cultural norms. When an adolescent develops a gender identity distinct from those around them, they may face confusion, isolation, and bullying, which can compound the challenges they already encounter at home, school, and work.

Hall (1904) pioneered the scientific exploration of adolescence, and since then, particularly over the past two decades, research has provided substantial insights into the concept of adolescent storm and stress. Studies confirm that some level of storm and stress is evident in areas such as parent-adolescent conflict, mood swings, and risk-taking behaviours. However, not all adolescents go through storms and stress, though it is more prevalent during adolescence than at other life stages. The extent to which adolescents experience these challenges varies based on individual differences and cultural contexts.

Hall (1904) was the first to explicitly and formally address the concept of storm and stress in adolescent development. However, the idea of adolescence being marked by emotional and behavioural distinctiveness had been observed earlier in Western thought. Hall (1904) theorized that during human evolution, there was a particularly challenging and tumultuous period, and the memory of that era has been passed down through generations. He believed this evolutionary legacy is reflected in the storm and stress experienced during individual adolescent development.

Hall (1904) observed that adolescents' storms and stress were particularly evident in their tendency to challenge and contradict parents, experience mood

swings, and engage in reckless or antisocial behaviour. While Hall is often seen as portraying adolescent storm and stress as universally biological, his perspective is more nuanced. He acknowledged individual differences, noting that conflicts with parents were more common among adolescents with "rougher temperaments." Hall believed that while a biological basis for adolescent storm and stress was universal, cultural factors shaped how it was expressed and experienced. He argued that this phenomenon was more prevalent in the United States of his time compared to "older societies with more conservative traditions."

Hall (1904) also attributed the intensification of adolescent storm and stress to the failure of institutions such as families, schools, and religious organizations to understand the nature of adolescence and adapt accordingly—a view echoed by modern scholars (Eccles et al., 1993; Simmons & Blythe, 1987). Since Hall's foundational work in defining adolescence as a field of scientific study, debates surrounding the concept of adolescent storm and stress have persisted, periodically resurfacing over the past century.

Anna Freud (1958, 1968, 1969) regarded adolescents who appeared unaffected by storm and stress with deep skepticism, suggesting that their outward composure masked an inner reality where they had likely developed excessive defences against their instinctual drives, leaving them emotionally impaired. Freud considered storm and stress to be both universal and inevitable, asserting that its absence could indicate underlying psychological issues. She famously stated, "To be normal during the adolescent period is by itself abnormal".

Buchanan and Holmbeck (Buchanan, 1998; Buchanan et al., 1990; Buchanan & Holmbeck, 1998; Holmbeck & Hill, 1988; Offer, Ostrov, & Howard, 1981) have examined public perceptions of adolescence as a period of storm and stress. Their research, conducted with American middle-class samples, consistently revealed that many in the American majority culture view adolescence as a relatively turbulent phase of life. Buchanan et al. (1990) found that most parents and teachers agreed with statements characterizing early adolescence as a challenging time for both adolescents and adults in their lives. Similarly, Buchanan and Holmbeck (1998)

reported that college students and parents of early adolescents perceived adolescents as more prone to issues like anxiety, insecurity, depression, and risk-taking or rebellious behaviours compared to younger children. Holmbeck and Hill (1988) also found that the majority of college students surveyed agreed that "adolescents frequently fight with their parents."

Symptoms of storm and stress in adolescence

When combining historical and theoretical perspectives with contemporary research, the storm-and-stress concept portrays adolescence as a uniquely challenging period of life (Buchanan et al., 1990). It is often considered more demanding than other life stages for both adolescents and those around them. Various aspects of storm and stress reach their peak at different stages of adolescence: conflicts with parents are most common in early adolescence (Paikoff& Brooks-Gunn, 1991), mood swings are most pronounced in mid-adolescence (Petersen et al., 1993), and risk-taking behaviours are more prevalent in late adolescence and emerging adulthood (Arnett, 1992, 1999). Each of these elements poses distinct challenges, contributing to the widespread perception of adolescence as a difficult and turbulent phase of life.

(i) Conflict with parents

Adolescence is marked by heightened conflicts with parents, often characterized by rebellious behaviour and resistance to adult authority. Hall (1904) described this phase as one where "the wisdom and advice of parents and teachers is overtopped" and, in less temperate individuals, met with outright defiance. He attributed this to both human evolutionary history and the tension between adolescents' growing need for independence and parents' tendency to view them as children, tightening control when greater autonomy is needed. Contemporary research supports Hall's observations, showing that parent-child conflicts increase during early adolescence compared to preadolescence, remaining elevated for a few years before gradually decreasing in late adolescence (Laursen, Coy, & Collins, 1998; Paikoff& Brooks-Gunn, 1991; Smetana, 1989). A meta-analysis by Laursen et al. (1998) revealed that

conflict frequency peaks in early adolescence, while conflict intensity is highest in mid-adolescence. Additionally, Montemayor and Hanson (1985) found that early adolescents reported conflicts with parents and siblings about 20 times per month. During this period, the frequency of daily conflicts increases, yet there is a decline in the time spent together and in emotional closeness between parents and their adolescent children (Larson & Richards, 1994).

Research indicates that conflicts are particularly frequent and intense between mothers and their early adolescent daughters (Collins, 1990). These conflicts pose challenges not only for the adolescents but also for their parents. Many parents view adolescence as the most challenging phase of their child's development (Buchanan et al., 1990; Pasley &Gecas, 1984; Small, Cornelius, & Eastman, 1983). However, significant individual variations exist, and some parents and adolescents experience minimal conflict despite the general increase in parent-child disagreements during adolescence. Conflicts are more likely to arise when adolescents face issues such as a depressed mood (Cole & McPherson, 1993), substance abuse problems (Petersen, 1988), or when the adolescent is an early-maturing girl (Buchanan et al., 1992).

Modern researchers highlight that increased conflict with parents during adolescence does not signify a lasting or severe disruption in parent-adolescent relationships (Hill & Holmbeck, 1987; Montemayor, 1986; Offer & Offer, 1975; Rutter, Graham, Chadwick, & Yule, 1976; Steinberg & Levine, 1997). Despite the frequency of disagreements, both parents and adolescents generally describe their relationships as positive, sharing fundamental values and maintaining a strong sense of mutual affection and attachment. These conflicts are typically centered on seemingly minor issues, such as clothing choices, dating, and curfews (Smetana, 1988). While parents and adolescents may disagree on day-to-day matters like curfews, dating, and clothing, they often align on more significant values, such as honesty and the importance of education. However, this alignment does not negate the challenges adolescence poses for both parties due to frequent, minor conflicts. Although these disputes may seem trivial, their regularity contributes to the perception of adolescence as a challenging period. Moreover, these seemingly small

issues might carry deeper significance than they initially appear. Some researchers, such as Steinberg (1990), argue that parent-adolescent conflict can benefit development by fostering individuation and autonomy within a supportive relationship. Nevertheless, even if these conflicts have developmental advantages, their intensity and frequency can still make adolescence a demanding time for both adolescents and their parents.

(ii) Mood disruptions

Adolescents are generally more emotionally volatile compared to children or adults. They are prone to experiencing intense mood fluctuations, shifting rapidly between extremes. Additionally, they are more likely to encounter frequent episodes of low or depressed mood.

The connection between adolescence and intense emotional experiences, particularly negative emotions, is one of the oldest and most persistent aspects of the storm-and-stress theory. Hall (1904) described adolescence as a period characterized by "rapid fluctuation of moods," encompassing both intense elation and deep sadness. Research that frequently measures mood has confirmed that adolescents report more extreme and frequent mood changes compared to preadolescents or adults. Numerous longitudinal studies consistently indicate that negative emotions become more prevalent during the transition from preadolescence to adolescence (Buchanan et al., 1992). Research supports the storm-and-stress perspective, suggesting that adolescence is marked by heightened mood fluctuations. Adolescents report experiencing intense emotions both positive and negative, with a stronger emphasis on negative emotions more frequently than their parents (Larson & Richards, 1994; Larson, Csikszentmihalyi, & Graef, 1980). They report feelings of being "self-conscious" and "embarrassed" two to three times more often than adults and are also more prone to feeling awkward, lonely, nervous, and overlooked.

Larson and Richards (1994) concluded that the rise in mood disturbances during adolescence is primarily influenced by cognitive and environmental factors rather than pubertal changes. They highlighted that mood disruptions are partly

driven by the numerous life transitions adolescents face, such as the onset of puberty, changes in school environments, and the initiation of romantic relationships. However, they emphasized that it is not merely the occurrence of these potentially stressful events but the way adolescents perceive and interpret these experiences that significantly contributes to their emotional fluctuations.

Petersen and his colleagues (1993) identified a "mid-adolescence peak" in studies examining age-related variations in depressed mood, revealing that adolescents experience higher levels of depressed mood compared to both children and adults.

(iii) Risk behaviour

Adolescents exhibit higher levels of reckless, rule-breaking, and antisocial behaviours compared to children or adults. They are more prone to actions that disrupt social norms and may pose risks to both themselves and those around them.

Adolescence has historically been linked to increased levels of antisocial, rule-breaking, and criminal behaviour, particularly among boys. Hall (1904) included this tendency as part of his concept of adolescent storm and stress, suggesting that "a phase of semi-criminality is typical for all healthy adolescent boys" Crime rates generally escalate during the teenage years, peaking around the age of 18, before declining sharply (Gottfredson & Hirschi, 1990). The prevalence of most forms of substance use reaches its highest point around the age of 20 (Johnston, O'Malley, & Bachman, 1994). Similarly, the incidence of automobile accidents and fatalities is at its peak during the late teenage years (U.S. Department of Transportation, 1995).While adolescents often find engaging in risky behaviours enjoyable (Arnett, 1992; Lyng, 1993), dealing with the consequences—such as encounters with the legal system or involvement in car accidents—is likely to be challenging. Additionally, it is understandable that parents may struggle as they observe their children navigate the ages when such behaviours are most prevalent. As with parent-child conflicts and mood swings, it is essential to acknowledge the existence of individual differences in this area. Adolescents show significant variation in their

involvement in risk-taking behaviours. In many cases, these differences can be predicted by behaviours exhibited before adolescence. Individuals who display behavioural problems during childhood are particularly prone to engaging in risky behaviours during their teenage years (Moffitt, 1993). Traits such as sensation-seeking and impulsivity also play a role in shaping these behaviours(Arnett, 1992; Zuckerman, 1983). However, even though not all adolescents engage in risky activities, most participate in some form of riskybehaviour at least occasionally (Arnett, 1992; Moffitt, 1993).

Occasionally, storm and stress have been associated with other aspects, such as academic challenges (Eccles et al., 1993) and self-image concerns (Offer & Offer, 1975). However, the three key elements highlighted here are consistently referenced in the works of Hall (1904), anthropologists like Mead (1928), psychoanalysts such as Bios (1962) and Freud (1968, 1969), and modern scholarsincluding Buchanan (1998), Eccles and colleagues (1993), Offer and Schonert-Reichl (1992), Petersen and colleagues (1993), and Steinberg and Levine (1997).

Storm and stress during adolescence are not inevitable components of the human life cycle. Significant cultural variations exist in the experience of storm and stress, and even within the same culture, individuals differ in how much they exhibit its various aspects. Moreover, describing adolescence as a period of storm and stress does not imply that it is solely defined by these challenges. Despite the difficulties, most adolescents find enjoyment in many areas of their lives, maintain satisfaction with most of their relationships most of the time, and remain optimistic about their future (Offer & Schonert-Reichl, 1992).

Hall (1904) characterized adolescence as both tumultuous and inspiring, describing it as "the birth of the imagination" and "the best decade of life," during which "the life of feeling reaches its peak." This duality highlights the paradox of adolescence, as it is simultaneously a period of significant challenges and a time of vibrant growth and creativity.

Religiousity

According to the Oxford Dictionary, religion is "the belief in and worship of a superhuman controlling power, especially a personal God or gods." Given the vast differences between religions, it is difficult to capture all of them in such a brief definition. In 2012, nearly 60% of the global population identified as religious (WIN-Gallup International, 2012)."Religion" refers to a set of beliefs concerning the relationship between humans and the events in their lives, as well as the world around them. It also includes rules that followers are expected to adhere to, which can govern aspects of life such as clothing, eating, or the participation of women in religious practices. Defining religion is challenging due to its diversity.

Sigmund Freud (1856–1939) described the origin of religion as a "fantasy structure" that individuals need to overcome to achieve maturity (Freud, 1976). In contrast, Carl Jung (1875–1961) viewed religious symbolism positively, emphasizing its deeper significance (Jung, 1960). Austrian psychiatrist Alfred Adler (1870–1937) argued that our concepts of God reflect how we perceive the world, shaping our aspirations and guiding our social interactions (Adler, 1927). Similarly, Gordon Allport (1897–1967) highlighted the varied ways people engage with religion, emphasizing a dynamic and open-minded approach that allows individuals to reconcile inconsistencies (Allport, 1950).

Geertz (1973) argues that for something to be considered a religion, it must possess several characteristics: (1) a system of symbols that (2) creates powerful, widespread, and enduring moods and motivations in individuals by (3) presenting ideas about the overall order of existence, and (4) presenting these ideas in such a way that they are perceived as factual, making (5) the resulting moods and motivations seem uniquely realistic.

Religion serves as a deterrent to suicide by promoting social integration and encouraging adherence to societal regulations (Durkheim, 1951). Religious organizations are valuable sources of positive emotions, emphasizing social connections and strengthening group cohesion. Adolescents who are more religious and spiritual tend to exhibit healthier behaviours, such as less drug and alcohol use

and later initiation of sexual activity, as well as better mental health outcomes (Wong et al., 2006; Bridges & Moore, 2002; Cotton et al., 2006). Religion is linked to various aspects of well-being (Kaldor et al., 2004), helps prevent suicide, provides a sense of meaning in life, and supports recovery from suicidal thoughts (Webb, 2009).

Religiousity is a complex concept with various definitions. Glock and Stark (1965) identified five dimensions of religiousity: experiential, ritualistic, ideological, intellectual, and consequential. Similarly, Khenfer and Roux (2012) noted that terms such as religious commitment, religious involvement, religiousness, religious orientation, and religiousity are frequently used interchangeably to describe the same idea.

Religiousity encompasses an awareness of God, acceptance of divine grace and love, repentance, social responsibility, faith, and trust. It also includes engagement in organized religion, fellowship, ethical conduct, and a willingness to embrace and understand the experiences of others (Moreira-Almeida et al., 2006). Religion can serve as a foundation for finding meaning, providing direction, and shaping personal identity, while also imbuing potentially isolating or challenging events with significance (Bailey, 1997). Expanding knowledge of the religious dimensions of human life enhances the ability of mental health professionals and researchers to fulfil their role in alleviating suffering and supporting individuals in leading more meaningful and fulfilling lives (Moreira-Almeida et al., 2006).

Religious commitment and involvement appear to influence longevity, particularly among men (Bailey, 1997). Church attendance has been linked more closely to drug abstinence than parental religiousity (Bailey, 1997). Additionally, both public and private religious practices contribute to coping with emotions such as anxiety, fear, frustration, anger, feelings of inferiority, anomie, despondency, and social isolation (Moreira-Almeida et al., 2006).

Religion plays a significant role in daily life (Crabtree & Pelham, 2009). However, certain religious groups have been found to experience higher rates of depression and mental illness. For example, individuals of Jewish descent (Kennedy

et al., 1994) and Pentecostals (Sethi & Seligman, 1993) showed higher prevalence compared to other religious groups (Koenig et al., 1994).

Viewing religion as a quest for meaning has significant psychological implications. It encompasses cognitive elements, such as beliefs about God and the pursuit of purpose, as well as motivational aspects, like the desire for control over life and striving to be accepted both socially and spiritually. In this way, religion is deeply embedded within society and interconnected with community life.

William James (1842–1910) differentiated between healthy-minded and sick-souled religiousness, emphasizing that individuals should evaluate whether religious practices are effective; if not, there would be little rational justification for continuing them (Spilka et al., 2003). Georg Wilhelm Friedrich Hegel (1770–1831) described all religious systems as manifestations of the fundamental drive of consciousness to understand itself and its environment. He regarded religion as a significant reservoir of wisdom that individuals could draw upon in their personal growth and struggles (Hegel, 1807).

Erik H. Erikson (1902–1994) believed that religion plays a significant role in successful personality development, with religious rituals aiding this process (Erikson, 1958). Similarly, Erich Fromm (1900–1980) argued that the right form of religion can nurture an individual’s greatest potential, offering answers to humanity's deepest questions (Fromm, 1950).

Researchers have highlighted both positive and negative influences of religion on health, particularly concerning mood disorders, personality disorders, and psychiatric conditions. As religion becomes increasingly recognized in psychotherapy, its principles and practices, such as prayer, forgiveness, and grace, are integrated into treatment to enhance its quality and effectiveness. Brown (2017) argues that biases can only be set aside to the degree that they cease to be biases.

Religiousity may be considered a component of spirituality, characterized by adherence to a specific religious doctrine or affiliation with a church (Richards & Bergin, 1997). Religion itself is defined as a structured system of beliefs, practices,

rituals, and symbols aimed at fostering a connection with the sacred or transcendent, such as God, a higher power, or ultimate reality (Moreira et al., 2006). Research by Nikkhah, Zhairi, Sadeghi, and Fani (2015) revealed that rural residents demonstrate significantly higher levels of religiousity in terms of beliefs and rituals compared to urban residents.

Religion comprises values, doctrines, and principles that offer an ethical and moral foundation for shaping understanding, motivation, and behaviour. While it is best suited to an individual's private life, it should not be enforced upon public institutions (Rhodes, 2003). Peach (2003) describes religion as the organization of a group's shared experiences into a structured system of beliefs and practices.

Pargament (2000) identified five central roles that religion serves:

(i) *Meaning and Understanding* – Religion aids in the search for significance and helps individuals interpret and make sense of challenging situations (Geertz, 1966).

(ii)*Control* – It provides mechanisms for regaining a sense of power and control when confronted with uncontrollable circumstances (Fromm, 1950).

(iii) *Comfort and Connection* – Religion alleviates stress and anxiety while fostering a desire to connect with a transcendent force beyond oneself (Freud, 1990).

(iv) *Life Transformation* – It brings about personal changes and introduces new meanings in life.

(v)*Social Cohesion and Identity* – Religion promotes social bonds and strengthens group identity (Durkheim, 1915).

Allport (1959) distinguished between extrinsic religiousity, which refers to the outward expressions of religious involvement, such as attending church, and intrinsic religiousity, which involves a deeper, personal sense of faith. He concluded that

these are two separate but parallel constructs, a distinction that has gained broad acceptance.

(i) Extrinsic religiousity

Allport and Ross (1967) explained that individuals with an extrinsic orientation tend to use religion for personal gain. The term, borrowed from axiology (the study of values), refers to an interest pursued because it serves other, more fundamental goals. Extrinsic values are practical and utilitarian. People with this orientation may find religion beneficial in various ways, such as providing comfort, social connection, status, or self-justification. Their religious beliefs are often held loosely or adapted to meet primary personal needs. Theologically, the extrinsic individual may turn to God but still prioritize their interests.

(ii) Intrinsic religiousity

A person with intrinsic religiousity lives according to their faith, viewing religion as an "end" in itself. These individuals fully internalize the teachings of their religion, making it the central guiding force in their lives. They align their personal needs with their religious beliefs, regarding other desires, no matter how strong, as less important in comparison. As much as possible, they seek to bring these needs into harmony with their religious values and principles. Once they adopt a creed, they strive to embody and follow it completely, thus truly living their religion.

Research on the impact of religion indicates that rituals and beliefs can be helpful in the aftermath of traumatic experiences, such as combat (Astin, Lawrence, & Foy, 1993). Many individuals turn to religion as a coping strategy to deal with trauma. Belief in a higher power can provide a greater sense of control and meaning (Pargament et al., 1990; Tedeschi & Calhoun, 1996). Weber, a well-known sociologist, argues that religion is essential for people as it explains the hardships and blessings in their lives. It helps individuals understand why things happen and provides reasons for events that they cannot explain on their own (Christiano, Swatos, &Kivesto, 2008).

Religiousity Influence on Adolescent Period

Adolescence is a critical phase for shaping personal and religious identity. Between the ages of 13 and 18, teenagers become more vocal and reflective about their sense of self, particularly concerning their parents and peers (Csikszentmihalyi & Larson, 1984; Erikson, 1958). It is also a time of heightened vulnerability regarding sexual identity, as adolescents adapt to significant physical and developmental changes (Csikszentmihalyi & Schmidt, 1998). Amid the emotional and physical changes of adolescence, many young people seek to define their spiritual beliefs, identify the values that matter to them, and decide on the moral principles that should guide their actions. Societal and peer pressures that conflict with family and religious beliefs can be challenging to navigate. Adolescents frequently feel uncertain about what to prioritize and what values to uphold, as they are often exposed to conflicting messages from family, friends, and media about values, beliefs, and appropriate behaviour. Growing research highlights the significance of offering adolescent's opportunities to cultivate moral reasoning and ethical conduct, fostering their growth into responsible, compassionate, and community-oriented adults (Damon, 2002; Wilson, 2001). Religiosity plays a crucial role in shaping the experiences of adolescents and young adults, impacting their values, actions, and overall mental and emotional well-being.

Embracing a religious identity can support adolescents in fostering a stronger and more positive sense of self as they transition into adulthood. It often provides them with inner resilience, a vital asset for navigating personal challenges. Adolescents frequently encounter significant stress and pressure from peers, facing complex decisions and dilemmas. In such situations, religiosity serves as a valuable spiritual resource, offering guidance and strength when dealing with social issues, relational uncertainties, and personal, moral, or ethical choices. Adolescents who engage actively in religious activities and are part of a religious community can benefit from opportunities for moral development and personal accountability, particularly as they become more socially and ethically aware. Participation in religious practices, like attending services, acts as a means of social integration. This

involvement reinforces the values and attitudes shared by their family and religious community, promoting positive aspirations and constructive behaviours (King & Elder, 1999; Regnerus & Elder, 2001). This is especially significant given that many public institutions, like schools, have embraced a stance of “moral relativism and ambivalence” (Damon, 2002), where principles such as honesty, fairness, compassion, and responsibility are seldom explicitly expressed or discussed. Most teenagers report having some level of religiosity (Regnerus et al., 2003; Smith, Denton, Faris, & Regnerus, 2002). Research on adolescent religiosity shows that for some, being religious involves active participation in an organized religious group, while for others, it reflects a broader sense of spirituality or belief in a specific deity. Additionally, the methods used to measure the extent of adolescents’ religiosity are often not entirely precise.

Many studies on religiosity rely on survey questions with response options ranging from "not at all" to "very religious." However, when these responses are analyzed, categories are often combined, making it challenging to differentiate between moderately religious individuals and those who are more or less religious. Despite varying personal interpretations of religiosity, it is typically regarded as a significant aspect of adolescent life. Religiosity can encompass various elements, including personal beliefs, participation in religious practices, and involvement in secular activities associated with religion, such as volunteering with a church-affiliated youth group (Hill & Hood, 1999).

Various scholars have sought to define religiosity by examining distinct facets of religious commitment (Ellison, Gay, & Glass, 1989) or through a social-psychological perspective on religious identity (Horowitz, 1999). These aspects of commitment often include personal faith, engagement in organized religious activities, and association with a specific religious denomination. Researchers have also highlighted components of religious identity, such as the personal perception of spirituality, religious practices, and connection to a religious community. The intersection of these frameworks suggests that defining religious commitment or identity requires distinguishing between ritual practices, religious affiliation, and an

individual's sense of belief. Focusing solely on participation or affiliation risks undervaluing the significance of religious identity in a person's life.

Family Role on Adolescent's Religiousity

For most adolescents, religious identity is shaped within the family environment. Religion often functions as a family-oriented activity, with participation levels being highest among families with school-aged children (Stolzenberg, Blair-Loy, & Waite, 1995). Unsurprisingly, family dynamics and religious practices are frequently interconnected, as engaging in religious activities as a family can help parents navigate their interactions with each other and guide their relationships with their children (Wilcox, 2001).

Schmidt (2003) conducted a study on adolescent religiosity and found that adolescents who report higher levels of religiousity tend to view their families as both more supportive and more challenging compared to those who identify as non-religious. Family support and challenge are recognized as hallmarks of "effective parenting," which play a crucial role in shaping adolescent achievement and ambition (Csikszentmihalyi & Schneider, 2000; Schneider & Stevenson, 1999). Support involves warm and caring family interactions, while challenge entails encouraging children to strive for their best. Effective parenting not only fosters a nurturing, goal-oriented environment but is also shaped by values rooted in a particular religious tradition. Religious affiliation can provide adolescents with a sense of belonging and a stable group identity, which contrasts with the often-shifting dynamics of teenage peer groups, thereby enhancing their sense of self (Schneider & Stevenson, 1999; Steinberg, Brown, & Dornbusch, 1997). Research indicates that mothers play a significant role in shaping their children's religious and moral development, as they are more likely than fathers to participate in religious activities and to identify as religious (Bao, Whitebeck, Hoyt, & Conger, 1999; Benson, Masters, & Larson, 1997).

Schmidt (2003) found that mothers who identify as religious, compared to those who do not, are more likely to spend quality time with their children, engage in

frequent discussions about rules and values, and create supportive and challenging family environments. Furthermore, adolescents who perceive their mothers as highly religious often exhibit a stronger sense of personal faith and well-being (Schmidt, 2003). This research suggests a connection between parental religiosity and the development of religious identity in adolescents. However, it remains unclear whether these influences stem directly from religiosity or from being "good parents" who display positive behaviours toward their children. Longitudinal studies examining religious identity over the life course may provide clearer insights into this relationship (Elder & Conger, 2000). Incorporating assessments of both positive and negative parenting styles, such as the degree of support and challenge offered to children could help differentiate the effects of religiousity from those of effective parenting practices.

Religiousity Influence on Academic Performance and Pro-social Behaviour

The connection between religious involvement, particularly through participation in religious activities, and academic outcomes like school performance tends to be moderate (Muller & Ellison, 2001; Regnerus et al., 2003). Religious participation may support other school-related behaviours, similar to those encouraged by extracurricular activities such as sports teams or service organizations. These activities often promote the development of leadership skills, teamwork, and other positive social behaviours. Increasingly, critics advocate for public schools to take a more active role in fostering adolescent growth by implementing programs aimed at enhancing cooperation, responsibility, and empathy. Beyond traditional classroom instruction, extracurricular programs are frequently viewed as suitable platforms for teaching values such as fairness, sportsmanship, and tolerance across ethnic and racial lines.

Similar to religious involvement, participation in school-sponsored extracurricular activities plays a role in shaping adolescents' self-identity (Guest & Schneider, 2003). Studies suggest that students engaged in these activities are more likely to develop a positive self-concept (Eccles & Barber, 1999). Participation in such activities may also foster pro-social and altruistic behaviours often associated

with religious engagement. However, the causal relationship remains unclear. Some adolescents might join extracurricular activities for practical reasons, such as enhancing their college applications, unrelated to religious motivations. Others may participate out of genuine interest in helping others, influenced by parental values and interests, which may or may not be linked to family religious beliefs, practices, or spirituality.

To understand the connection between religiousity and adolescent development, it is essential to consider school and community influences that may independently shape adolescents' values, relationships, and self-esteem. The uplifting or pleasurable aspects of religion such as the joy and increased self-esteem derived from certain religious practices could also be experienced through activities like winning a sports game or singing in a choir. One might argue that the satisfaction of achieving personal goals, such as performing on stage, editing the school newspaper, or completing a scientific experiment, could surpass the emotional fulfilment gained from religious participation. However, the happiness associated with religious practices or spirituality may carry a moral dimension that distinguishes it from the gratification tied to more worldly pursuits. If so, religion could serve a unique and significant role in the lives of young people, particularly those with limited access to school-sponsored activities.

Spirituality

Spirituality can be defined in theological terms, focusing on belief in a divine being, as well as through sociological, philosophical, and psychological lenses (Cox, 1996). Spirituality lacks a definitive or universally accepted definition. It can be both a personal experience and a collective one. Activities like attending church or mosque, gathering for prayer, or spending time meditating or practising yoga can all be considered forms of spirituality. When discussing spirituality, there is no singular God or entity identified as the higher power. Instead, the belief in a higher power, or in the existence of something greater, is what characterizes someone as spiritual. Spirituality and religion differ in their nature.

Canda and Furman (1999) introduce the concept of "nonreligious spiritual propensity" to describe individuals who are spiritual but do not base their beliefs on religion, suggesting that all aspects of spiritual tendency can exist outside of religious frameworks. When examining spirituality's connection to well-being, psychological definitions are often the most relevant, especially in theories that propose causal, moderating, or mediating relationships.

In psychology, spirituality is examined as part of a set of healthy variables that form a network of theoretical relationships, providing a basis for the field of positive psychology, which focuses on studying positive subjective experiences (Seligman, 2002; Snyder & Lopez, 2002). Pargament and Mahoney (2002) argue that spirituality should be studied due to its links with various factors, including mental health (Koenig, 1998), substance use (Benson, 1992), responses to life stressors (Pargament, 1997), illness, and death (Ellison & Levin, 1998). Within positive psychology, spirituality is seen as offering a framework for coping, personal growth, adjustment, and realizing one's full potential.

In the medical field, spirituality is recognized as a crucial factor in understanding patients' needs, attitudes, and treatment decisions. Spiritual beliefs also impact health-related beliefs (Furnham, 1994), and some clinical research has found potential connections between spirituality and the effectiveness of medical treatments (King, Speck, & Thomas, 1994).

Regardless of whether researchers adopt a religious or nonreligious perspective on spirituality, certain defining characteristics are commonly found across different scholarly fields. These definitions often describe spirituality as a human aspect that seeks meaning and purpose (Canda & Furman, 1999; Doyle, 1992), a connection with something greater than oneself (Cox, 1996), transcendence (Mauritzen, 1988), and a pursuit of the sacred—those things considered extraordinary and deserving of respect (Pargament & Mahoney, 2002). Spirituality is thus seen as a construct that embodies a sense of meaning, purpose, and power (Wulff, 1997).

Recent research on spirituality has concentrated on the different definitions of the term (Koenig, McCullough, & Larson, 2001). Major challenges for researchers include the lack of clear operational definitions, the tendency to treat religious measures and spirituality measures as interchangeable, and the absence of valid and reliable measurement tools (Daaleman, Frey, Wallace, & Studenski, 2002a; Sloan, Bagiella, & Powell, 1999). Canda and Furman (1999) note that, outside of religious studies, the term "spirituality" is not frequently used by scholars. However, when it is used, three strategies for defining it have emerged. One approach defines spirituality in context-specific terms, recognizing it as different for different people at different times. A second approach applies general concepts and theories, assuming their relevance across cultures and periods. The third approach acknowledges the diversity of spiritual definitions while attempting to identify a common set of underlying components.

Another way to categorize the various definitions of spirituality is based on how much it is defined as a religion-centered concept. Individuals may identify as both religious and spiritual, viewing these constructs as distinct yet possibly interconnected aspects of human experience (Zinnbauer et al., 1997).

Spirituality has been associated with positive physical health outcomes, such as improved coping with pain and substance abuse (Piedmont, 2004). Walker (2010) supports these findings through her study of African American college students, where she explored the connection between spirituality, religiousity, and both subjective and psychological well-being. In her study, psychological well-being was defined by factors such as self-acceptance, environmental mastery, positive relationships, personal growth, life purpose, and autonomy, while happiness and life satisfaction were part of subjective well-being. Walker found that spirituality, but not religiousity, was a positive predictor of both subjective and psychological well-being, although she also found a significant relationship between spirituality and religiousity. It is essential and valuable to explore why spirituality is associated with positive outcomes in students and how it relates to motivation. Among the few studies that have attempted to understand spirituality in higher education students, Kuo et al., (2014) have contributed to this area of research.

Religiousity and Spirituality on Psychological Functions

While there is general agreement on the definition of religiousity as an organized belief system (Muller & Dennis, 2007), encompassing shared feelings, practices, and beliefs within a cultural context (Hay, Reich & Utsch, 2006), and institutional rituals (Oman & Thoresen, 2002), the definition of spirituality remains more ambiguous (Zinnbauer, 1997). Historically, figures like Jung (1933, cited in Hackney & Sanders, 2003) viewed religion as a source of meaning and stability, contributing to positive psychological well-being. Spirituality, on the other hand, is not necessarily tied to a specific religion but represents a belief system that shapes daily behaviours (Underwood, 2006). While religion or religiousity relates to the extent to which individuals adhere to and practice beliefs and rituals, spirituality is more about a personal and intimate connection to divinity.

Religion is an organized institution with structure, laws, and commands that must be followed. It requires practices such as prayer and visiting a place of worship to seek help and protection from a higher being. A person can change, be coerced into, or abandon their religion. In contrast, spirituality is more personal, stemming from within, and tends to be more abstract and less defined by specific rules than religion.

Religiousity refers to a formal, institutional, and outward expression of faith (Cotton et al., 2006) and encompasses practices and beliefs such as attending religious services, praying, holding theological convictions, and believing in a higher power (Iannello et al., 2019). In contrast, spirituality is focused on the search for meaning and purpose in life and involves a transcendent relationship with a higher being, which may not necessarily be tied to organized religion (Jenkins & Pargament, 1995). Spirituality represents a personal journey to understand life's ultimate questions, explore meaning, and connect with the sacred or transcendent. This quest may or may not lead to the development of religious practices or the establishment of a communal faith (Moreira et al., 2006).

Some studies use the terms religiousity and spirituality interchangeably (Underwood, 2006), while others view them as distinct and separate concepts

(Joshanloo, 2012; McIntosh, Poulin, Silver & Holman, 2011; Seeman, Dubin, & Seeman, 2003; Sessanna, Finnell, Underhill, Chang & Peng, 2011). While some researchers have tried to distinguish spirituality from religion (Miller & Thoresen, 2003), an increasing number of scholars recognize an overlap between the two concepts (Thoresen & Harris, 2002). Walker and Dixon (2002) emphasize an important point that individuals who identify with religion may experience a sense of spirituality, and those who view themselves as spiritual may also express their spirituality through religious practices. They found that there is a significant overlap between the two concepts and experiences.Underwood (2006) advocates for using the combined term religiousity/spirituality, as it reflects the multidimensional nature of a construct that is still evolving in terms of both instrument development and consensus on definitions and concepts. While the current study acknowledges religiousity and spirituality as potentially separate experiences, it also recognizes the overlap in personal experiences. It accepts that one can be religious without being spiritual, and vice versa, while also understanding that religiousity and spirituality can intertwine, with spirituality being rooted in religiousity and religiousity being grounded in spirituality.

Kuo, Arnold, and Rodriguez-Rubio (2014) surveyed 301 Canadian undergraduate students to explore the relationship between coping, spirituality, and psychological distress in a culturally diverse group. They found a negative correlation between intrinsic spirituality and psychological distress. Intrinsic spirituality was distinguished from extrinsic spirituality, with the former being rooted in personal beliefs and values that are not driven by external pressures or social expectations, whereas extrinsic spirituality is more linked to ritualistic and socially motivated religious practices. Additionally, intrinsic spirituality was associated with greater use of collective coping strategies and a reduction in avoidance coping. The study also revealed that coping styles influenced psychological distress, with engagement coping reducing distress, while avoidance coping led to increased distress.

Ellison and Fan (2008) examined the connection between daily spiritual experiences and psychological well-being in adults, finding a positive relationship between the two, independent of religious practices. Daily spiritual experiences refer to personal, routine thoughts and feelings that are not tied to any organized religion. These experiences have been linked to positive mental health outcomes (Ellison & Fan, 2008), including among college students (Ciarrocchi & Deneke, 2004).

Some studies treat religiousity and spirituality as interchangeable terms (Underwood, 2006), while others consider them as distinct and separate concepts (Joshanloo, 2012; McIntosh, Poulin, Silver & Holman, 2011; Seeman, Dubin, & Seeman, 2003; Sessanna, Finnell, Underhill, Chang & Peng, 2011). Some researchers have tried to distinguish spirituality from religion (Miller & Thoresen, 2003), while an increasing number recognize the overlap between the two concepts (Thoresen & Harris, 2002).

Religiousity and spirituality have been explored in relation to coping, resilience, and psychological well-being (Newton & McIntosh, 2010; Pargament, Smith, Koenig & Perez, 1998; Walker, 2010), with research showing a high prevalence of religious coping, ranging from 60-90% (Aldwin, 2007) in clinical and hospital environments (Cotton et al., 2006; Ironson, Stuetzie& Fletcher, 2006; Mela et al., 2008).

Walker and Dixon (2002) emphasize that while individuals who identify with religion may experience a sense of spirituality, those who consider themselves spiritual may also express their spirituality through religion, with significant overlap between the two concepts and experiences. Underwood (2006) advocates for using the combined term religiousity/spirituality, as it reflects the multidimensional nature of a construct that is still developing in terms of measurement tools and agreed-upon definitions. While the current study recognizes religiousity and spirituality as potentially distinct experiences, it also acknowledges their overlap in personal experiences. It understands that one can be religious without being spiritual, and vice versa, while also recognizing the interconnected nature of the two, where spirituality can be rooted in religiousity, and religiousity can be grounded in spirituality.

Several studies (McCullough et al., 2000; Powell, Shahabi & Thoresen, 2003; Strawbridge et al., 1997) emphasize the importance of gaining a deeper understanding of religiousity and spirituality, especially in connection to physical and psychological health, as both spirituality and religiousity have been linked to improved outcomes.

The importance of spirituality and religion is increasing, and there is a need for further research, particularly on its significance in daily life and the workplace (Duffy, 2006). Many organizations and leaders believe that a workforce with a spiritual mindset may exhibit better attitudes, stress-coping strategies, and a stronger collective work ethic, which could enhance performance (Gibson, 2005). This can lead to positive outcomes in both physical and mental health (Taylor et al., 2004; Williams et al., 1991), improved job attitudes (Gibson, 2005; Sikorska-Simmons, 2005), and more ethical decision-making (Fernando & Jackson, 2006).

Religiousity and spirituality serve five key functions that can act as coping mechanisms: providing comfort by alleviating fears and anxieties related to potential challenges; fostering intimacy to promote social connection; offering a search for meaning to help individuals understand and interpret their experiences; restoring a sense of control when adversities push individuals beyond their comfort zones; and facilitating life transformations by introducing new sources of significance (Pargament, Koenig & Perez, 2000). These factors may play an important role in academic motivation and achievement. However, the specific ways these factors contribute to the well-being and motivation of higher education students have not been thoroughly explored.

The positive effects of religion and spirituality on trauma survivors are supported by sufficient data in the literature, reinforcing the importance of recognizing these benefits (Bryant-Davis, Ellis, Burke-Maynard, Moon, Counts, & Anderson, 2012).

Patient care is influenced by the attitudes and behaviours shaped by religious and spiritual beliefs (Ganzini, Johnston, McFarland, Talle, & Lee, 1998; Meier et al., 1998). Social work researchers argue that because religious and spiritual experiences

and beliefs are so common in people's lives, they must be considered when understanding clients. In an extensive review of spirituality in social work, Canda and Furman (1999) support this view and propose an operational model that suggests humans have an inherent drive to attain spiritual qualities. They contend that for spirituality to be recognized as a valid research variable, it should be understood as something that can manifest in various forms, including religious expressions, spiritual development, personal experiences, and the fundamental drive to be spiritual.

Johnson (2008) reviewed studies on academic performance and found that 16 out of 19 studies supported the idea that religiousity positively impacts academic outcomes. Park (2001) also found a connection between religion and improved academic performance.

Hopelessness

Aaron Beck (1963) first introduced the concept of hopelessness, noting that individuals with depression often have negative expectations about themselves and the future. Later studies have demonstrated that hopelessness is a strong predictor of suicidal behaviour and is linked to depression as well as various other clinical conditions (Beck, Brown, Berchick, Stewart, & Steer, 1990; Beck, Riskind, Brown, & Steer, 1988).

Hopelessness is characterized by negative expectations about the future, reflecting a pessimistic outlook (Yenilmez, 2010). It is a major factor contributing to academic failure (Yenilmez, 2010) and is associated with various mental health issues. Particularly, hopelessness is one of the primary causes of suicide, a significant public health concern. In our country, the high incidence of suicide, especially among individuals aged 15-24 and 25-34 (Uçan, 2005), has prompted research across various disciplines on the topic.

Hopelessness is described as a state where there is a total absence of optimism or belief in our ability to handle a situation. Researchers suggest that when

we consistently expect negative outcomes and feel powerless to alter them, we experience hopelessness (Abramson et al., 1989).

Hopelessness is a central element in major cognitive theories of depression (Abramson et al., 1989; Beck, 1987; Clark et al., 1999), but there is limited understanding of how hopelessness develops. Helplessness is described as "the belief that all possible actions have been taken, leading to an inability to summon energy or effort" (Shea and Hurley, 1964).

Theorists have long believed that early negative experiences may play a role in the development of psychopathology. Childhood victimization and negative life events contribute to the formation of a negative cognitive style (Rose & Abramson, 1992), with repeated failures leading to feelings of hopelessness.

Hopelessness is a negative emotional state that arises from the belief that nothing will improve, problems will remain unsolved, and the future looks bleak. It involves the expectation that life holds no possibilities, goals will not be achieved, and nothing positive is forthcoming (Beck, Weissman, Lester, &Trekles, 1974). Snyder, Wrobleski, Parenteau, and Berg (2004) described hopelessness as the absence of hopeful thoughts, goals, direction, or motivation. People experiencing homelessness often share cognitive patterns, such as believing that bad events are unavoidable and beyond their control. These individuals may also develop negative self-perceptions, thinking they are worthless after failures, such as failing an exam. They tend to view a single setback as a sign of further negative events, for example, thinking they will never graduate if they fail a test (Metalsky& Joiner, 1992).

The transition into adolescence is often challenging, as childhood behaviours cease and new expectations begin to form. When these expectations are not met, adolescents may exhibit violent behaviours towards themselves and others (United Nations Children's Fund (UNICEF) and Board of Health, 2005).

Self-traumatization refers to individuals inflicting harm upon themselves, with suicide being one of the leading causes of death during adolescence. The most common age range for suicides globally and in our country is between 15 and 19

years. According to data from TUIK, 2,933 people died by suicide in 2010 alone. Many studies investigating the causes of suicide highlight hopelessness as one of the primary factors contributing to these deaths (Dilbaz& Seber, 1993; Tumkaya, 2005; Oguzturk& Frie, 2011).

According to Kashani and Frie (1989), high levels of hopelessness in children increase the risk not only of suicide and depression but also of various other forms of psychopathology. Fromm (1995) defines hope as being prepared for something that has not yet materialized, but not succumbing to despair if it does not come to fruition. Hope is neither passive waiting nor forcing unrealistic expectations under impossible circumstances.

Kierkegaard defines existence as "daring to be oneself" and views the lack of courage or failure to act as "hopelessness." According to Kierkegaard (2012), one of the primary forms of hopelessness is the despair that arises from the absence of belief. He argues that seeing death as the ultimate end leads to despair, as it denies the essence of existence, which is the belief that life holds meaning. Hopelessness, arising from the loss of the last hope, is synonymous with Kierkegaard's concept of "to die of death." The philosopher asserts that existence can transcend to the realm of "Existence" through belief, and that true hopelessness lies in "self-despair." In contemporary times, it is often believed that despair over external circumstances constitutes true hopelessness, but in reality, true hopelessness stems from self-despair, with a high likelihood of leading to death.

As Marcel suggested, there are studies that show how art or art education can help adolescents express themselves physically, mentally, and psychologically, providing an opportunity to alleviate the tensions of the adolescent period. For example, Freud (2007), in his analysis of the characteristics of fantasy, states that only those who are unsatisfied can dream, as happy people do not dream. He divides dreams into two categories: night dreams, which reveal disguised fulfillments of repressed wishes, and daydreams, where more pleasant desires emerge. Freud then draws a parallel between artists' works, which are freely created, and their daydreams, claiming that artists fulfill their wishes through their creations.

According to Malchiodi (2007), since expressing emotions through words can be challenging, many people find that performing art helps in conveying feelings of depression, confusion, anxiety, hopelessness, or disappointment. Art provides a way to express complex emotions that are often difficult to articulate or resist.

Hopelessness is a serious concern, as it is linked to a higher risk of suicide (Beck, 2006), reduced quality of life (Scogin et al., 2016), and heightened anxiety symptoms (Kocalevent et al., 2017). Additionally, it is a prominent symptom of depression.

Beck and colleagues' cognitive theory of depression (1963; 1979) suggests that repeated exposure to stressful life events can foster negative attitudes, which result in a tendency to process information in an overly negative manner (i.e., interpretation bias). When individuals consistently view situations negatively, they may come to expect that future events, relationships, and efforts will also end in disappointment. This continuous pattern of interpreting uncertainty in a negative light can eventually lead to feelings of hopelessness.

Managing the shift between feelings of hope and hopelessness is crucial for adolescents' psychological and emotional development. Adolescents tend to feel hopeful when they successfully develop their identity, but they may become hopeless when faced with failure. Hopeless adolescents often focus solely on the present, without any expectations for the future, leading to feelings of weakness, isolation, and a lack of belonging (Vasta, 2015). According to Kashani, Suarez, Allan, & Reid (1997), adolescents with high hopelessness scores may harm themselves or others, exhibit socially inappropriate behaviours, display anger and aggression impulsively, and experience a range of negative emotions, including shame, fear, guilt, and hostility. They may also struggle to experience positive emotions like interest or joy.

Atabek (1990) described hopelessness as a human emotion that leads individuals to feel that there is nothing they can do, causing them to become hopeless. Young and colleagues (1996) suggested that hopelessness is not a fixed trait; rather, it fluctuates within the same person over time. Adolescents often

experience hopelessness both at school and at home, particularly when their future seems uncertain and lacks direction. Failures and significant changes in life circumstances can trigger negative emotions, which, in turn, impact the individual's sense of self.

Life satisfaction

Life satisfaction is considered the cognitive aspect of subjective well-being, involving an overall assessment of one's life quality. As it is the most stable element of subjective well-being, life satisfaction is frequently used as the primary measure of an individual's perceived quality of life (Huebner et al., 2006).

Life satisfaction is often viewed as a subjective evaluation process, where individuals compare their expectations and goals with their ability to make progress toward achieving them (Diener et al., 1985; Myers & Diener, 1995). It involves an overall assessment of one's life by weighing accomplishments against challenges and expectations (Diener et al., 1985, 1999; Rees, 2017; Suldo& Huebner, 2006; Veenhoven, 1996). Thus, it is a relative measure that depends on both life outcomes and personal expectations. Life outcomes are partly influenced by an individual's actions and choices, but external factors beyond one's control can also have a significant impact. On the other hand, expectations are entirely psychological and can be adjusted to some extent. As a result, life satisfaction can be influenced not only by objective outcomes but also by modifying expectations, providing an opportunity for intervention.

Other researchers have observed a decline in subjective well-being (SWB) from early to late adolescence across various national samples and using different measures (Chui & Wong, 2015; Goldbeck et al., 2007; Liu et al., 2016; Park, 2005; Petito & Cummins, 2000; Soares et al., 2019). The findings suggest a decrease in subjective wellbeing linked to ageing up to around 15 or 16 years. However, Willroth et al. (2021) studied life satisfaction trajectories from middle adolescence (age 14) to late adolescence (age 17) and found that, on average, life satisfaction remains relatively stable between the ages of 14 and 17.

Life satisfaction is a key element of subjective well-being and a crucial area of research in psychology. It represents an individual's overall assessment or cognitive evaluation of their life as a whole. Life satisfaction includes various factors such as personal fulfillment, happiness, contentment, and the degree to which one's goals and desires are achieved (Landry, 2000).

Life satisfaction is affected by an individual's dispositional mood (positive or negative affect) and personality traits, such as neuroticism and extraversion. However, it is noted that the influence of other personality dimensions on life satisfaction remains uncertain. Furthermore, life satisfaction is generally found to be stable over time (Andrew & Withey, 1976; Heady & Wearing, 1989).

Kashdan and Steger (2007) suggest that discovering meaning in life is closely linked to well-being. They contend that having a sense of purpose and meaning enhances psychological well-being. When people view their lives as meaningful, they are more likely to experience greater life satisfaction, resilience, and overall positive well-being. This is consistent with the results of another research on the topic.

Suikkanen (2011), theory of life satisfaction presents an interesting perspective: a person is satisfied with their life when "a more informed and rational hypothetical version of them" would conclude that their life meets their ideal life plan. This approach addresses a key problem found in simpler versions of the theory, where a person is considered happy simply when they believe their life aligns with their ideal life plan.

The issue with this simpler version of the theory is that it may mistakenly suggest that someone is satisfied with their life simply because they feel temporarily or spontaneously happy, without taking into account a deeper reflection on how their life is progressing (Suikkanen, 2011). While experiencing spontaneous happiness is not problematic, true-life satisfaction requires more than just fleeting moments of happiness.

Recent studies have identified Life Satisfaction (LS) as a key component of Subjective Well-Being (SWB), which includes both cognitive and affective dimensions (Campbell et al., 1976). The cognitive dimension reflects an individual's overall satisfaction with their life (Overall Life Satisfaction) or with specific areas such as family, social relationships, or health (Domain Satisfactions). The affective dimension pertains to moods and emotions, which are further divided into positive and negative affect. Cognitive SWB is generally considered more stable over time compared to affective SWB, which can fluctuate based on daily events (Rees, 2017). This classification of SWB into cognitive satisfaction (overall or domain-specific), positive affect, and negative affect is known as the "tripartite model," a term coined by Arthaud-Day et al. (2005) and further developed by Metler and Busseri (2017).

Ryff (1989) defined psychological well-being (PWB) as the pursuit of excellence to fully realize an individual's potential. Well-being is characterized by the absence of anxiety, depression, and other psychological disorders (Ryff, 1995; Ryff & Keyes, 1995). It reflects the efficiency of an individual's psychological functioning (Gechman& Wiener, 1975; Jamal & Mitchell, 1980; Martin, 1984; Sekaran, 1985; Wright &Cropanzano, 2000), a sense of fulfillment in both personal and professional life, and optimal functioning (Deci & Ryan, 2008). It can indicate that life is progressing smoothly, a person feels good and performs tasks effectively (Huppert, 2009; Çankır& Semiz, 2018). Studies have shown that factors such as burnout, work engagement, workaholism, and job satisfaction are key indicators of psychological well-being (Bakker & Oerlemans, 2012; Mäkikangas et al., 2015) and positively influence work engagement and performance (Brunetto et al., 2012; Holman &Totterdell, 2002; Wright et al., 2007). Research also revealed a positive relationship between PWB (including environmental mastery, personal growth, and self-acceptance) and resilience (DeCaroli, 2014). In a study, 38.6% of participants had good mental health, 35.7% had moderate mental health, and about 25.7% had low positive mental health (Lakshmana &Dhanasekara, 2012).

General well-being is the subjective sense of happiness, contentment, and satisfaction with life experiences, as well as one's role in the workplace, sense of

achievement, purpose, and belonging, all without distress, dissatisfaction, or worry (Verma et al., 1989). Spiritual health is expressed through an individual's spiritual well-being (Fisher et al., 2000), which is reflected in their relationships with themselves (personal), others (communal), nature (environment), and God (or a transcendental being).

Well-Being

Well-being is an internal state where an individual feels that their psychological, physical, social, and environmental aspects are functioning well. It encompasses both objective and subjective elements and is considered the positive aspect of mental health. Synonyms for well-being include happiness, satisfaction, contentment, fulfillment, and joy—emotions that indicate a rich and complete life. Well-being is not a fixed state that one reaches after surpassing a certain level of good feelings; instead, it exists along a spectrum, from very low well-being (such as severe depression and hopelessness) to very high well-being (genuine, sustained happiness). Humans seek more than just the absence of pain; they strive for pleasure, meaning, and joy. Health is a key predictor of well-being across all ages.

Subjective well-being is an extensive concept that encompasses positive emotions, minimal negative moods, and high life satisfaction (Diener et al., 2002). It is a broader term than happiness. While happiness includes both emotional and cognitive dimensions, it is defined personally by each individual and is viewed as a relatively stable condition rather than a fleeting emotional experience (Veenhoven, 2011).

Well-being is an internal sense that encompasses overall psychological, physical, social, and environmental harmony. It consists of both objective and subjective aspects. Well-being represents the positive dimension of mental health and is synonymous with happiness, joy, satisfaction, enjoyment, fulfillment, pleasure, contentment, and other markers of a fulfilling life. It is not a fixed state achieved after reaching a certain level of happiness, but rather exists along a continuum, from very low well-being (such as severe depression and hopelessness) to very high well-

being (such as genuine happiness) that is maintained over time. Humans aim not just to avoid pain but to experience pleasure, joy, completeness, and meaning.

Health is the most significant factor influencing well-being in both younger and older individuals. A meta-analysis examining the relationship between well-being and health found a consistent correlation of about 0.32, with stronger correlations observed in women (Koenig et al., 2012). Subjective well-being refers to a person's overall assessment of their life, which includes both emotional responses to events and cognitive evaluations of life satisfaction and fulfillment.

As early as 1969, Bradburn observed that a person's psychological well-being is high when positive emotions outweigh negative ones, and low when negative emotions dominate over positive ones. Some researchers have suggested that subjective well-being, or happiness, consists of three key elements: positive emotions, life satisfaction, and the absence of negative emotions like depression or anxiety (Argyle et al., 1995).

Diener and colleagues (2002) suggested that the balance between positive and negative emotions is a key factor in determining subjective well-being or happiness. Seligman (2002) introduced a theory of happiness that consists of three elements: positive emotions and pleasure, engagement, and meaning. Happiness can be viewed from two main perspectives: (1) hedonism, which focuses on attaining pleasure and avoiding pain, and (2) eudaimonia, a concept from Aristotle referring to living in alignment with virtues and higher values. In this sense, well-being comes from finding meaning in life. Eudaimonia emphasizes what is intrinsically valuable for humans, fostering a sense of purpose and fulfillment (Ryan et al., 2008). Those who score high on eudaimonia seek to develop and utilize their best qualities.

The terms "*mental health*" and "*psychological well-being*" are often used interchangeably, but their meanings vary across different definitions and measures (Akin, 2008; Bennett, 2005; Gartoulla et al., 2015; Kinderman et al., 2011; Rose et al., 2006; Ryff & Keyes, 1995; Thatcher & Milner, 2014; Veit & Ware, 1983). Wilkinson and Walford (1998) caution against this interchangeable use and suggest

that it can lead to confusion in research. Akin (2008) agrees, highlighting that the lack of clarity and the interchangeability of terms such as happiness, mood, affect, subjective well-being, quality of life, and emotional health contributes to the inconsistent understanding of psychological well-being. Over time, the focus of research has shifted from measuring psychological dysfunction and distress to emphasizing positive psychology, which highlights positive functioning and the protective factors that contribute to mental health and psychological well-being.

Psychological well-being is seen as the presence of positive protective factors, going beyond simply the absence of psychological ill health symptoms. In contrast, psychological distress refers to the presence of symptoms that indicate poor mental health, which must exceed a certain threshold to be classified as distress. Common signs of psychological distress include depression and anxiety, often triggered by stress and compounded by a limited sense of ability to cope with it (Deasy et al., 2014). Psychological distress has been associated with higher rates of anxiety, depression, substance abuse, and personality disorders (Verger et al., 2009).

Resilience

Resilience refers to the capacity to reduce the impact of a disaster, recover to a condition equal to or better than before the event, and achieve this recovery in the shortest time possible. On the other hand, resistance describes the ability to endure a hazard with minimal damage. In this context, resilience encompasses resistance, but also extends to the ability to bounce back after experiencing harm from a hazard (Gilbert, 2010).

The concept of 'resilience' has been understood in various ways. It first emerged in the late 1800s to early 1900s, when researchers began exploring the physiological responses to coping and the psychological impacts of stress (Tusaie& Dyer, 2004). Early studies on resilience were indirect, stemming from medical and psychological research. Dawber, Meadors, and Moore Jr (1951) looked at disease patterns in adults and suggested that resilience was demonstrated by those who remained free of illness. Garmezy (1974) studied the psychological impact of

schizophrenia and observed that some individuals showed better adaptive functioning. Although Garmezy's finding was somewhat accidental, other research, such as Werner and Smith's (1989) longitudinal study, specifically examined the 'protective factors' (or resilience) in children exposed to harmful conditions like perinatal stress. The ability to overcome adversity or shield oneself from setbacks was believed to be linked to an individual's psychological and physiological traits.

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Rutter (1999; 2000) defined resilience as the ability to resist psychosocial risks to varying degrees. This perspective emphasizes a variety of outcomes, not solely positive ones. It does not necessarily assume that protection comes from positive experiences, nor does it suggest that the solution lies in how an individual copes with a negative experience in the moment.

The American Psychological Association (APA) defines resilience as the ability to successfully adapt in the face of trauma, tragedy, threats, or other major sources of stress (Southwick et al., 2014).

Resilience is described as a "process, ability, or result of effective adaptation in the face of challenges or threatening situations," as well as "positive outcomes despite being at high risk, maintaining competence under pressure, and recovering from trauma" (Masten, Best, &Garmezy, 1990).

Hunter (1999) views resilience as existing on a continuum with two extremes: less optimal resilience and optimal resilience. Less optimal resilience involves "survival strategies such as violence, risky behaviours, and social or emotional

withdrawal" (Hunter, 1999). Hunter argues that adolescents exhibiting this type of resilience often face maladaptation as adults.

Resilience is the inherent human ability to live life effectively. It is a quality possessed by all people akin to wisdom and common sense. It involves understanding how you think, your spiritual identity, your origins, and your future path. The key is learning to tap into this natural resilience, which is a fundamental right of every person. It requires understanding our inner spirit and discovering a sense of purpose (Heavy, Runner, and Marshall, 2003).

Resilience is understood as a dynamic process of change (Rutter, 2013). It typically refers to the capacity to overcome stress or adverse situations, or to withstand environmental risks (Bowes & Jaffee, 2013). Resilience can also describe a dynamic system's ability to endure or recover from significant challenges that threaten its stability, survival, or development. In human terms, resilience is the ability to adapt when facing hardship, adversity, and ongoing, substantial stress in life (Ma, Wang, Hu, Tao, Zhang & Shi, 2019).

Resilience is considered a protective factor within individuals, playing a crucial role in reducing stress and enhancing mental health (Morote, Hjemdal, Krysinska, Martinez, &Corveleyn, 2017; Ogińska& Michalska, 2020). Currently, three main models of resilience are recognized: the compensation model, the protection model, and the challenge model (Luthar, Cicchetti & Becker, 2000; Fergus & Zimmerman, 2005). The compensatory model of resilience is typically tested through direct effects, while the protective model is evaluated using interactions in multiple regression analysis (Anyan & Hjemdal, 2016).

Resilience, as a broad concept related to how individuals manage stress and recover from trauma, is viewed as a form of positive development, focused on the future and hope. It includes aspects like positive coping, harmony/compliance, and competence (Murphy, 1987). More generally, resilience is defined as the ability to successfully adapt, demonstrate significant effort and achieving success despite challenging and threatening circumstances.

Davydov and colleagues (2010) identified factors associated with resilience, some of which support and safeguard mental health. These factors include cognitive flexibility, such as reappraisal; meaning, which encompasses religion and spirituality; and the ability to transform feelings of traumatic helplessness into learned helpfulness, also referred to as motivation (Charney, 2004). Reappraisal and meaning will be discussed in more detail in the following sections, after exploring the concept of control. Specifically, it will be suggested that spirituality, reappraisal, and perceived stress contribute to resilience, which, in turn, influences motivation.

The American Psychological Association (APA) identified several factors that can help develop and strengthen resilience in individuals. However, these factors may not have the same effect on everyone, as different strategies work for different people. A personalized approach is important. While some individuals may prefer to handle stress on their own, others may benefit more from group settings. Nevertheless, the following strategies are generally helpful in many situations: "building connections, avoiding the perception of crises as overwhelming, accepting change as a natural part of life, working towards your goals, taking decisive actions, seeking opportunities, fostering a positive self-image, maintaining perspective, staying hopeful, and prioritizing self-care".

Factors of Resilience

The different factors of Resilience are:

(i) Protective Factors: A protective factor acts as a shield against challenges, helping to reduce or eliminate the impact of difficulties and promoting healthy adaptation and the development of an individual's competencies (Masten, 1994). The presence of protective factors, either within the individual or in their environment, can prevent problems from arising and decrease the likelihood of problematic behaviour. Additionally, these factors help individuals cope with difficulties by strengthening behaviours, attitudes, and knowledge, ultimately enhancing their emotional and physical well-being and reducing the impact of existing issues (Romano & Hage, 2000).

(ii) Social factors: Social factors encompass supportive relationships, access to resources, social support networks, and community ties. The presence of a strong social network and the availability of support from others can greatly influence an individual's ability to manage life stresses and crises. This support can come from family, friends, colleagues, or anyone within one's social circle who offers emotional, social, or even financial assistance. Research has shown that having these relationships can play a crucial role in an individual's ability to cope with significant stressors such as job loss, divorce, or chronic illness. Social support is often viewed as a combination of both practical and emotional support (Masten, 2007; Reinelt et al., 2015).

(iii) Psychological factors: Psychological factors include cognitive processes, problem-solving abilities, positive emotions, self-esteem, and emotional regulation. Both psychological and neurobiological factors are crucial in maintaining and restoring well-being after trauma or setbacks. Research on resilience examines various elements of an individual's makeup that affect their ability to handle adversity and attain well-being. These factors may involve personality traits, coping mechanisms, physical and cognitive capabilities, as well as neurocognitive structures and neural reactions to stress (Feder, Nestler, & Charney, 2009; Luthar et al., 2000).

(iv) Cultural factors: Cultural factors, such as beliefs, values, and traditions, influence how individuals perceive and express resilience. According to Healy (2006), community or cultural resilience refers to the ability of a specific community or cultural system to withstand disruptions and adapt to changes, all while maintaining essential aspects of its structure and identity that preserve its uniqueness.

Luthar (2006), and Masten and Obradović (2006) emphasized that a person’s environment and social influences play a role in shaping their resilience. It is now believed that resilience is a developmental process, rather than an innate trait, and it evolves throughout a person’s life (Cicchetti, 2010; Egeland et al., 1993; Kim-Cohen, 2007). Egeland and colleagues (1993) describe resilience as a transactional process that results from the interaction of biological, genetic, psychological,

sociological, and environmental factors. The outcome of this development is unique to each individual's experiences and how they respond to these interactions.

Henderson and Milstein (1996) describe resilience as a characteristic that varies from person to person and can fluctuate over time. Haynes (2005) highlights the key traits of resilient individuals, categorizing them into three areas: *a) social traits, b) emotional traits, and c) cognitive/academic traits.*

(a) Social characteristics are defined by the ability to form friendships, establish positive relationships with others, communicate effectively using appropriate language, and seek assistance when necessary.

(b) Emotional characteristics include a strong sense of self-efficacy, high self-confidence, self-esteem, and self-acceptance. They also involve the ability to regulate emotions, maintain awareness, quickly adapt to new situations, and endure anxiety and obstacles.

(c) Cognitive/academic characteristics are defined by a strong motivation to achieve, the ability to plan and consider the future, and the capacity to cope rationally with stressful and traumatic events. These individuals tend to make more internal attributions (such as effort or ability) rather than external ones (like luck). They also work to shape and improve their environment for the benefit of others. In summary, resilience includes personal traits that enable success despite challenges and is viewed as a dynamic, multi-dimensional quality that varies based on different circumstances (Garmezy, 1985; Garmezy& Rutter, 1985; Werner & Smith, 1992; Seligman & Csikszentmihalyi, 2000).

The resilience theory focuses on understanding the risk factors faced by adults, their strengths, and how they can experience healthy development despite challenges (Fergus & Zimmerman, 2005). In essence, the development of competence is linked to effective coping and positive adaptation in response to significant risks, difficulties, or trauma, which are central to the explanation of resilience as a dynamic process (Wolin & Wolin, 1993; Luthar & Cicchetti, 2000; Luthar, Cicchetti, & Becker, 2000; Masten & Reed, 2002).

Polk (1997) identifies four patterns that encompass the characteristics defining resilience:

1) *Dispositional pattern* – This includes ego-related and physical traits. Physical factors refer to inborn and genetic characteristics linked to resilience, such as intelligence, temperament, and health. Ego-related factors include self-confidence and self-reliance.
2) *Relation pattern* – This pattern involves the individual's social network, the support they can access, as well as their social activities, hobbies, and willingness to seek out connections.
3) *Situational pattern* – Resilience in this pattern is seen as a characteristic approach to stressors, involving cognitive appraisal, problem-solving skills, and the ability to take action in challenging situations. Traits like situational awareness, active problem-solving, curiosity, and creativity are part of this pattern.
4) *Philosophical pattern* – This pattern encompasses personal beliefs and ways of interpreting life events, such as the belief in life having purpose, that everything happens for a reason, or that there is inherent justice in the world.

Winfield (1994) argues that resilience is something that can be nurtured. From a young age, children can be taught how to become more resilient. This development can begin as early as preschool and continue through to college, with resilience being cultivated within a supportive environment. This environment can be created by fostering stronger relationships with peers and teachers, encouraging openness to giving and receiving help, setting long-term life goals, and providing students with mentors. Luthans, Vogelgesang, and Lester (2006) also outline several strategies for building resilience, including the use of positive emotions, self-enhancement, optimistic thinking, and hardiness.

Perry (2002) defines resilience as the ability to handle stressors without a significant negative impact on one's functioning. In developmental literature, resilience is often described in terms of protective psychological factors that promote positive outcomes and healthy personality traits (Bonanno, 2004). It is also

associated with positive coping, adaptation, or persistence (Greene et al., 2002). Researchers agree on the fundamental concept of resilience, which is the ability to manage risks in various ways, depending on individual differences. While some individuals may struggle with stress and adversity, others can adapt to challenges and even thrive despite them (Rutter, 1987).

Benard (1991) highlighted the importance of creating the right environmental conditions to nurture resilient individuals. She stated that resilient children possess social competence, problem-solving skills, autonomy, a sense of purpose, and hope for the future. Adult support is a crucial protective factor, helping children identify and solve problems. Social support is considered an essential factor in maintaining healthy behaviours (Celikel&Erkorkmaz, 2008). It is defined as the information that helps an individual feel loved, valued, cared for, and connected to a social network (Cobb, 1976). Research shows that individuals with strong social support systems are better at coping with stress, overcoming psychological issues (Callaghan & Morrissey, 1993; Shonkoff, 1984), and experiencingless anxiety, behavioural problems, and depressive symptoms (Barrera, Fleming & Khan, 2004). A lack of social support can negatively affect resilience and increase the frequency of depressive symptoms.

Resilience, as a broad concept related to how individuals manage stress and recover from trauma, is viewed as a form of positive development that fosters hope and a forward-looking attitude. It encompasses positive coping strategies, adaptability, and competence (Murphy, 1987). More generally, resilience is described as the ability to successfully adapt, putting in significant effort to thrive despite challenging and threatening circumstances. In the literature, resilience is defined in three main ways. The first refers to the ability to overcome difficulties and show better development than expected under high risk, or the belief in one’s strengths. The second emphasizes an individual's capacity to quickly adjust to stressful life experiences.Some research has focused on examining multiple stressors occurring simultaneously, exploring the protective factors that reduce the negative impacts of various stress sources on children and their behaviour, as well as the factors that increase their vulnerability. The third aspect of resilience involves

recovery from trauma. Studies in this area focus on individual characteristics and differences that play a key role in recovering from the potential effects of trauma. While destructive life experiences are generally expected to diminish an individual's quality of life, the concept of invulnerability—though frequently discussed—has never been fully accurate, as no one is truly "invulnerable." When stressors become overwhelming or life-threatening, resilience may give way to more severe traumatic experiences (Masten, 1994).

Resilience in high school students is complex and can be viewed in different ways, depending on whether it is considered as a capacity, process, or outcome (Lee et al., 2012). When seen as a capacity, resilience refers to an individual's ability to adapt positively to changes and stressful situations.

Depression

Depression is a mood disorder characterized by intense feelings of sadness and a loss of interest in activities. It is a common mental health issue among teenagers and can significantly impact their lives. Depression is a mood disorder that hinders individuals from functioning normally in their work, social life, or family interactions. Seligman (1973) described depression as the "common cold" of psychiatry due to its high prevalence.

Depression affects how teens think, feel, and behave, leading to emotional, functional, and physical challenges. Although it can occur at any stage of life, depression is a serious condition where individuals feel hopeless, worthless, and unable to lead a normal life. This mood disorder can cause severe emotional distress and changes in brain function that also affect the body. It can alter physical activity, lifestyle, and thought patterns, and contribute to a range of physical problems, impacting everything from the heart to the immune system.

Studies have shown that there are 197.3 million people with mental disorders in India, making up 14.3% of the country's total population. Among these, depressive disorders account for the largest share (33.8%), followed by anxiety disorders (19.0%), intellectual disabilities and developmental disorders (10.8%), schizophrenia

(9.8%), bipolar disorder (6.9%), and conduct disorder (5.9%). Additionally, the prevalence of depressive and eating disorders is significantly higher in females than in males (GBDS, 2020).

Depression is a prevalent global condition, affecting over 264 million people annually (GBDS, 2017). Major depression impacts 16% of the general population and ranks as one of the top ten causes of premature death and disability in the United States (Kessler et al., 2003; McKenna et al., 2005). Childhood abuse including sexual, physical, or emotional abuse (Collishaw et al., 2007; Lizardi et al., 1995; Ritchie et al., 2009); trauma exposuresuch as serious accidents, physical or sexual assault; and sudden or unexpected death of a loved one (Alim et al., 2008; Crichlow et al., 2006) are the significant risk factors for depression.

Depression is a global issue, with major depressive disorder affecting 6.7% of people in the United States, and severe depression impacting 2.0% (Kessler et al., 2005). This disorder significantly impairs a person's ability to function in work, relationships, and other life areas. The World Health Organization (WHO) forecasts that by 2020, major depression will be the second leading cause of disability worldwide, following cardiovascular diseases (Murray & Lopez, 1996). Among individuals aged 15 to 44 in the U.S., major depression is currently the leading cause of disability days (WHO, 2004). Depression not only affects daily functioning and quality of life but also contributes to physical health issues, such as driving people to suicide (over 1 million lives lost annually worldwide, according to WHO, 2009) or disrupting essential physiological functions like immune, endocrine, and cardiovascular systems. In the U.S., depression is estimated to cost over $65 billion annually (Berto et al., 2000).

Depression is a prevalent mood disorder influenced by both genetic and environmental risk factors, particularly the experience of stressful life events (Bouma et al., 2008; Maughan et al., 2013). When individuals face uncontrollable situations, they often exhibit feelings of helplessness and a loss of motivation, which can contribute to the development of depression (Seligman, 1972).

Religion and spirituality have been found to lower the risk of depression (Miller et al., 2012), although whether this effect is due to religious beliefs, behaviours, or social support remains debated. One study of over 1,000 adult residents in Detroit (Ellison et al., 2001) explored this issue. It found that attending religious services (such as church, temple, or synagogue) was linked to better psychological well-being and less emotional distress. However, frequent prayer was associated with lower well-being and more distress, and belief in eternal life was linked to greater well-being but not to reduced distress. Religious attendance was associated with lower distress even after adjusting for factors like age, gender, education, health issues, financial problems, family interactions, and personal resources like self-esteem. However, after accounting for health behaviours, social networks, and support, religious attendance no longer predicted lower depressive symptoms (Yeager et al., 2006). Overall, studies suggest that religious coping behaviours might be more protective against depression than religious beliefs alone.

Research has offered valuable insights into how resilience impacts psychiatric symptoms (Alim et al., 2008; Campbell-Sills et al., 2006; Collishaw et al., 2007). For example, children who experienced emotional neglect in childhood but had higher resilience exhibited fewer general psychiatric symptoms compared to those with low resilience (Campbell-Sills et al., 2006). Similarly, individuals who experienced childhood sexual or physical abuse showed no psychiatric issues (Collishaw et al., 2007), and those exposed to traumatic events were less likely to develop lifetime psychiatric disorders (Alim et al., 2008).

Depression is the leading cause of illness and disability globally. The World Health Organization (WHO) has raised ongoing concerns about this condition, as it affects more than 300 million people worldwide and carries a high risk of suicide, which is the second most common cause of death among individuals aged 15 to 29 (WHO, 2017).

Adolescent depression can negatively impact a teenager's social interactions, family relationships, and academic performance, often leading to serious long-term effects. Depressed adolescents face a higher risk of frequent hospitalizations,

recurring depression, social difficulties, alcohol abuse, and antisocial behaviours as they mature. The most tragic potential outcome of adolescent depression is suicide, which is the third leading cause of death among older adolescents (Centers for Disease Control, WISQARS).

Depression is a highly prevalent mental disorder among adolescents. Recent studies suggest that between 14.19% and 26.5% of teenagers globally experience depression (Islam et al., 2021; Paul & Usha, 2021). In Vietnam, the rate of depression among adolescents was found to be 31.7% (Tran et al., 2020; Tran et al., 2020). Depression has been linked to academic stress (Hoa et al., 2016; Jayanthi et al., 2015; Kang et al., 2013) which refers to the emotional strain students feel during their time in school. Academic stress impacts not only physical health but also the mental well-being of students (Acevedo et al., 2021).

Types of Depression

There are different types of Depression, which are:

(i) Major depressive disorder: Major depressive disorder is marked by a persistently low mood for most of the day, nearly every day, although in children and adolescents, this mood may be more irritable than sad. The disorder also leads to a significant loss of interest or pleasure in most activities, substantial weight fluctuations, sleep disturbances (either insomnia or excessive sleep), physical restlessness or sluggishness, fatigue, feelings of worthlessness, or inappropriate guilt. It can also affect concentration, provoke recurring thoughts of death or suicide, and may include a suicide attempt or a specific plan. These symptoms result in notable distress or dysfunction in social, work, or other critical aspects of life. In the United States, the 12-month prevalence rate is approximately 7%, with rates being three times higher among those aged 18 to 29 compared to those aged 60 and above. Additionally, women are about 1.5 to 3 times more likely to experience depression than men.

(ii) Persistent depressive disorder (dysthymia): Persistent depressive disorder (also known as dysthymia) combines chronic major depressive disorder and dysthymic

disorder as defined by the DSM-5. It is characterized by a depressed mood lasting most of the day, more days than not, for at least two years. In children and adolescents, the mood may be irritable, and the duration must be at least one year. The DSM-5 also states that individuals who meet the diagnostic criteria for major depressive disorder for two years should be diagnosed with persistent depressive disorder. During a depressive episode, individuals must show at least two of the following symptoms: poor appetite or overeating, insomnia or excessive sleeping, low energy or fatigue, low self-esteem, difficulty concentrating, or making decisions, and feelings of hopelessness. The prevalence of this disorder in the United States is 0.5%.

(iii) Premenstrual dysphoric disorder: The diagnostic criteria for premenstrual dysphoric disorder require that, in most menstrual cycles, at least five symptoms must occur during the final week before menstruation begins, with individuals experiencing improvement a few days after the start of menstruation, and the symptoms disappearing or nearly disappearing in the week following. Key features of the disorder include mood swings, severe irritability or anger, increased interpersonal conflicts, significant depressive mood and/or excessive excitement, and anxiety symptoms, which may be accompanied by behavioural and physical symptoms. These symptoms must occur during most menstrual cycles over the past year and negatively impact social and occupational functioning. The most conservative estimates suggest that 1.8% of women meet the criteria without experiencing functional impairment, while 1.3% meet the criteria and also experience functional impairment and other associated mental health disorders.

(iv) Substance/medication-induced depressive disorder: Substance/medication-induced depressive disorder is characterized by depressive symptoms, similar to those of major depressive disorder that are triggered by the use of a substance, such as through consumption, inhalation, or injection. These symptoms persist even after the effects of intoxication or withdrawal have subsided. Certain medications can also cause depressive symptoms, making it important to distinguish whether the symptoms are a direct result of the medication or if the depressive disorder occurred

independently while the medication was being used. In the United States, the prevalence of this disorder is 0.26%.

Depression can manifest as feelings of sadness, weakness, disappointment, frustration, despair, helplessness, and hopelessness (Sarason&Sarason, 2002). Many individuals experiencing depression may struggle in their academic lives due to a lack of confidence in their abilities. They might feel they are not meeting the expected performance standards, leading to ongoing feelings of disappointment and despair. Their negative perception of themselves and their situation can make them view themselves as failures, which can contribute to significant academic challenges, such as poor grades.

Chapter- 2

REVIEW OF LITERATURE

Adolescence is a crucial developmental stage, often referred to as the transitional period between childhood and adulthood. During this time, adolescents undergo rapid physical, mental, cognitive, social, and emotional growth. However, they also face a variety of challenges that they must navigate. According to Jessor (1991), risky behaviors in adolescents are those that hinder their ability to meet developmental tasks and fulfil expected roles, impacting their sense of competence and success and preventing a smooth transition into adulthood. These risky behaviors threaten adolescents' well-being and hinder their progress toward becoming responsible adults (Lindberg, Boggess & Williams, 2000; McWhirter et al., 2004).

Recent studies indicate that in the United States and other Western countries, the highest prevalence of various risk behaviors (those that could potentially harm oneself or others) occurs during the teenage years and early twenties. This trend is observed in behaviors such as criminal activity, substance use, risky driving, and unsafe sexual practices (Arnett, 1992; Moffitt, 1993). Unlike issues like parental conflict or mood disturbances, the rates of risky behaviors are at their highest in late adolescence or emerging adulthood, rather than in early or middle adolescence (Arnett, 1999).

Adolescence is a time of rapid change, especially evident in the hormonal and physiological transformations that occur during puberty (Susman et al., 2003). Alongside these physical changes, significant psychological and emotional shifts also take place. In the years after puberty, adolescents must navigate the challenge of developing their own identity, distinct from their parents, which can be stressful (Kroger, 2007). During this period, there is also an increase in risky behaviors such as substance use, delinquency, and sexual activity, particularly among boys (Bachman et al., 2002). One defining feature of adolescence is that development happens at varying rates across different areas, meaning that while adolescents may appear or feel mature in some ways, they may still exhibit immaturity in others.

Adolescents are highly social beings, spending a significant amount of time with their peers both in person and online (Boyd, 2014). They also devote considerable time to reflecting on their peer relationships (Richards, Crowe, Larson,

& Swarr, 1998). Studies show that adolescent friendships are more intricate than those in childhood, involving deeper levels of intimacy, trust, and reciprocity (Laursen & Hartup, 2002). The growing complexity and significance of these friendships are likely influenced by changes in social cognition, which refers to how we perceive and process social information about others.

Adolescents today face more challenges and difficulties than previous generations, yet they receive less guidance and support for their personal growth (Pajares &Urdan, 2004). Studies by Aldwin & Greenberger (1987), Bonner & Rich (1987, 1988), and Wilburn & Smith (2005) suggest that the stress experienced by adolescents and college students is linked to negative outcomes such as anxiety, depression, and suicidal thoughts. Conversely, effectively managing stress can enhance adolescents' overall well-being.

Adolescent and Religiosity

In recent years, developmental psychology has shown growing interest in adolescent religiosity and its impact on adolescent adjustment (Hardy et al., 2019). While religious practices vary based on culture, politics, local communities, and individuals, religion plays a significant or even central role in the lives of many people worldwide (Fisher, 2005; Hood et al., 2003).

Religion plays a significant role in development by serving as a context for socialization, particularly in areas such as moral behavior, and by providing emotional support throughout an individual's life (Hood et al., 2003; Roof, 1999). Research generally shows that religiosity is a positive predictor of pro-social behaviors in youth (e.g., social initiative) and a negative predictor of antisocial behaviors (e.g., substance use, delinquency). In terms of pro-social behaviors, Wagener and colleagues (2003) found positive outcomes linked to religiosity. Additionally, religiosity has been associated with lower levels of antisocial behavior. Chadwick and Top (1993) found that private religious practices (such as praying privately, reading scripture, and engaging with church literature) were negatively correlated with delinquency among Mormon adolescents.

Research has shown that higher perceived importance of religion can serve as a protective factor against antisocial behaviors, including substance use and abuse (Wagener et al., 2003; NCASA, 2001; Sinha & Gelles, 2007; Walker et al., 2007; Wills et al., 2003), truancy, sexual activity (Sinha & Gelles, 2007), and conduct problems, such as harming others (Wagener et al., 2003). Additionally, church attendance and other forms of organizational religious involvement have been negatively associated with risky behaviors like smoking, alcohol use, drug use, sexual activity, delinquency, and harming others (Wagener et al., 2003; Good & Willoughby, 2006; Sinha & Gelles, 2007; Walker et al., 2007; Johnson et al., 2000). Overall, there is strong evidence supporting the link between religiosity and positive social behaviors in youth, as well as the avoidance of negative behaviors, although much of this research has focused on Western populations.

Some research findings evinced a connection between adolescents' self-perceived religiosity and their levels of school engagement and helping behaviors (Wagener et al., 2003; Dowling et al., 2004)). "Religious importance" (Wallace & Forman, 1998) was also a predictor of positive health behaviors, including seat belt use, healthy eating habits, sleep patterns, and exercise among high school seniors. Furthermore, studies based on representative samples of adults in the U.S. and Canada revealed that higher frequencies of prayer and religious reading were positively associated with volunteerism (Lam, 2002) and civic participation (Loveland et al., 2005).

Furthermore, Good and Willoughby (2006) found that church attendance was uniquely linked to higher levels of life satisfaction. Positive correlations have also been observed between personal prayer and self-esteem (Francis & Evans, 1996), as well as between overall religiosity and self-esteem (Ball et al., 2003).

Religiosity has been shown to protect against negative psychological outcomes in youth, such as depression. For instance, the perceived importance of religion (Sinha et al., 2007), "relational spirituality" (Wright et al., 1993), and the "meaningfulness of religion" have all been associated with lower levels of depression in youth. Participation in worship and other religious activities has also been linked

to lower depression levels among both American youth (Sinha & Gelles, 2007; Wright et al., 1993) and Canadian youth (Good & Willoughby, 2006). Additionally, higher frequencies of prayer have been associated with lower depression among adolescents in Ireland (Francis & Evans, 1996) and young adults in the UK (Maltby, 1999). Overall, there is substantial evidence supporting the connection between religiosity and improved psychological well-being in youth.

Religiosity is linked to greater self-control and improved emotional regulation, which help reduce risky behaviors (Hardy et al., 2020; Holmes et al., 2019). Moreover, faith-based communities play a role in social control by promoting moral values that oppose deviant behavior (King, 2003).

Religiosity can also serve as a protective factor against adolescent depression and internalized symptoms (Cooley et al., 2021; Wenger, 2011). The importance placed on religion can provide support and comfort when dealing with personal challenges. In particular, involvement in organized religious activities enables adolescents to interact with peers and adults, gain psychological support, and alleviate feelings of loneliness.

While the protective effects of religiosity against externalized and internalized risks are well-established, research has only recently begun to explore its role in fostering positive adolescent development and well-being (Iannello et al., 2020). According to the Positive Youth Development (PYD) framework (Lerner et al., 2009), religiosity is seen as a resource that supports both individual and social growth in youth. Studies have shown that religiosity positively influences prosocial behavior, social skills, psychological well-being, and life satisfaction (Abdollahzadeh Rafi et al., 2020; Bjorck et al., 2019; Fariddanesh& Rezaei, 2019; Yonker et al., 2012). Moreover, the value placed on religiosity has been found to significantly enhance psychological well-being, even beyond the effects of religious participation and the frequency of public or private prayer (Hardy et al., 2019; Longo et al., 2018).

Multiple studies have acknowledged the protective role of religiosity in addressing various challenges that adolescents may face. Regarding externalized

problems, this protective effect is largely attributed to the adherence to traditional values, which oppose deviant behaviors (Hardy et al., 2019).

Adolescent and Hopelessness

Hopelessness plays a significant role in the overall behavioral development of adolescents. Defined as having negative expectations about oneself and the future, hopelessness is a contributing factor to various psychopathological conditions. These negative expectations can make adolescents more susceptible to stress, leading to behavioral disorders. Children with high levels of hopelessness tend to exhibit a temperamental profile similar to that of a "difficult" child: characterized by a negative mood, low adaptability, aggression, violence, and withdrawal (Kashani et al., 1991). Due to the pressures and stressors linked to these negative traits, such children may be perceived as "obstinate" by others.

Research has shown that in high school adolescents, hopelessness levels decrease as emotional expression, particularly positive emotional expression, increases (Çelik, 2015). Similarly, a negative relationship was found between loneliness and emotional expression, meaning that as emotional expression improves, loneliness tends to decrease (Akın, 2012). Studies exploring the link between emotional intelligence and loneliness also report a negative relationship, with loneliness decreasing as emotional intelligence increases (Mercan et al., 2015; Lee & Ko, 2018). However, it has also been found that loneliness and hopelessness levels tend to rise and fall together, indicating a positive relationship between the two (Chang et al., 2010; Girgin, 2009; Kırımoğlu et al., 2010).

Adolescence is often seen as a time when emotions, both positive and negative, are experienced intensely, and reactions tend to be extreme (Yörükoğlu, 1993). During this period, individuals may lose self-confidence and feel overwhelmed by hopelessness (Yörükoğlu, 1992). Comer (2002) defines hopelessness as a persistent, pessimistic, and discouraged mindset. In this state, individuals hold beliefs related to their unchanging emotional conditions, situations, and problems. Atabek (1990) noted that hopelessness is a human emotion that leads

individuals to feel as though there is nothing that can be done, resulting in a sense of despair.

Hopelessness is not a fixed trait but rather something that can change over time within the same individual (Young et al., 1996). Adolescents may experience hopelessness at various times, both at school and at home. Uncertainty about the future, difficulties in self-guidance, failures, and significant changes in living conditions can lead to negative feelings. These feelings, in turn, can impact their sense of self. Self-respect refers to an individual's overall sense of self-worth, self-confidence, and self-acceptance (LeRoy, 1996). It is an assessment of one's value (Kılıççı, 2006). In this context, self-respect is linked to the belief that one is talented, successful, valuable, and important (Salami, 2010). It involves the need to evaluate oneself positively, with high self-respect characterized by fully accepting, appreciating, and trusting oneself as an individual (Salmivalli et al., 1999).

Recent research has continued to examine hopelessness as a cognitive risk factor and has consistently found that it plays a significant role in suicidal behaviors among adults (McCullumsmith et al., 2014; Kuo et al., 2004; Brown et al., 2000). Hopelessness has been linked to suicidal thoughts (Smith, Alloy, & Abramson, 2006), suicidal intent (Dyer& Kreitman, 1984; Wang et al., 2015), and suicide attempts (Beck et al., 1990). Additionally, some studies suggest that hopelessness may act as a mediator between depressive symptoms and suicidality (Rosellini & Bagge, 2014; Woosley, Lichstein, Taylor, Riedel, & Bush, 2014), indicating that hopelessness could help explain the connection between depression and suicidal behaviors.

Beck and his colleagues (1974) identified hopelessness as a crucial factor connecting depression and suicidality in adults. They later proposed that hopelessness might offer more insight than depressive symptoms when examining suicidal thoughts (Steer et al., 1993). More recent studies have also explored hopelessness as a predictor of suicidality (Beck, Brown, Steer, Dahlsgaard, & Grisham, 1999) which predicts suicidal ideation, even after accounting for depressive symptoms (Labelle et al., 2013).

Adolescents who experience higher levels of hopelessness are at a greater risk for suicide (DeCamp& Bakken, 2016). Additionally, Bergen and colleagues (2003) identified a strong link between hopelessness and suicide risk, including suicidal ideation. In a study by Horwitz and colleagues (2017) examining the impact of hopelessness on suicidal behavior, the results showed that having no positive expectations for the future, rather than holding negative expectations, is a key indicator of future suicidal behavior in adolescents.

Stewart and colleagues (2005) found that hopelessness is the most significant factor contributing to suicidal thoughts in adolescents, even when accounting for depression (Nock &Kazdin, 2002; Labelle et al., 2013). Along with the strong link between hopelessness and suicidality, demographic factors, such as gender, have also been recognized as risk factors for suicidal behaviors in adolescents (Cash & Bridge, 2009).

Over the past two decades, several studies have explored the connections between depression, hopelessness, and suicidal thoughts (Beck, 1986). Pfeffer et al., (1988) suggested that hopelessness was not linked to suicidal thoughts in healthy children, while Cole (1989) found that hopelessness was not associated with suicidal behaviors in male high school students and only showed a moderate link in female students when depression was accounted for. In contrast, Asarnow and Guthrie (1989) discovered that hopelessness was positively correlated with suicidal ideation in child psychiatric inpatients.

Adolescent and Life Satisfaction

Longitudinal studies have highlighted the significance of adolescent life satisfaction, showing that lower levels of life satisfaction are linked to future externalizing and internalizing behaviors, as well as experiences of peer victimization (Haranin et al., 2007; Martin et al., 2008).

Adolescence is a unique developmental period, distinct from both childhood and adulthood, characterized by specific challenges and opportunities. While it can be a time of good health and well-being, the vulnerabilities related to self-discovery

and growing independence present significant risks to adolescents' health (Irwin, Burg, & Cart, 2002).

Throughout adolescence, the quality of family relationships is more influential on overall life satisfaction than peer relationships, school experiences, or community involvement (Dew & Huebner, 1994; Huebner, 1991). Although adolescents spend more time with peers, family relationships remain the most significant factor in their lives. Therefore, it is essential to identify which specific aspects of family dynamics contribute to optimal well-being and life satisfaction.

Research has shown that adolescents' life satisfaction is linked to various family factors, including parental involvement, positive parent-child relationships, and parental social support (Ash & Huebner, 2001; Demo &Acock, 1996; Dew & Huebner, 1994; Flouri& Buchanan, 2002; Gilman & Huebner, 2006; Gilman et al., 2000; Leung & Zhang, 2000; Storksen et al., 2005; Suldo& Huebner, 2004; Suldo& Huebner, 2006; Young et al., 1995; Zimmerman et al., 1995).

Suldo and Huebner (2006) highlighted the importance of parental support for adolescent well-being by examining individuals with low, average, and high levels of life satisfaction. Their findings showed that the level of parental support varied across the three groups, with higher support linked to greater life satisfaction. Parental support was found to be a crucial factor for high life satisfaction, as over 92% of adolescents in the high-satisfaction group reported above-average parental support. Overall, a negative family environment is associated with lower well-being, and adolescents who experience high levels of conflict, disagreement with parents, and family-related stress tend to report lower life satisfaction (Ash & Huebner, 2001; Bradley & Corwyn, 2004; Demo &Acock, 1996; Phinney & Ong, 2002).

Research has also shown a strong link between family structure and life satisfaction (Bradley & Corwyn, 2004; Demo & Acock, 1996; Flouri & Buchanan, 2002; Storksen et al., 2005; Zullig, et al., 2005).

Low life satisfaction in adolescence has been linked to adjustment issues during the adolescent years as well as lower life satisfaction in adulthood. However,

there are limited well-established tools to assess life satisfaction in adolescents. Additionally, few studies have examined the measurement invariance of these tools, despite evidence suggesting that their effectiveness may vary across different racial and ethnic groups (Zeng et al., 2018).

Suldo and Huebner (2004) discovered that adolescents with high life satisfaction were less likely to display future externalizing behaviors following major life stressors. Thus, life satisfaction can be considered a valuable psychological resource that supports positive development.

Many researchers believe that students' overall satisfaction is influenced by various factors, including their academic achievement, relationships with teachers, social life, workload, finances, security, and other aspects of their experiences (Lounsbury et al., 2005).

Research has demonstrated that an individual's self-esteem plays a significant role in determining their level of life satisfaction. In individualistic cultures, how a person feels about themselves is more closely related to their life satisfaction than to their satisfaction with community life (Diener & Diener, 1995). Previous studies in Western contexts have shown that self-esteem is a strong predictor of life satisfaction (Diener & Diener, 1995).

An increasing amount of research highlights the importance of life satisfaction for the psychological, educational, social, and physical well-being of children and adolescents (Suldo et al., 2009), underscoring the need for a comprehensive understanding of both stable and changeable factors that influence life satisfaction in youth.

Suldo and Shaffer (2008) emphasized the importance of understanding life satisfaction in youth, showing that students with high life satisfaction and low levels of psychopathology tend to have better academic performance, social relationships, and physical health compared to their peers who, despite having low psychopathology, report lower life satisfaction. Other studies have suggested that the benefits of high life satisfaction include more positive attitudes toward teachers and

school (Gilman & Huebner, 2006), greater cognitive engagement (Lewis et al., 2011), and higher academic aspirations (Proctor et al., 2010). A thorough understanding of the factors related to life satisfaction is crucial, particularly to identify which elements are most likely to put students at risk for lower life satisfaction.

Research has indicated that adolescents who display greater openness to experience tend to have higher life satisfaction, aligning with earlier studies that highlight the connection between openness and positive traits, such as academic achievement, in youth (Barbaranelli et al., 2003; Mervielde et al., 1995).

As research on life satisfaction has grown to include adolescents, a similar pattern has been observed. Lower life satisfaction is linked to higher levels of aggression and victimization in middle school-aged and older adolescents (Valois et al., 2006; Martin et al., 2008).

A longitudinal study showed that adolescents with high life satisfaction exhibited fewer externalizing behaviors following stressful events compared to those with low life satisfaction (Suldo& Huebner, 2004). Additionally, recent findings suggest that life satisfaction plays a key role in fostering optimal functioning in adolescents (Suldo & Shaffer, 2008). Suldo and Shaffer's research found that even without significant psychopathological symptoms, adolescents with low life satisfaction experienced poorer social functioning, physical health, and academic achievement.

Unlike individuals with depression, those who value life make efforts to overcome challenges and persist through difficult circumstances. Life satisfaction supports this resilience. It is closely linked to morale, adaptation, and psychological well-being (McDowell, 2010). Life satisfaction involves individuals' cognitive evaluations of their own lives and is considered a fundamental aspect of subjective well-being (Joshanloo, 2013). It refers to a person's internal, subjective assessment of their life quality. When life satisfaction decreases in children and adolescents, traits like extroversion, internal locus of control, self-concept, active coping, and pro-social behavior tend to decline, while behaviors such as substance abuse and

psychopathological issues increase (Huebner, 2004). Skills that boost self-esteem and help cope with stress have been identified as significant predictors of life satisfaction in secondary school students (Sahin-Baltaci, 2013).

Adolescent and Resilience

Adolescence is a phase of rapid growth and transformation, during which individuals face a variety of stressors. During this time, resilience is crucial as an adaptive, stress-resistant quality. Recent research suggests that several factors contribute to resilience in adolescents, with internal characteristics such as self-esteem, self-efficacy, perseverance, internal locus of control, and effective coping and adaptation skills playing a key role.

Resilience in high school students is a complex concept that can be viewed as a capacity, process, or outcome (Lee et al., 2012). As a capacity, resilience refers to an individual's ability to positively adjust to changes and stressful situations.

Hartley (2011) proposed that resilience plays a crucial role for students navigating the challenges of higher education. While stressful situations can adversely affect students physically, psychologically, and academically, many continue to thrive and succeed in their pursuit of a higher education. Tinto (1975) suggested that academic persistence, which can be understood as academic resilience, is closely linked to students' motivation to attend classes and study. In a study of 605 undergraduate students in the United States, Hartley found that resilience positively influenced grade point average (GPA) scores.

Gizir (2004) examined the academic resilience of eighth-grade students in primary education and found that key external protective factors influencing the academic resilience of economically disadvantaged students include high expectations at home, supportive and caring relationships at school, and nurturing friendships.

Ozcan (2005) reported that high school students with intact families exhibit higher levels of resilience and protective factors compared to those with divorced

parents. Additionally, no significant gender differences were found in their resilience levels.

Sipahioglu (2008) discovered that adolescents from different risk groups showed varying levels of resilience, influenced by factors such as family poverty, living with a single parent, gender, and the type of school attended. Onat (2010) noted that first-grade high school students who view their parents as democratic tend to have significantly higher levels of resilience. Adolescents who experience negative life events tend to have lower resilience scores compared to those with few or no such experiences (Hjemdal et al., 2006). Resilience has evolved into a broad concept that includes nearly all protective factors.

Physical activity appears to contribute to positive psychosocial outcomes (Andreassen, 2009; Biddle & Asare, 2011; Pickett et al., 2012), with adolescents who engage in regular physical activity reporting higher levels of protective factors associated with resilience compared to their peers (Hjemdal et al., 2006; Strohle, 2009).

Research has shown that adolescents involved in activities requiring social interaction and cooperation tend to score higher in resilience than those who are not (Hjemdal et al., 2006). Additionally, a study by Gerber et al., (2012) found that individuals who met the recommended level of physical activity demonstrated greater mental toughness compared to those who did not.

Recent studies on wellbeing and resilience have emerged in response to the growing rates of anxiety and depression among young people (Australian Bureau of Statistics, 2007; Department for Education and Child Development, 2016).

Benard (1991) highlighted the importance of creating suitable environmental conditions to nurture resilient individuals. She noted that resilient children possess social competence, problem-solving skills, autonomy, a sense of purpose, and hope for the future.

Research has shown that individuals with strong social support systems are better at managing stressful life events (Callaghan & Morrissey, 1993; Shonkoff, 1984), overcoming psychological challenges (Lara, Leader & Klein, 1998), and experience lower levels of anxiety, behavioral issues, and depressive symptoms (Barrera et al., 2004). A lack of social support, on the other hand, negatively impacts resilience as a protective factor and plays a significant role in the frequency of depressive symptoms.

Positive family traits have a beneficial impact on children's resilience. Additionally, supportive relationships with neighbors, as well as positive connections with friends and teachers, are also factors that enhance resilience (Soest et al., 2009).

Gizir (2004) studied the academic resilience of eighth-grade primary school students and found that key external protective factors influencing the academic resilience of economically disadvantaged students include high expectations at home, support and care in school relationships, and nurturing friendships. Ozcan (2005) noted that high school students with both parents together show higher levels of resilience and protective factors than those with divorced parents, and there are no significant gender differences in their resilience.

Dayioglu (2008) discovered that learned strength, perceived social support, and gender are significant predictors of resilience in adolescents preparing for the university entrance exam. Additionally, Dayioglu (2008) reported that males exhibit higher levels of resilience than females.

Oktan (2008) found that resilience in adolescents preparing for the university entrance exam varied significantly based on problem-solving ability and life satisfaction. Onder and Gulay (2008) identified a significant connection between self-concept and resilience in eighth-grade students.

Onat (2010) reported that first-grade high school students who perceive their parents as democratic exhibit significantly higher levels of resilience. Additionally, students' resilience levels were found to differ significantly based on factors such as the school they attend, age, number of siblings, family income, mother's education

level, parents' occupations, the father's place of upbringing, the protective attitude of the parents, and the parenting style employed.

Karatas and Savi-Cakar (2011) discovered that self-esteem and hopelessness are key predictors of resilience in adolescents. Savi-Cakar and Karatas (2011) also found that adolescents perceived social support significantly predicts their resilience levels. There is a positive correlation between adolescents' resilience and the social support they receive from family, friends, and teachers, with girls exhibiting higher resilience levels than boys.

Adolescent and Depression

Adolescent-onset depression is associated with more chronic, severe, and disabling symptoms, higher rates of family history, and an increased risk of suicide attempts compared to depression that begins in adulthood (Zisook et al., 2007). Adolescents with a major depressive disorder often experience recurrent episodes and differ from adults in that sadness is less prominent; instead, they are more likely to exhibit irritability, anhedonia, suicidality, hypersomnia, and issues with cognitive function and circadian rest-activity rhythms (Emslie et al., 2005; Sørensen et al., 2005; Teicher et al., 1993). While the diagnostic criteria for depression are similar for children and adolescents, the specific symptoms vary by age group.

Some studies have found that higher levels of physical activity and sports participation are linked to lower depressive symptoms (Hallal, Victora, Azevedo, & Wells, 2006; Kirkcaldy et al., 2002; Motl et al., 2004; Sagatun et al., 2007; Sund et al., 2011). However, other research has reported no connection between physical activity and depressive symptoms (De Moor, et al., 2008; Rothon et al., 2010).

A negative outlook on the world during early childhood can lead individuals to develop self-doubt. As a result, the negative aspects of their experiences become more pronounced, and life events that cause significant stress heighten the risk of depression (Erdogan, 2006). Depression can manifest through motivational symptoms such as apathy and boredom, while physical symptoms may include sleep disturbances, fatigue, and loss of appetite (Steinberg, 2002).

Negative cognitive patterns, such as cognitive distortions, negative attributions, hopelessness, and low self-esteem, are prevalent across children, adolescents, and adults. However, the core symptoms of depression, such as anhedonia and helplessness, can make it challenging to identify the disorder promptly in school settings. It is important to note that depression that begins during adolescence is typically more chronic, severe, and disabling, with higher rates of family history and more suicide attempts compared to depression that starts in adulthood (Zisook et al., 2007).

Adolescents with major depressive disorder experience recurrent episodes, and unlike adults, sadness is less pronounced. Instead, they are more likely to exhibit irritability, anhedonia, suicidality, hypersomnia, as well as cognitive and circadian rest–activity rhythm issues (Emslie et al., 2005; Sørensen et al., 2005; Teicher et al., 1993). While the diagnostic criteria for depression are similar for children and adolescents, the specific symptoms vary by age group.

Kovacs et al., (1963) observed that adolescents with depression tend to experience more hypersomnia, fewer changes in appetite and weight, and report fewer delusions compared to children. In contrast, depressed preschool-aged children exhibit typical depression symptoms, such as mood disturbance and anhedonia, but have fewer "masked" symptoms, like sleep disturbances and appetite changes.

Similar to anxiety disorders, the prevalence of depression is higher in females than in males starting from adolescence, but not before (Wade et al., 2003). The onset of depression in female adolescents is linked to hormonal changes triggered by menarche, which often include symptoms such as anxiety, fatigue, and disturbances in sleep and appetite (Patton et al., 1996). For those experiencing premenstrual dysphoric disorder, which commonly includes body image dissatisfaction, feelings of failure, concentration issues, and work difficulties, a hypothesis suggests that a progesterone withdrawal syndrome may explain these symptoms, as observed in both clinical and preclinical studies (Saavedra et al., 2006). Female adolescents are more likely to display cognitive and physical symptoms, while depressed boys often

experience heightened boredom, possibly due to a greater level of anhedonia in boys (Bennett et al., 2005).

Adolescent depression is a condition that arises during the teenage years and is characterized by prolonged sadness, feelings of hopelessness, low self-esteem, and a lack of interest in typical activities like hobbies and games. Adolescents are particularly vulnerable to depression, with community prevalence rates ranging from 2.9% to 8%, and up to 25% of young people meeting the criteria for a major depression diagnosis by late adolescence (Lewinsohn et al., 1993).

Sigfusdottir and Silver (2009) investigated the impact of negative life events on anger and depressive mood in adolescents. Their findings revealed that (i) boys and girls typically encounter different types of negative life events, (ii) both genders experience similar levels of anger in response to these events, (iii) negative life events are more strongly linked to depressive mood in girls than in boys, and (iv) conflicts with family and friends are more predictive of anger and depression in both genders than other negative life events.

During adolescence, there is a significant increase in the risk of depression for girls, with a sharp rise in the rates of symptoms and disorders between the ages of 13 and 15, while the rates for boys remain relatively unchanged (Galambos et al., 2004). By early adulthood, women are twice as likely as men to experience depression. In a longitudinal study of children in grades 6 through 12, Petersen and Spiga (1982) found no gender differences in depressed mood before 8th grade.

Rudolph and Hammen (1999) conducted a study with 88 teenage boys and girls, averaging 13 years old, who were receiving treatment at a mental health clinic. The teens and their parents shared information about specific challenging events in the teens' lives, such as conflicts with parents, academic failures, or relocating to a new home. The adolescents also filled out standard questionnaires assessing their symptoms of depression and anxiety. Depression was found to be more prevalent among adolescents who faced high levels of conflict with others (Center for the Advancement of Health, 1999).

Xiaojia and colleagues (1994) studied the trajectories of life events and depressive symptoms during adolescence. They found that the patterns of depressive symptoms differ between boys and girls. Girls, compared to boys, experienced a higher number of depressive symptoms after the age of 13. Changes in uncontrollable events were linked to increased depressive symptoms in girls but not in boys. Latent growth curve analyses revealed that, over a period of four years: (i) depressive symptoms in girls followed a curvilinear pattern associated with changes in stressful events; (ii) the level of depressive symptoms was related to the level of life events for both genders; and (iii) changes in depressive symptoms were significantly linked to changes in stressful events only for girls. Additionally, girls with less supportive mothers were found to be more vulnerable to the negative impacts of life changes.

Depression is a prevalent condition worldwide and a significant contributor to mental health challenges (Sarokhani et al., 2013). The mental health of students is a universal concern, affecting societies across the globe, regardless of their level of development or cultural background (Bayram &Bilgel, 2008). University students, in particular, encounter numerous pressures and conflicting demands as they strive for academic success (Arslan et al., 2009).

Understanding issues related to students' mental health is crucial. Research has shown that mental health problems, including depression, are more common among students than in the general population (Yusoff et al., 2013). Furthermore, recent studies suggest that psychological and mental health challenges among students are on the rise (Field et al., 2012).

Depression is one of the most common mental health issues and poses a significant challenge within the student population (Ibrahim et al., 2013). It greatly affects students' academic performance, satisfaction, and overall achievement (Arslan et al., 2009). Research by Wechsler, Lee, Kuo, and Lee (2000) revealed that students experiencing depressive symptoms tend to earn lower grades and participate less actively in class compared to their peers without such symptoms. These findings

highlight the critical need for psychological support to address this widespread issue among students.

In recent years, numerous studies have examined the prevalence of depression among students (Chen et al., 2013). These studies indicate that depression is a widespread issue and is steadily increasing within the student population (Sarokhani et al., 2013). For example, one study found that the prevalence of depression among university students in Turkey ranged from 10% to 40% (Ustun& Kessler, 2002). Additionally, other research has reported that over 27% of students experience depressive symptoms, making it one of the most frequent concerns addressed by university counseling centres (Mobley, 2008).

Gender Difference in Religiosity

Research indicates that religiosity levels vary between genders. Females tend to attend church more frequently than males (Wright et al., 1993) and engage in personal prayer more often (Francis & Evans, 1996). In general, young women seem to demonstrate stronger religious beliefs and practices compared to young men (Smith et al., 2002).

Studies suggest that boys exhibit higher levels of self-esteem (Plunkett et al., 2007; Lawrence et al., 2006) and are more likely to engage in antisocial behavior (Pedersen & Kolstad, 2000; Storvoll & Wichstrøm, 2003) compared to girls. However, boys tend to have lower rates of depression (Galambos et al., 2004; MacPhee & Andrews, 2006).

Several trends have emerged in sociological research on religiosity. Church attendance has decreased over the past decades, particularly among men (Walter, 1990). Men are also more likely to drift away from church membership at a younger age compared to women; a behavior often deemed socially acceptable (Francis & Lankshear, 1991; as cited in Francis & Wilcox, 1998). Numerous surveys assessing religious belief and practice consistently show that women display more positive attitudes toward religion than men (Francis & Stubbs, 1987; Francis & Wilcox, 1998;

Walter, 1990) and that religion plays a more significant role in their daily lives (Thompson, 1991). Conversely, teenage boys tend to view religious beliefs as secondary to other aspects of spirituality, focusing instead on developmental milestones such as forming relationships (Engebretson, 2004). These findings collectively suggest that women are generally more religious than men in both personal devotion and public worship, with few exceptions to this pattern (Thompson, 1991) while various theories seek to explain this disparity.

Research suggests that gender influences the relationships between various socialization contexts, such as parental influences, and youth development (Heaven & Ciarrochi, 2008). Additionally, gender is associated with both youth religiosity and overall functioning, making it worthwhile to explore whether gender moderates the relationship between religiosity and youth outcomes. Only one study has specifically examined this question. Milot and Ludden (2009) identified significant gender interactions for academic self-efficacy and school bonding, with religiosity offering greater protective benefits for males. However, gender interactions were not significant for outcomes like depression, self-esteem, substance use, or school misbehavior about the importance of religion or attendance.

Numerous studies have documented this gender difference through observations and analyses. For instance, a longitudinal study on adolescent religious involvement confirmed that females generally perceive themselves as more religious and participate more actively in religious activities compared to males (King & Boyatzis, 2004; McCullough et al., 2003).

Research has consistently highlighted gender differences in religiosity among adolescents (Smith & Denton, 2005; Wallace et al., 2003). Smith and Denton found that adolescent girls aged 13–17, compared to boys of the same age, (1) attend religious services more often, (2) perceive religion as having a greater influence on their daily lives, (3) are more likely to make personal commitments to live for God, (4) participate more frequently in religious youth groups, (5) pray alone more regularly, and (6) feel a stronger sense of closeness to God. These gender differences,

though relatively small in magnitude, persist even after accounting for the adolescents' social backgrounds. Moreover, these differences tend to continue into adulthood (Batson et al., 1993; Donahue & Benson, 1995).

Gender difference in Hopelessness

Recent research indicates that female adolescents are 2.16 times more likely to experience suicidal ideation than their male peers (Rew et al., 2016). Similarly, hopelessness was found in females and twice as likely to report suicidal thoughts as hopeless males, even when depression was accounted for (Labelle et al., 2013). Female adolescents who experience suicidal ideation are also more likely to attempt suicide (American Association of Suicidology, 2016; Nock et al., 2013). However, adolescent males are more likely to die by suicide ("WISQARS Leading Causes of Death Reports," 2015).

Researchers explored gender differences in depression within the context of the hopelessness theory of depression (Stone et al., 2009). The study investigated how negative inferential styles mediate gender differences in depressive symptoms. A sample of 458 participants was used, and data were gathered using various measurement tools. The analysis revealed that boys experienced greater hopelessness than girls. Additionally, the study concluded that stress and inferential styles play a moderating role in hopelessness, contributing to the development of depressive symptoms among adolescents.

Burton et al., (2009) explored gender-based differences in how adolescents respond emotionally to stress. The study found that males are more likely to express stress through externalizing behaviors, such as aggression, rather than internalizing it. This tendency to externalize emotional distress could explain why males often report lower levels of hopelessness compared to females.

Gender Difference in Life Satisfaction

Gender differences have been seen in nearly every aspect of health and healthcare (Crose et al., 1992). Similarly, a study conducted in Taiwan by Lu (2000)

identified gender differences when examining marital congruence in role experiences and subjective well-being. Inglehart (2002) found that men generally enjoy higher incomes, more prestigious jobs, and greater authority across most societies—factors associated with higher levels of subjective well-being. Consequently, women tend to report lower levels of happiness compared to men.

Research indicates that men and women experience similar levels of happiness and overall life satisfaction. However, gender differences in psychological well-being suggest that men tend to score higher on indicators of psychological health compared to women. Carmel and Nigavekar (2007) found that women scored lower than men on psychological well-being measures.

In the broader Australian population (Australian Bureau of Statistics, 2008), similar trends have been observed. Chow (2010) also reported that male students in Canada exhibited higher levels of psychological well-being compared to female students.

Studies have demonstrated that gender plays a significant role in life satisfaction. Men and women encounter different circumstances, leading to life events impacting each gender in distinct ways. Earlier research has revealed that women are generally more likely than men to experience happiness (Judge & Watanabe, 1993).

Gender Difference in Resilience

Research indicates that males generally exhibit higher resilience than females (Erdogan et al., 2014; Bahadir, 2009; Sürücü & Bacanli, 2010). However, a study by Önder and Gülay (2008) found that females demonstrated greater resilience than males. Other studies suggest that resilience does not vary by gender (Sezgin, 2005; Aktay, 2010; Özcan, 2005). Additionally, research has shown that male adolescents have significantly higher self-esteem than females, with the difference being statistically significant at the 0.01 level (Bleidorn et al., 2016). However, some studies report findings contrary to these results.

Oktan (2008) found that adolescents preparing for university exams showed significant differences in resilience depending on their problem-solving skills and life satisfaction. Similarly, Onder and Gulay (2008) identified a significant correlation between self-concept and resilience among eighth-grade students. Their study also revealed that girls exhibited higher resilience levels compared to boys.

Karatas and Savi-Cakar (2011) discovered that self-esteem and hopelessness are significant factors influencing resilience in adolescents. In a related study, Savi-Cakar and Karatas (2011) found that perceived social support significantly predicts adolescents' resilience levels. A positive correlation exists between adolescents' resilience and the social support they receive from family, friends, and teachers. Additionally, resilience levels vary by gender, with girls exhibiting higher resilience compared to boys.

Studies have found that boys tend to exhibit higher levels of resilience compared to girls (Campbell-Sills et al., 2009; VicHealth, 2015). While this difference could partly result from reporting bias, with males potentially aiming to appear stronger under stress, other research using alternative measures has also identified significantly higher resilience levels in males (Bonanno et al., 2007). The observation that girls, on average, report lower resilience aligns with the higher prevalence of psychiatric disorders among females, such as anxiety and phobias, which often involve stress-related components (Craske, 2003).

Some studies reveal intriguing gender differences in resilience, with boys reporting stronger intrapersonal traits, while girls report greater social and interpersonal resources (Hjemdal et al., 2006; Hjemdal et al., 2011).

Oktan (2008) found that adolescent girls demonstrated higher levels of resilience compared to boys. Researchers discovered that female students scored significantly higher on resilience subscales related to social resources and family cohesion whereas male students scored higher on the subscale measuring personal competence (Hjemdal et al., 2011).

Gender Difference in Depression

Hankin and Abramson (2001) note that gender differences in depression prevalence begin to emerge during adolescence. Similarly, Cicchetti and Toth (1998) observed that differences in depression between males and females start to appear between the ages of 11 and 13. Studies consistently show that males report lower levels of depression compared to females, particularly in self-reported measures. However, it is essential to consider potential self-report bias, as the response bias hypothesis suggests that males may underreport their levels of depression relative to females (Sigmon et al., 2005).

Gender differences can be categorized into three aspects: physical or biological, psychological, and social differences. Physical differences refer to genetic variations, such as females inheriting XX chromosomes and males inheriting XY chromosomes. Psychological differences, or phenotypic expressions, are reflected in distinct behaviors influenced by gender and cultural norms. Social differences are shaped by societal roles assigned to each gender. Reviewing gender-related research, most previous studies suggest that adolescent females are at a higher risk of developing depression compared to males (Garber, 2002; Ay & Save, 2004).

Piccalilli and Wilkinson (2000) conducted research on gender differences in depression, focusing on identifying risk factors contributing to these differences. Their findings highlighted various factors influencing gender disparities in depression, including social support, gonadal hormones, the adrenal and thyroid axes, the neurotransmitter system, adverse life events, vulnerability, and coping styles. They concluded that girls are more likely to experience depression than boys.

Kim (2018) conducted a study on gender differences in depression and found that females experience higher levels of depression than males. Both psychosocial and biological factors were examined, revealing that females are more likely to display bodily symptoms and suicidal behaviors associated with depression, while males are more prone to impulsivity and acting out. Factors such as sexual assault,

coping styles, gender role stereotypes, restrictions, and discrimination were identified as contributing to depression among females.

Piccinelli and Wilkinson (2000) proposed that childhood environment and adverse experiences heighten the risk of depression and anxiety disorders at younger ages, with social roles and cultural norms contributing to the increased vulnerability of females to depression. Similar findings were observed in an Australian university sample, where Stallman (2010) reported that female university students experienced higher levels of psychological distress compared to males. Females consistently scored higher in the moderate, high, and very high categories of psychological distress, while scoring lower than males in the low distress category.

Research indicates that girls report higher levels of depressive symptoms than boys (Dishman et al., 2006; Hjemdal et al., 2011; Moksnes, Moljord, Espnes, & Byrne, 2010), with depressive symptoms and disorders showing a notable increase among girls during mid-adolescence (Dishman et al., 2006; Hjemdal et al., 2011; Moksnes et al., 2010; Motl et al., 2004). Additionally, the frequency of leisure-time physical activity and exercise tends to decline during adolescence, with girls participating less frequently than boys (Duncan et al., 2007; Nesheim & Haugland, 2003; Sagatun et al., 2007; Trost et al., 2002). However, a more recent study found no gender differences in physical activity frequency (Moljord et al., 2011).

Research evinced that, overall, depression is more prevalent among females than males in the general population (Piccinelli& Wilkinson, 2000). Nolen-Hoeksema and colleagues (1999), in their study on gender differences in depression, noted that while such differences are well-documented in numerous studies, the underlying reasons remain unclear. A twin study in this field revealed no connection between gender differences in depression and genetic risk, suggesting that these differences are more likely influenced by environmental factors such as family history, social support, economic conditions, and life events (Tenant, 2002).

Research highlighted that female students are at a higher risk of experiencing depression compared to their male counterparts (Dahlin et al., 2005; Ceyhan et al.,

2009). Similarly, it was found that depressive symptoms were more prevalent among female undergraduate students than male undergraduate students (Eisenberg et al., 2007).

Algood-Merten, and Colleagues (1990), along with Hoeksema and Seligman (1991) found that 13% of girls and 3% of boys met the criteria for major depressive disorder, highlighting significant gender differences in depression.

Hoeksema and Girgus (1994) discovered that depression rates are similar between prepubescent boys and girls. However, after the age of 15, girls and women are approximately twice as likely to experience depression as boys and men. Similarly, Azizi (2011) conducted a study comparing school-related stress among high school girls and found that third-grade students reported higher levels of stress compared to other grades.

Relationship between Religiosity and hopelessness

According to Koenig et al., (2001), religiosity plays a significant role in reducing feelings of hopelessness by offering individuals a framework of meaning, purpose, and optimism. These elements allow people to better manage distress and navigate life challenges, providing a psychological buffer against despair. By fostering a sense of hope and a belief in divine support or order, religious engagement enhances emotional resilience and helps individuals maintain a positive outlook in difficult circumstances.

Ozmen and colleagues (2008), in their study titled *"The Hopelessness and Factors Affecting the Level of Hopelessness in Students,"* found that first-year students generally remain optimistic about the future. However, a notable proportion still experiences hopelessness, particularly among children from families with lower socioeconomic status who receive limited access to social welfare. The stress experienced during adolescence, often linked to frustration and difficulty in self-expression, underscores the importance of creating spaces and opportunities for individuals to enhance their self-expression. Fields such as art and sports are highlighted as effective avenues for addressing these challenges.

Fromm (1995) explains when discussing profound emotions like love, hate, or hope, people often struggle to articulate their thoughts adequately. Artistic forms such as poetry, music, and other creative expressions are more suitable for conveying human experiences because they adhere to their own rules, offering clarity and avoiding the ambiguity often associated with conventional verbal symbols of personal experiences.

Marcel (2001, as cited in Koc, 2008: 173) described *'ontological necessity'* as a fundamental *'need for existence'* or *'thirst for being.'* This concept reflects a deep longing to exist, often manifesting in various forms, such as striving for self-actualization through the creation of scientific, philosophical, or artistic works, driven by dissatisfaction with current circumstances. It may also involve seeking spiritual experiences or an inclination to transcend the abstract and objective world.

Researchers have been monitoring levels of hopelessness during the pandemic. A recent study in Turkey revealed notably elevated levels of hopelessness among healthcare workers, individuals who experienced a decline in income during the pandemic, and those living with someone at high risk for COVID-19 (Hacimusalar et al., 2020). Another study (Saricali et al., 2020) identified fear of COVID-19 as a predictor of hopelessness.

It comes as no surprise that depression and anxiety rates have surged during the pandemic. In the spring of 2020, U.S. adults were three times more likely to screen positive for depression and/or anxiety compared to 2019, with over one-third of adults showing positive results in a national study by the U.S. Census Bureau (Twenge & Joiner, 2020). However, while mental illness has markedly increased during the pandemic, not everyone facing adversity experiences hopelessness or develops mental health issues. A recent study revealed that 39.3% of nurses reported posttraumatic growth following the pandemic (Chen et al., 2020). This highlights the importance of exploring the factors that influence feelings of hopelessness during challenging periods.

Research increasingly suggests that emotional abuse and verbal victimization during childhood contribute to later changes in children's inferential styles (Gibb & Abela, 2008; Gibb et al., 2006). However, it remains uncertain whether such adverse childhood experiences also play a role in developing other forms of hopelessness. Previous studies have identified several factors associated with an elevated risk of suicidal behavior, including suicidal ideation and actions in individuals with depression (Pompili et al., 2015), hopelessness (Kovacs et al., 1975; Chang, 2017), anxiety (Hill et al., 2011), and depression (Lester, 2014). Additionally, subjective well-being has emerged as a potential predictor. Evidence shows that higher levels of depression severity, hopelessness, and stress significantly increase the likelihood of suicidal behavior among college students (Lester, 2014; Bauer et al., 2014).

Relationship between Religiosity and life-satisfaction

Studies indicate that religion significantly influences adolescents' lives, contributing positively to academic performance, educational aspirations, worldview, and optimism about the future (Regnerus et al., 2003). Religiosity has also been linked to psychological well-being, a positive self-concept, and better physical health among adolescents (Donahue & Benson, 1995; Ellison, 1991; Oleckno & Blacconiere, 1991). Furthermore, religious adolescents are less likely to engage in risky behaviors such as smoking, drug use, and alcohol consumption (Hays et al., 1986; Rohrbaugh & Jessor, 1975; Woodroof, 1985).

Lightsey (2006) explored the connections between meaning in life, resilience, and well-being. The findings indicated that individuals with a stronger sense of meaning in life demonstrated greater resilience and higher levels of well-being. This suggests that discovering a sense of purpose can strengthen one's capacity to navigate difficulties and foster overall psychological health.

A meta-analysis examining the relationship between well-being and health found a consistent correlation of around 0.32, with stronger associations observed among women (Koenig et al., 2012). Subjective well-being is described as an individual's cognitive and emotional assessments of their life, encompassing both

emotional responses to events and cognitive evaluations of satisfaction and fulfillment.

Antaramian (2015) explored the dual factor model of mental health by analyzing participants based on reported psychological symptoms (high and low) and subjective well-being (high and low). Four distinct groups emerged from the analysis. The first group, labeled *well-adjusted*, included students with low levels of psychological symptoms and high levels of subjective well-being. Consistent with traditional single-continuum mental health models, a second group, referred to as *distressed*, displayed high psychological symptoms and low subjective well-being. However, the dual factor model is further supported by two additional groups. The *ambivalent* group exhibited high levels of psychological symptoms alongside high subjective well-being. This group demonstrates that experiencing psychological distress does not necessarily preclude life satisfaction or subjective well-being, as protective factors and positive functioning can coexist with negative symptoms. Lastly, the *at-risk* group was characterized by low psychological symptoms but also low subjective well-being, emphasizing that the absence of psychopathology does not guarantee good mental health.

Abdel-Khalek and Lester (2010) examined the relationship between religiosity, subjective well-being—which includes happiness, life satisfaction, love of life, and physical and mental health—and psychopathology, defined as anxiety and depression, among college students in Kuwait and the United States. Their findings revealed that students with higher levels of religiosity also reported greater well-being. Additionally, the researchers reviewed previous studies that demonstrated a positive correlation between religiosity and subjective well-being, as well as physical and emotional health, while showing a negative correlation between religiosity and psychopathology in participants from Kuwait, Saudi Arabia, and Algeria. These findings underscore the cross-cultural significance and applicability of religiosity as a potential protective factor against psychopathology in students.

Religion appears to provide individuals with hope, meaning, optimism, and a sense of security (Hadaway, 1978; Moberg, 1979). Several studies have suggested

that both religiosity and religious participation are positively associated with subjective well-being (Moberg, 1972; Wilson, 1967). Religious activities, such as attending church, may enhance subjective well-being by fostering a sense of social integration (Rosow, 1967). Additionally, religiosity may support subjective well-being by aiding individuals in successfully addressing the developmental challenge of ego integrity versus despair (Erikson, 1959).

Relationship between Religiosity and Resilience

A sense of purpose and a meaningful life has been associated with resilience (Feder et al., 2010). Research on spirituality and religiosity highlights spirituality as a significant source of resilience (Kim & Esquivel, 2011). Kim and Esquivel (2011) found that spirituality positively impacts adolescents in various ways, including fostering healthy development, enhancing coping skills, improving mental health, promoting psychological well-being, and supporting academic success. However, it is important to recognize potential negative effects of religiosity, such as feelings of abandonment or punishment by a deity, which have also been documented (Pargament et al., 2001).

Psychologists suggest several ways in which spirituality and religion might enhance resilience. These include fostering positive and healthy relationships, increasing access to social support—especially through religious practices—shaping behavior and personal values, and promoting opportunities for personal growth and development. While these outcomes can certainly be achieved through other means, spirituality is proposed as one potential pathway for cultivating resilience and psychological well-being (Kim & Esquivel, 2011). It does so by encouraging a positive perspective and helping individuals find meaning in challenging and adverse experiences.

Resilience is linked to various factors, including coping skills, self-efficacy, optimism, social support, adaptability, religious and spiritual beliefs, positive emotions, self-esteem, and a sense of meaning and purpose in life (Helmreich et al., 2017).

Although spirituality and resilience are correlated, they are distinct concepts with unique characteristics. Smith et al., (2012) proposed that spirituality can enhance resilience in at least four ways: by fostering relationships, shaping life values, providing personal meaning, and supporting coping mechanisms. They concluded that spirituality is more likely to influence resilience and positive emotions than the other way around. Therefore, while resilient individuals may not necessarily possess spirituality or religiosity, those with spirituality or religiosity are more likely to exhibit higher levels of resilience. Numerous researchers have highlighted the significance of spiritual and religious beliefs in enhancing resilience (Brewer et al., 2014).

Relationship between Religiosity and Depression

Numerous studies have explored the connection between depression and religion (Sanders et al., 2015; Stearns et al., 2018; Yonker et al., 2012). For instance, individuals experiencing challenges with personal religiosity—such as feelings of abandonment by God, loss of faith, personal trials, or perceptions of unworthiness—tend to exhibit poorer mental health outcomes (Rippentrop et al., 2005). Conversely, Stearns and colleagues (2018) discovered that individuals with higher levels of religiosity reported lower levels of depression. A meta-analysis revealed that spirituality and religiosity positively influence psychological outcomes in adolescents and young adults (Yonker et al., 2012). Moreover, participation in religious services has been identified as a protective factor against suicide (Anderson et al., 2015).

Ellison and Smith (1991), in their review of spirituality and its relationship to various dimensions of well-being, including psychological health, highlighted earlier studies suggesting that spirituality can influence levels of depression following life events. Cotton and colleagues (2005) investigated the link between religion, spirituality, and depression among adolescents. They examined spiritual well-being, which includes religious and existential well-being, and found that higher depression levels were correlated with lower existential well-being and greater emphasis on religion. The relationship between existential well-being and reduced depression

implies that the meaning-making aspect of spirituality and religion plays a critical role in alleviating depression among adolescents. Similarly, studies on adolescents with anxiety found that higher levels of spiritual and existential well-being predicted lower anxiety, whereas religious well-being alone did not have the same effect (Davis et al., 2003).

Kim and Esquivel (2011) suggested that the observed link between a greater emphasis on religion and higher levels of depression might stem from individuals using religion as a coping mechanism during depressive episodes. Additionally, other research (Hill & Pargament, 2003; Pargament et al., 1998) has identified potential adverse effects of religion, such as fostering fear of God or feelings of alienation from cultural communities.

Cotton and colleagues (2005) investigated the relationship between religion, spirituality, and depression in adolescents. They assessed spiritual well-being, which includes religious well-being and existential well-being, and found that higher depression levels were linked to lower existential well-being and greater emphasis on religion. The association between existential well-being and reduced depression highlights that the meaning-making aspect of religion and spirituality plays a crucial role in alleviating depression among adolescents. Similar findings were observed in adolescents with anxiety, where higher levels of spiritual and existential well-being were associated with lower anxiety levels, whereas religious well-being showed no such effect (Davis, Kerr, & Kurpius, 2003). Kim and Esquivel (2011) proposed that the link between a stronger focus on religion and increased depression might result from individuals using religion as a coping mechanism during depressive episodes. However, other studies (Hill & Pargament, 2003; Pargament et al., 1998) suggested that religion could also contribute to negative outcomes, such as fostering fear of God or feelings of social isolation from cultural groups.

Spirituality has also been associated with positive physical health outcomes, such as improved coping with pain and substance abuse (Piedmont, 2004). Supporting these findings, Walker (2010) conducted a study on African American college students to explore the connection between spirituality, religiosity, subjective

well-being, and psychological well-being. Walker defined psychological well-being as encompassing self-acceptance, environmental mastery, positive relationships, personal growth, life purpose, and autonomy, while subjective well-being was characterized by happiness and life satisfaction. The study found that spirituality, rather than religiosity, served as a positive predictor of both subjective and psychological well-being, though a significant relationship between spirituality and religiosity was observed. This highlights the importance of investigating why spirituality contributes to positive outcomes in students and how it aligns with their motivation.

Kuo and colleagues (2014) surveyed 301 Canadian undergraduate students to explore the relationship between coping mechanisms, spirituality, and psychological distress in a culturally diverse group. Their findings revealed a negative correlation between intrinsic spirituality and psychological distress. Intrinsic spirituality, characterized by personal beliefs and values independent of external religious instruments or societal expectations, differs from extrinsic spirituality, which is driven by ritualistic, instrumental, and doctrinal motivations. The study also showed that intrinsic spirituality promoted collective coping strategies while decreasing reliance on avoidance coping. Additionally, they identified varying effects of coping styles on psychological distress—engagement coping was associated with reduced psychological distress, whereas avoidance coping was linked to higher levels of distress.

Koenig (2009) conducted a review of studies examining the relationship between religion, spirituality, and mental health, focusing on areas such as anxiety, depression, psychosis, substance abuse, and suicide. The findings indicated that religious beliefs and practices are linked to effective coping mechanisms for anxiety, depression, psychosis, substance abuse, and suicide. However, the review also noted that religious delusions are associated with psychotic disorders, complicating the assessment of whether religious beliefs and practices serve as a protective resource or a potential liability.

Brown and colleagues (2013) examined the relationship between spirituality (including religious coping and spiritual well-being) and psychological factors such as depression and anxiety. Their study revealed a positive association between greater levels of religiosity and spiritual well-being. This was linked to reduced mental and emotional health issues, elevated existential well-being, and lower levels of depression and anxiety. Furthermore, the study highlighted that existential well-being was closely tied to spirituality and mental health. Additionally, the findings suggested that individuals who are more religiously active tend to exhibit fewer symptoms of depression (Brown et al., 2013).

Allen and colleagues (2008) explored the relationship between religiousness/spirituality, depression, anxiety, and the wish for a quick death among 81 male inmates in Alabama, USA, taking into account factors like age, ethnicity, and crime type. Data was collected through oral interviews lasting between 30 to 60 minutes. The findings revealed that frequent spiritual experiences and not feeling rejected by God were linked to better emotional well-being (Allen et al., 2008).

Vitorino and colleagues (2018) examined the relationship between varying levels of religiousness and spirituality and their impact on anxiety, depressive symptoms, optimism, happiness, and quality of life in a sample of 1,046 Brazilian adults. This cross-sectional study found that individuals with higher levels of both spirituality and religiousness experienced better outcomes compared to those with either one or none. Additionally, higher levels of religiousness, even without spirituality, were also associated with improved outcomes (Vitorino et al., 2018).

Previous research by Moreira-Almeida and colleagues (2014) concluded that spirituality and religiosity are generally linked to improved mental health, including reduced levels of depression, anxiety, stress, suicidal ideation, and substance use.

Relationship between Hopelessness and Life Satisfaction

Research has found a significant relationship between life satisfaction and hopelessness in adolescents, indicating that as life satisfaction increases, levels of hopelessness decrease. Life satisfaction is associated with positive perceptions and

outcomes in life (Diener & Seligman, 2002), while hopelessness is linked to negative factors such as pessimistic expectations for the future, a belief in the inability to overcome failures, and difficulties in problem-solving (Beck et al., 1974; Dilbaz & Seber, 1993; Abramson et al., 1989).

Relationship between Hopelessness and Resilience

Adolescence is a phase of significant growth and transformation. During this period, adolescents encounter numerous stressors, making resilience a vital trait for adaptation and stress resistance. Key internal attributes linked to resilience include self-esteem, self-efficacy, perseverance, an internal locus of control, and effective coping and adaptation skills.

Resilience, broadly defined, refers to how individuals manage stress and recover from trauma. It is viewed as a positive developmental trait, characterized by forward-looking attitudes and hope, including effective coping, adaptability, and competence (Murphy, 1987). More generally, resilience is described as the ability to adapt successfully, demonstrate significant effort, and achieve success despite facing challenging and threatening circumstances.

Adolescence marks a transitional phase between childhood and adulthood, characterized by spiritual growth and preparation for life. This period of rapid development culminates in physical, sexual, and spiritual maturity. Universally, adolescence is often perceived as an exciting, daring, and turbulent time. However, it is equally a phase marked by episodes of depression, anger, conflict, and anxiety. Intense emotions and extreme reactions, whether positive or negative, are common during this stage (Yörükoğlu, 1993). Moreover, adolescents may experience a loss of self-confidence and feelings of hopelessness (Yörükoğlu, 1992).

Comer (2002) defines hopelessness as a persistent, pessimistic, and despondent mindset. This state often coexists with unchanging spiritual conditions, emotions, and challenges. Atabek (1990) noted that hopelessness is a human emotion that leads individuals to feel there is no solution or way forward, fostering a sense of despair. Young et al., (1996) contended that while hopelessness varies over time in

the same person, it is not fixed or unchanging. Adolescents may encounter hopelessness both at home and at school, often due to uncertainty about the future or an inability to find direction. Failures and significant changes in their circumstances can evoke strong negative emotions, which, in turn, impact their sense of self.

Salami (2010) investigated the mediating role of self-esteem and social support in the relationship between resilience and post-traumatic stress disorder (PTSD) among adolescents exposed to violence. The study identified a significant negative relationship between resilience, self-esteem, and PTSD. This finding aligns with previous research. Self-esteem is frequently regarded as a protective factor in resilience studies (Moran & Eckenrode, 1992; Taylor, 1994; Rak & Patterson, 1996; Masten, 2001), with high self-esteem highlighted as a crucial strength that enhances adolescents' resilience (Cicchetti et al., 1993; Spencer et al., 1993; Connell et al., 1994; Kumpfer, 1999; Mandleco & Peery, 2000; Werner & Smith, 2001).

It has been noted that resilient children tend to exhibit a stronger sense of autonomy and independence (Anthony, 1987; Benard, 1993; Gordon & Song, 1994) and a greater ability to manage their environments (Martinek & Hellison, 1997). Resilient adolescents often display higher levels of hope and optimism (Martinek & Hellison, 1997; Kumpfer, 1999; Tusaie-Mumford, 2001; Benard, 2004; Black & Ford-Gilboe, 2004). Furthermore, resilience encompasses behaviors that safeguard individuals from challenges such as depression, psychological difficulties, loneliness, psychosocial isolation, and physical health issues (Smith, 2009).

Resilience strengthens an individual's capacity to adapt and cope effectively when confronted with significant stressors. Research demonstrated that resilience serves as a strong predictor of hopelessness, even after accounting for external factors such as stressful life events and symptoms of depression and anxiety (Hjemdal et al., 2012).

Research suggests that when individuals face stress without sufficient or available resilience resources, hopelessness may emerge as a likely consequence

(Hjemdal et al., 2012). Conversely, extraversion has been associated with more effective stress management strategies (Schneider et al., 2012).

Relationship between Hopelessness and Depression

Negative attribution style and hopelessness are two maladaptive cognitive patterns linked to adolescent depression. A negative attribution style involves attributing negative events to internal (self-directed), stable (long-lasting), and global (impacting many areas of life) causes while attributing positive events to external, unstable, and specific causes (Abramson et al., 1978). Hopelessness is defined as the expectation of a negative future that cannot be changed (Beck et al., 1974). Several theories, including the hopelessness theory of depression (Abramson et al., 1989), identify negative attribution style and hopelessness as key cognitive vulnerabilities leading to depression. According to this theory, negative attribution style, when combined with negative life events, fosters hopelessness, which subsequently contributes to depressive symptoms. In essence, hopelessness is proposed to mediate the relationship between attribution style and depression. While various aspects of this theory have received empirical support (Metalsky & Joiner, 1992; Joiner, 2001; Hankin, 2008), evidence for this mediation remains inconsistent across studies involving both children and adults (Alloy & Clements, 1998; Abela, 2001; Hankin et al., 2001).

Hopelessness is characterized by negative thoughts and expectations about oneself and the future (Beck, 1963). Research has shown that hopelessness is closely associated with depressive symptoms, suicidal ideation, and other clinical conditions (Beck & Beck et al., 1990; 1998). It is marked by extreme pessimism and despair about the future and is a key component of the "cognitive triad" outlined in the cognitive model of depression, which includes a negative evaluation of oneself, the world, and the future. According to Shneidman (1996), hopelessness and helplessness are the most frequently experienced emotions among individuals who have attempted suicide. Abramson et al., (1989) conducted a longitudinal study spanning from 1978 to 1989 to investigate the theoretical underpinnings of

hopelessness and its relationship to depression. Their findings revealed that hopelessness serves as a causal factor in the development of depression.

Greene (1989) examined the relationship between depression and hopelessness. The study concluded that while hopelessness is a significant predictor of depression, its influence diminishes during the most severe stages of depression. Additionally, a link between hopelessness and suicide was identified. Both Beck's cognitive theory and Brown and Harris's psychosocial model propose the concept of depression that occurs without hopelessness, referred to as "non-hopelessness" depression.

Hopelessness is widely regarded as an early indicator of depression and plays a significant role in its onset. Characterized by a lack of optimism and hope, it is a key factor to address in understanding the causes of depression (Sun et al., 2022). The concept of hopelessness is rooted in the learned helplessness theory (Seligman & Maier, 1967), which posits that individuals may develop a sense of helplessness when they perceive themselves as unable to change a situation, despite their best efforts (Nunn & Thompson, 1996).

Hopelessness is a defining characteristic of clinical depression, with individuals experiencing depression often anticipating overly negative outcomes for their future (Beck et al., 1974). This particular symptom may explain the association between depression and suicidal behavior. It is suggested that hopelessness specifically, rather than depression as a whole, could be the driving factor behind suicidal tendencies (Beck et al., 1975).

Relationship between Life Satisfaction and Resilience

Oktan (2008) discovered that adolescents preparing for university exams demonstrated varying levels of resilience depending on their problem-solving skills and life satisfaction. Onder and Gulay (2008) identified a significant correlation between self-concept and resilience among eighth-grade students, noting that girls exhibited higher resilience than boys. Sipahioglu (2008) found that resilience among

adolescents from different risk groups varied according to factors such as poverty (living with their family), single-parent households, gender, and school type. Onat (2010) reported that first-year high school students who perceived their parents as democratic had significantly higher resilience levels. Additionally, resilience levels were influenced by factors such as the student's school, age, number of siblings, family income, mother's education level, parental professions, the father's upbringing environment, the parents' protective attitudes, and parenting styles.

Karatas and Savi-Cakar (2011) identified self-esteem and hopelessness as significant predictors of resilience in adolescents. Furthermore, Savi-Cakar and Karatas (2011) found that perceived social support was a significant predictor of resilience. A positive relationship was observed between adolescents' resilience levels and the social support they received from family, friends, and teachers. Gender differences were also noted, with girls displaying higher resilience than boys.

Resilience is closely tied to increases in individuals' life satisfaction. Karairmak (2007) found a correlation between resilience and life satisfaction in a study involving individuals affected by an earthquake. Similarly, Oktan (2008) concluded that life satisfaction significantly predicts resilience among adolescents preparing for university entrance exams. Adolescents with higher life satisfaction demonstrated greater resilience, while those with lower life satisfaction exhibited lower resilience levels, aligning with the findings of this research.

Additionally, while depression alone shows a significant negative correlation with resilience, it does not emerge as a significant predictor in the overall model. This may be due to the mitigating effects of social support and life satisfaction, which appear to buffer the impact of depression on resilience.

Relationship between Life Satisfaction and Depression

Bhullar and colleagues (2014) examined psychological well-being among 278 Australian university students. They utilized the Psychological Well-Being Scale (Ryff & Keyes, 1989), which assesses six dimensions: autonomy, personal growth,

self-acceptance, positive relationships, environmental mastery, and purpose in life. Psychological distress was measured using the Depression, Anxiety, and Stress Scale-21 (Lovibond & Lovibond, 1995). Their study found that higher psychological well-being was associated with lower levels of depression, while lower psychological well-being correlated with higher depression levels, suggesting a possible cyclical relationship between the two.

Notably, autonomy, or a sense of control, emerged as a protective factor against depression. The study found no gender differences, contrasting with Piccinelli and Wilkinson (2000), who identified females as being at greater risk of depression due to childhood environments, adverse experiences, social roles, and cultural norms. Supporting these earlier findings, Stallman (2010) observed that female university students reported higher levels of psychological distress than males in an Australian sample. Women consistently scored higher in moderate to very high psychological distress and lower in the low-distress category, mirroring trends observed in the broader Australian population (Australian Bureau of Statistics, 2008).

Chow (2010) observed that male students in Canada reported higher levels of psychological well-being compared to their female counterparts. However, Boughton and Street (2007) noted that while gender differences in depression have been reported, these findings are not consistently observed in university populations. Hankin and Abramson (2001) highlighted that gender differences in depression prevalence typically begin to manifest during adolescence. Similarly, Cicchetti and Toth (1998) found that these differences emerge between the ages of 11 and 13 years.

Research consistently shows that males report lower levels of depression than females, particularly in self-reported data. However, it is important to account for potential self-reporting biases related to gender. The response bias hypothesis posits that males may underreport their levels of depression compared to females, potentially skewing findings (Sigmon et al., 2005).

Relationship between Resilience and Depression

Studies consistently indicate that individuals with greater resilience are less likely to experience depression, anxiety, and other mental health challenges. They demonstrate stronger coping mechanisms and are better prepared to navigate difficult life situations. Resilient individuals often maintain a more optimistic perspective, report higher levels of perceived social support, and possess strong problem-solving abilities, all of which help them manage stress effectively and sustain their mental well-being (Hu et al., 2015).

Benard (1991) highlighted the importance of creating the right environmental conditions to foster resilience in individuals. She stated that resilient children possess social competence, problem-solving skills, autonomy, and a sense of purpose, along with hope for the future. Support from adults is a crucial protective factor that helps children recognize and address challenges. Social support plays a key role in maintaining healthy behaviors (Celikel & Erkorkmaz, 2008) and is defined as the information that helps individuals feel loved, valued, cared for, and connected to a social network (Cobb, 1976).

Research has shown that individuals with robust social support systems are better at coping with stressful life events (Callaghan & Morrissey, 1993; Shonkoff, 1984) and overcoming psychological difficulties (Lara et al., 1998). They tend to experience lower levels of anxiety, behavioral issues, and depressive symptoms (Barrera, Fleming & Khan, 2004). A lack of social support negatively impacts resilience as a protective factor and is also linked to a higher frequency of depressive symptoms.

Depression is typically characterized by negative thoughts, feelings of disappointment, hopelessness, and reluctance (Cicchetti & Toth, 1998). A pessimistic view of the world in early childhood can lead individuals to become disappointed with themselves. The negative impact of life experiences intensifies, and situations

that cause significant stress can heighten the risk of depression (Erdogan, 2006). Motivational symptoms of depression include apathy and boredom, while physical symptoms may include sleep disturbances, lack of energy, and changes in appetite (Steinberg, 2002).

Chapter- 3

STATEMENT OF THE PROBLEM

Adolescence is a crucial developmental stage marked by significant physical, emotional, and psychological changes. During this period, mental health issues such as depression, anxiety, and stress are common, presenting considerable challenges to adolescents' well-being. While adolescence is often a time of growth, exploration, and excitement, it can also be a period of worry and difficulties, particularly in the modern world. In many ways, adolescence can be seen as both "the best of times and the worst of times" (Coon, 1992).

Adolescents today face more challenges and difficulties than previous generations, yet they receive less guidance and support for their personal growth (Pajares &Urdan, 2004). Studies have indicated that stress experienced by adolescents and college students is linked to outcomes such as anxiety, depression, and suicidal thoughts (Aldwin & Greenberger, 1987; Bonner & Rich, 1987 & 1988; Wilburn &Smith (2005). Conversely, effectively coping with stress can enhance adolescents' well-being.

Researchers have found that during adolescence, there is an increased tendency toward engaging in risky behaviors (Aras et al., 2007; Bulut, 2010; Jessor, 1991; Ögel, Tarı & Eke-Yılmazçetin, 2006; Siyez, 2007; Bayar &Sayıl, 2005). These behaviors include actions that lead to unintentional injuries (such as not wearing seat belts or drunk driving), violent behaviors (carrying weapons or engaging in fights), substance abuse (tobacco, alcohol, and drugs), risky sexual behaviors (leading to pregnancies or sexually transmitted diseases), unhealthy eating habits, physical inactivity, truancy, lying, theft, depression, suicide, and antisocial behaviors (Adams &Berzonsky, 2003; Haugaard, 2001). The Problem Behavior Theory (Jessor, 1991) explains these problem behaviors (such as drinking, smoking, drug use, antisocial actions, and early sexual activity) through the lens of protective and risk factors (Jessor, 1991; Jessor, Turbin & Costa, 1998; Siyez, 2006; 2007; 2009).

Religiousity and adolescents

Numerous studies have highlighted the role of religiosity and spirituality as protective factors during adolescence (Benson et al., 2003; Bridges & Moore, 2002;

Kerestes & Youniss, 2003). Given that adolescence is a transitional period filled with unique challenges, several studies have explored the connection between religiousness and personality (Emmons & Paloutzian, 2003). It is important to examine how religious values influence adolescents' psychological functioning (Heaven & Ciarrochi, 2007), considering the developmental challenges they face (Smetana et al., 2006).

It is widely accepted that religious beliefs and behaviors are an essential part of an individual's "psychological reality" (Spilka et al., 1985) and a core aspect of their identity (Ozer & Benet-Martinez, 2006). According to Pargament and Mahoney (2002), the "search for the divine" or "spiritual striving" is considered a key component of an individual's motivational system (Emmons, 2005). Religion offers a framework for setting personal goals and guides how to achieve them (Park, 2005).

Many studies have found a positive correlation between religiosity, particularly intrinsic religiousity, and psychological health (Genia & Shaw, 1991; Fehring et al., 1997; Koenig & Larson, 2001). However, some research has either found no significant relationship or even negative associations between religiosity and mental health (Nelson et al., 2002; Woods et al., 1999; Fitchett et al., 1999; Pargament et al., 1998). Additionally, several studies have shown that higher levels of spiritual well-being are linked to lower levels of psychological distress, including depression, hopelessness, a desire for hastened death, and suicidal thoughts, particularly among severely ill patients (Nelson et al., 2002; Woods et al., 1999; Fitchett et al., 1999; Pargament et al., 1998; McClain et al., 2003).

Religiousity and spirituality are important factors that significantly influence the personality development of young individuals (King & Boyatzis, 2015; Yonker et al., 2012). They are especially impactful during periods of 'identity confusion' (Erikson, 1968) and are linked to the formation of a sense of purpose (Francis, 2013; Pfund et al., 2020).

Hopelessness and adolescents

The transition to adolescence is a challenging period, as childhood habits fade and new expectations emerge. When these expectations are unmet, adolescents may resort to violent behavior toward themselves and others (United Nations Children's Fund (UNICEF) & Board of Health, 2005). Self-harm, where individuals inflict harm upon themselves, and suicide are the leading causes of death during adolescence, particularly between the ages of 15 and 19. According to TUIK data, 2,933 people died by suicide in 2010 alone. Many studies have identified hopelessness as a key factor contributing to suicides (Dilbaz & Seber, 1993; Tumkaya, 2005; Oguzturk & Frie, 2011).

Research has shown that adolescents who face stressors they perceive as uncontrollable tend to adopt passive or avoidant coping strategies and experience feelings of hopelessness (Griffith, 1993). Hopelessness, in turn, has been linked to the development of psychopathological conditions (Kashani et al., 1991). Theoretical and empirical studies connect hopelessness to depression (Abramson et al., 1989; Alford et al., 1995; Beck et al., 1988; Maier & Seligman, 1976), and it has also been found to predict engagement in high-risk behaviors and violence among youth (DuRant et al., 1994), as well as adolescent suicide (Cole, 1988; Cotton & Range, 1996).

Most studies on adolescent stress and hopelessness have primarily focused on European American, middle-class youth (Grant et al., 2004). However, the impact of chronic, uncontrollable stressors on low-income urban youth of color is less understood. Research on this group indicates that low-income urban youth are at greater risk for psychological issues overall (Attar et al., 1994; Grant et al., 2004) and are particularly vulnerable to hopelessness (DuRant et al., 1994; Greene, 1993). Furthermore, uncontrollable stressors are believed to play a significant role in the development of hopelessness in this population over time (Bolland et al., 2005).

Hopelessness is defined as a negative outlook on the future, characterized by pessimism about what lies ahead (Yenilmez, 2010). It is a significant factor

contributing to academic failure (Yenilmez, 2010) and is also linked to various mental health issues. Notably, hopelessness is a key factor in suicide, which has long been considered a major public health concern. In our country, the high prevalence of suicides, particularly among individuals aged 15-24 and 25-34 (Uçan, 2005), has prompted research across different fields to address this issue.

Studies have indicated that when adolescents face stress combined with limited coping resources, their levels of hopelessness tend to increase (Brewster-Smith, 1983; Cole, 1988). In contrast, those who are skilled at coping may be protected from the negative consequences of chronic stress exposure (Compas et al., 2001; Hinds & Martin, 1988; Li et al., 2000; Weisenberg et al., 1993). Therefore, coping mechanisms may either moderate or mediate the relationship between uncontrollable stressors and hopelessness in low-income urban adolescents (Baron & Kenny, 1986; Holmbeck, 1997). In other words, ongoing exposure to uncontrollable stressors might lead to the development of ineffective or maladaptive coping strategies, which could, in turn, contribute to a heightened sense of hopelessness in urban youth (DuRant et al., 1994; DuRant et al., 1995; Garbarino & Sherman, 1980; Kaufman, 1991; Marsella, 1998).

Life satisfaction and adolescents

Adolescence is a period marked by numerous biological and psychosocial changes, which can lead to a decline in subjective well-being. To promote positive development in young people, it is important to identify factors that enhance life satisfaction. Positive psychology focuses on recognizing strengths that support healthy development and the environments that nurture both physical and psychological well-being (Compton and Hoffman, 2019). This approach has placed significant emphasis on subjective well-being, which is considered a crucial factor for development (Steinmayr et al., 2019).

Research has shown that adolescents with higher levels of life satisfaction tend to have better school performance, including greater self-efficacy, self-esteem, engagement, academic achievement, and peer relationships, along with fewer issues

such as absenteeism, dropouts, and behavioral problems (Proctor et al., 2009; Fergusson et al., 2015). In contrast, adolescents with lower life satisfaction are more likely to experience internalizing and externalizing problems, social stress, and substance abuse (Zullig et al., 2001; Haranin et al., 2007).

Longitudinal studies have highlighted the significance of adolescent life satisfaction, demonstrating that lower levels of life satisfaction predict future internalizing and externalizing behaviors, as well as peer victimization (Haranin et al., 2007; Martin et al., 2008). Additionally, Suldo and Huebner (2004a) found that adolescents with high life satisfaction were less likely to engage in externalizing behaviors after experiencing significant life stressors. Therefore, life satisfaction can be considered an important psychological strength that supports adaptive development.

Researchers have explored the factors that contribute to life satisfaction in adolescents. In addition to individual factors like temperament and attributional style, various contextual factors have been identified as influencing adolescent life satisfaction. Studies have shown that, throughout adolescence, the quality of family relationships holds more significance for overall life satisfaction than peer, school, or community-related factors (Dew & Huebner, 1994; Huebner, 1991). Despite spending more time with peers, the quality of family relationships remains most crucial to adolescents' well-being. Therefore, it is essential to identify the specific aspects of family dynamics that contribute to optimal well-being and life satisfaction.

Research has shown that high life satisfaction enhances positive emotions and helps individuals cope better with stress (Gilman & Huebner, 2006). Adolescents with higher life satisfaction are also more likely to succeed, exhibiting better school attendance and attitudes (Suldo & Shaffer, 2008). Additionally, life satisfaction is negatively associated with issues like anxiety, substance abuse, and aggression in adolescents (Gilman & Huebner, 2003).

Studies on life satisfaction have found that high levels of life satisfaction in children and adolescents are positively associated with better social, emotional, and

educational adaptation (Diener & Seligman, 2002; Gilman & Huebner, 2006; Huebner et al., 2004). High life satisfaction enhances positive emotions and aids in coping with stress (Gilman & Huebner, 2006). Adolescents with higher life satisfaction tend to perform better academically, showing improved attendance and attitudes towards school (Suldo& Shaffer, 2008). Moreover, it is negatively correlated with issues like anxiety, substance abuse, and aggression (Gilman & Huebner, 2003). Ash and Huebner (2001) found that negative life events lower life satisfaction, and adolescents with higher satisfaction tend to experience fewer emotional and behavioral problems. Gilman and Huebner (2006) also noted that adolescents who engage in bullying behaviors often report lower well-being, greater difficulty in social adaptation, and higher levels of anxiety, depression, and suicidal thoughts (Karaman et al., 2006). Additionally, life satisfaction has been linked to violent behaviors, such as carrying weapons, school assaults, drunk driving, and feelings of un-safety at school (Valois, 2001).

Resilience and adolescents

There is a growing body of research across various fields such as education, social work, and psychology that explore the concept of resilience, yet there is ongoing debate about whether it should be viewed as a characteristic, a process, or an outcome. Understanding resilience from an adolescent's perspective is particularly challenging, as adolescence is a complex stage marked by physical, psychological, and emotional changes. This period is crucial because the experiences adolescents go through can have lasting effects. While some individuals are naturally more resilient than others, everyone has certain limits (Rutter, 1993). During this developmental phase, adolescents often face risk factors (Masten, 2001), which can negatively affect their psychological growth and are linked to issues such as vulnerability, mental health challenges, and problematic behaviors. These risk factors can lead to behaviors like aggression, academic failure, substance abuse, teen pregnancy, violence, delinquency, and anti-social conduct (Masten, Best, & Garmezy, 1990; Rutter, 1987), which can harm their psychological and biological development.

However, some young people respond to these challenges by exhibiting a positive attitude, demonstrating resilience, and coping effectively with life's stressors.

In a constantly changing world where individuals face new challenges daily, resilience plays a crucial role, as resilient people are better equipped to handle life's difficulties and tend to have higher levels of functionality and quality of life (Leppin et al., 2014). The American Psychological Association (APA) defines resilience as the capacity to recover and adapt to adversity, trauma, threats, or stressors. However, being resilient does not imply that individuals will avoid difficulties or discomfort in such situations (American Psychological Association (APA), 2020). Resilience refers to the ability to recover and adjust to challenging circumstances. Since resilience encompasses both cognitive and behavioral dimensions, it can be fostered through strategies that support these areas, particularly during childhood and adolescence. It is regarded as a vital factor in promoting and maintaining adolescents' psychological well-being, serving as a defense against potential threats to their well-being throughout life (Khanlou & Wray, 2014). Resilience is a strength-based concept that focuses on developing youth's positive qualities rather than emphasizing their weaknesses (Khanlou & Wray, 2014).

Enhancing adolescents' resilience is key to fostering long-term mental health outcomes, as it enables them to face life's challenges, maintain mental well-being, and thrive despite adversity. In the context of adolescent mental health, resilience refers to the capacity to adapt effectively to difficult situations despite challenging circumstances. It plays a vital role in adolescents' development, significantly influencing their overall well-being, sense of identity, and self-efficacy. Resilience-promoting factors in adolescents include individual characteristics, family support, and societal influences (Garmezy, 1991; Werner, 1995). It is believed that young people with relevant competencies, skills, and resources tend to be more resilient. Promoting resilience in adolescents requires protective factors at three levels: individual, family, and community (Olsson et al., 2003). These factors foster positive coping mechanisms and rapid recovery during tough times, leading to improvements

in mental and physical health, including enhanced self-esteem, hope, problem-solving abilities, and greater confidence in handling challenges.

Research indicates that a person's resilience is shaped by various factors, including individual, biological, and psychological traits, relationships with family and peers, and environmental influences such as those within schools and the wider community (VicHealth, 2015b). Throughout their lives, children and adolescents may experience different vulnerabilities and protective factors that influence their resilience. For instance, adolescents may be especially susceptible to stressors related to family, friendships, and school (Wright & Masten, 2005). Major changes in social environments during late adolescence, such as entering the workforce, pursuing higher education, or leaving the family home, can also impact resilience (Burt &Paysnick, 2012; Masten et al., 2004).

Prevalence of depression among adolescents

Empirical studies show a high prevalence of depressive symptoms among adolescents. Boyd and colleague (2000) found that 14.2% of 1,299 randomly selected adolescents scored above the clinical cutoff for depression, with girls reporting significantly higher rates of depression than boys. Additionally, research by (Field et al., 2001) revealed that 29 out of 79 adolescents scored above the clinical cutoff for major depression.

Depression is a common mental health issue among students at various educational levels, including high school, college, and university (Arslan et al., 2009). Previous research has indicated that psychological disorders, particularly depression, are widespread among students (Adewuya et al., 2006; Dahlin et al., 2005). Counselling Center studies have shown that depression is one of the top five most frequent issues faced by college students, accounting for 39% of the cases, which is higher than rates for anxiety, romantic relationship problems, and issues related to self-esteem (Erdur-Baker, Aberson, Borrow & Draper, 2006; Green, Lowry & Kopta, 2003).

Recent studies have focused on the prevalence of depression among students (Chen et al., 2013), highlighting that depression is a significant and growing issue within the student population (Sarokhani et al., 2013). For example, one study found that depression rates among university students in Turkey ranged from 10% to 40% (Ustun& Kessler, 2002). Additionally, Green and colleague (2003) found that adult students reported higher levels of depression symptoms compared to their non-student counterparts. Other research has shown that depression symptoms affect over 27% of students, with these symptoms being among the most common issues addressed by university counseling centers (Mobley, 2008).

Adolescence is often considered a time of emotional instability, leading some to view depression as a normal aspect of pubertal changes (Petersen, 1988). However, research has shown that adolescent depression is not just a typical phase of development, but rather a mood disorder that disrupts normal functioning (Lewinsohn et al., 1993). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), major depression impacts various aspects of life, including personal, behavioral, emotional, somatic, and cognitive functioning (DSM-IV, 1994). In adolescents, depression affects not only their mood but also areas such as sleep, appetite, energy levels, and interest in previously enjoyable activities. It can also impair their ability to concentrate and think clearly, leading to poorer school performance. Feelings of worthlessness, hopelessness, and helplessness may emerge, potentially resulting in suicidal thoughts (DSM-IV, 1994).

Depression during adolescence not only increases the likelihood of experiencing future depressive episodes in later life (SAMHSA, 2007), but also predicts future challenges such as academic difficulties (McCarty et al., 2008). Adolescent depression raises the risk of dropping out of school (Fortin et al., 2006), engaging in antisocial behavior (Ritakallio et al., 2008), delinquency (Meadows, 2007), violent behaviors (Brooks et al., 2002), drug use (Bartkowski & Xu, 2007), and suicidal tendencies (Ang & Huan, 2006). Given the increase in adolescent depression and its negative consequences, researchers have explored various factors that might mitigate or prevent depressive symptoms. Many studies suggest that

supportive relationships, including social support, religiosity, and spirituality, can reduce vulnerability to depression (Meadows, 2001; Pearce et al., 2003; Yi et al., 2006). However, while these studies highlight a negative relationship between depression and supportive relationships, research within faith-based settings remains underexplored.

Depression is a widespread mental health issue and a significant concern within the student population (Ibrahim et al., 2013). It also has a notable impact on academic performance, satisfaction, and achievement (Arslan et al., 2009). A study by Wechsler, Lee et al., (2000) found that students with depression symptoms tend to have lower grades and are less engaged in class compared to their peers without such symptoms. These findings highlight that depression is a major issue that calls for psychological support for many students. However, there have been few recent studies examining the prevalence of depression among students.

Adolescence is a critical developmental period marked by significant emotional, psychological, and social changes. During this stage, many adolescents face a range of challenges, including the risk of developing depression, experiencing feelings of hopelessness, and struggling with low life satisfaction. These challenges often result in adverse outcomes, including academic difficulties, social problems, and even suicidal ideation. As mental health concerns among adolescents continue to rise, it is essential to explore protective factors that may help buffer against these negative outcomes.

One such factor is religiosity, which has been suggested to play a role in influencing adolescents' mental health and well-being. Religiosity, encompassing an individual's religious beliefs, practices, and experiences, may contribute positively to psychological functioning by promoting resilience, enhancing life satisfaction, and reducing feelings of hopelessness. However, the relationship between religiosity and these psychological constructs remains complex and underexplored, especially in adolescent populations.

Previous research has shown that religiosity can serve as a source of emotional support, offer a sense of purpose, and provide coping mechanisms that mitigate the effects of stress, potentially reducing the risk of depression and hopelessness. Conversely, the impact of religiosity on life satisfaction and resilience in the face of adversity is less well understood. While some studies suggest that religious involvement can lead to higher levels of life satisfaction and resilience, others have found no or negative associations, indicating that the influence of religiosity on adolescents' mental health may depend on various factors, including cultural context, family dynamics, and individual differences.

Given the potential importance of religiosity in shaping adolescents' mental health outcomes, this study aims to investigate the role of religiosity in influencing hopelessness, life satisfaction, resilience, and depression among adolescents. Understanding how religiosity interacts with these psychological factors can inform the development of targeted interventions to enhance adolescent well-being and mitigate the impact of mental health challenges during this critical life stage.

Population under study

Mizoram is located in the northeastern region of India and is recognized for its rich culture and history. It shares borders with Assam, Manipur, and Tripura within India, as well as Myanmar and Bangladesh. Aizawl, the state capital, is the largest city in Mizoram. The name "Mizoram" means "Land of the Highlanders" and is home to various tribes united by shared customs, traditions, and culture, including language and rites. The official language is Mizo, although several other languages such as Hmar, Mara, Lai, Paite, and Gangte are spoken by different ethnic groups, adding to the state's linguistic diversity. Mizoram spans approximately 21,087 square kilometers, with about 91% of the land covered in forests. The state was granted its statehood on February 20, 1987, becoming the 23rd state of India.

Historians suggest that the Mizo are part of the Mongolian race, migrating into eastern and southern India centuries ago. During the 19th century, they came under the influence of British colonization and Christian missionaries, and today, the

majority of Mizo are Christians. The missionaries introduced formal education and the Roman script for the Mizo language, playing a key role in the educational and literacy development of the Mizo people. The term "Mizo" refers to the people living in the hills (Mi = men, Zo = hills) or highlanders. The Mizo are of Mongoloid descent and speak dialects from the Tibeto-Burman language family. They are closely related linguistically and culturally to the Kuki-Chin tribes. The term "Mizo" encompasses various tribes or clans residing in modern-day Mizoram, united by common cultural practices, traditions, dialects, languages, and lifestyles.

Mizoram is characterized by a rugged mountainous terrain that stretches mainly from north to south. The state's geological composition primarily consists of sandstone and shale, which have been deposited in deltas and along riverbanks. However, no significant mineral deposits have been discovered in the region. Most of the rivers in Mizoram flow in a north-south direction, with the River Tlawng being the longest. These rivers are primarily fed by monsoon winds, and the state experiences an average annual rainfall of 254 cm. The average elevation of the mountain ranges in Mizoram is around 900 meters.

As per the 2011 census, Mizoram has a population of 1,091,014, making it the second least populous state in India. The state is divided into eleven districts: Aizawl, Kolosib, Khawzawl, Serchhip, Mamit, Saitual, Lunglei, Hnahthial, Champhai, Siaha, and Lawngtlai. Each district is led by a Deputy Commissioner (DC), who oversees the administration. Mizoram is one of only three states in India with a Christian majority, accounting for 87% of the population. The state also boasts a higher literacy rate compared to the national average. In the 2011 census, Mizoram's literacy rate stood at 92%, second only to Kerala, and significantly higher than the national literacy rate of 74%. Aizawl, the capital district of Mizoram, had a population of 404,054 in 2011, ranking 557th out of 640 districts in India. The district's population density is 113 people per square kilometer, and its population growth rate from 2001 to 2011 was 24.07%. Aizawl has a sex ratio of 1009 females per 1000 males and an impressive literacy rate of 98.5%.

Christianity is the predominant religion in Mizoram, with 87% of the population identifying as Christians from various denominations. Religion plays a central role in the daily lives of the Mizo people, and Christianity has a significant influence on the state's culture. As a result, Christianity has been granted special recognition by the government, while maintaining a basic secular framework. According to the 2011 census, out of a population of 1.09 million, approximately 956,000 (87.16%) are Christians, 94,000 (8.51%) are Buddhists, and 30,000 (2.75%) are Hindus. A small percentage, 0.09%, reported no religion, while 1.48% belong to other religions. These figures reflect the deeply religious nature of the Mizo community.

Adolescence, spanning from ages 10 to 19, is a critical phase of development between childhood and adulthood. It is a period marked by rapid physical, cognitive, and psychosocial changes, which influence how adolescents feel, think, make decisions, and interact with their surroundings. While often considered a healthy phase, adolescence is also associated with significant rates of death, illness, and injury, many of which are preventable or treatable. During this stage, adolescents establish behavioral patterns—such as those related to diet, physical activity, substance use, and sexual behavior—that can either protect or jeopardize their health now and in the future. To ensure healthy growth and development, adolescents need access to accurate information, including age-appropriate sexuality education, opportunities to develop life skills, health services that are accessible, equitable, and effective, and environments that are safe and supportive. They should also be given the chance to actively participate in the planning and delivery of health interventions. Addressing these needs is essential for promoting adolescent health. Adolescent development is a complex process involving biological, emotional, cognitive, social, and cultural factors. This period of rapid change, second only to infancy, often leads adolescents to seek guidance from spiritual beliefs and religious institutions when facing challenging questions or decisions (Marin, 2016).

The development of spiritual concerns in adolescence is partly due to their growing ability to think abstractly (Piaget, 1972). Adolescents become increasingly

capable of deeply considering social, moral, and political issues (Bruce & Cockreham, 2004). According to Erikson's (1968) fifth stage of development, identity vs. identity confusion, adolescents become aware of their role in society, and their quest for self-understanding influences their actions and thoughts. They seek to distinguish their beliefs and values from those of their parents or caregivers. Achieving a clear sense of identity is a crucial milestone, allowing teens to contribute positively to their communities and avoid identity confusion. Ideological frameworks provide adolescents with defined values, beliefs, and worldviews that form the foundation of their identity (Muuss, 1988). Faith traditions can offer adolescents a set of values and beliefs that help them establish a sense of identity, purpose, and belonging as they transition into adulthood. However, as adolescents begin thinking more abstractly, they may interpret their past and present experiences in new ways (Phelps, 2006).

Adolescence with its developmental changes and the process of identity formation, offers a distinct opportunity for individuals to establish their own spiritual values and either reinforce or reevaluate their faith (Kor et al., 2019). As a result, religiosity and spirituality (R/S) can become important factors influencing adolescents' well-being and overall development (Abdel-Khalek, 2011; King & Boyatzis, 2015).

In recent years, developmental psychology has increasingly focused on adolescent religiosity and its role in adolescent adjustment (Hardy et al., 2019). While religious practices vary across cultures, political boundaries, communities, and individuals, religion remains an influential and often central aspect of life for many people worldwide (Fisher, 2005; Hood et al., 2003). Generally, religiosity has been found to positively predict pro-social behaviors in youth (e.g., social initiative) and negatively predict antisocial behaviors (e.g., substance use, delinquency).

Adolescence is viewed as a crucial period for religious development, as the growing abilities for abstract thinking, hypothetical reasoning, and meta-cognition play a significant role in the exploration and commitment to religious identity. Religiosity and spirituality (R/S) can become important factors connected to

adolescents' well-being and overall development (Abdel-Khalek, 2011; King & Boyatzis, 2015).

Objectives: As provided by the available literature the following objectives were framed for the present research:

1) To examine the significant difference on Hopelessness, Life Satisfaction, Resilience and Depression between High Religious and Low Religious samples.
2) To examine the significant difference on Hopelessness, Life Satisfaction, Resilience and Depression between Male and Female samples.
3) To examine any significant difference between High Religious Male Samples, Low Religious Male Samples, High Religious Female Samples and Low Religious Female Samples on Hopelessness, Life Satisfaction, Resilience and Depression.
4) To explore any significant relationship between Hopelessness, Life Satisfaction, Resilience and Depression.
5) To discern any significant independent effect of 'religiosity' and 'gender' on Hopelessness, Life Satisfaction, Resilience and Depression.
6) To study the interaction effect of 'religiosity and gender' on Hopelessness, Life Satisfaction, Resilience and Depression.
7) To examine the prediction of Religiousity on Hopelessness, Life Satisfaction, Resilience and Depression among the samples.

Hypothesis: To meet the objectives of the study, the following hypotheses were framed for the present study:

1) High Religious samples will have lower Hopelessness and Depression but higher Life satisfaction and Resilience than Low Religious samples.
2) Male Samples will have lower Hopelessness and Depression but higher Life Satisfaction and Resilience than Female Samples.
3) There will be a significant difference between High Religious Male Samples, Low Religious Male Samples, High Religious Female Samples and Low

Religious Female Samples on the level of Hopelessness, Life Satisfaction, Resilience and Depression.

4) There will be a significant relationship between Hopelessness, Life Satisfaction, Resilience and Depression.
5) It was expected that 'Religiosity' and 'Gender' will have a significant independent effect on Hopelessness, Life Satisfaction, Resilience and Depression.
6) There will be a significant interaction effect of 'Religiosity and Gender' on Hopelessness, Life Satisfaction, Resilience and Depression.
7) It was expected that Religiosity will have a significant prediction on Hopelessness, Life Satisfaction, Resilience and Depression among the samples.

Chapter- 4

METHODS AND PROCEDURE

Sample

To achieve the objectives, 240 Mizo High School Students (120 high religious and 120 low religious) were screened out from different High Schools of Mizoram (targeted population) with equal representation of gender (120 male and 120 female adolescents), age between 13-16 years to serve as the sample. Samples were drawn from the list of different high schools in Aizawl city following multi-stage sampling procedures. The Duke University Religion Index (DUREL; Koenig et al., 1997) was employed for screening high and low religiosity, and out of 600 Mizo High School students 240 students were screened out (M±5) to serve as a sample. Other variables including age, permanent address, birthplace, family type, size of the family, place in birth order, several siblings, family income, etc were under control to have well-matchedhigh and low religiousity along with male and female students using socio-demographic data and also used for cross-checking of the true representation as per the designs.

Psychological tools used

The study used the following psychological scales to measure the psychological function of the samples such as:

1) ***The Duke University Religion Index (DUREL: Koenig, Parkerson & Meadow (1997):*** The Duke Religion Index (DUREL) is a five-item measure of religious involvement and was developed for use in large cross-sectional and longitudinal observational studies. It measures three dimensions of organizational religious activity, non- organizational religious activity and intrinsic religiosity (or subjective religiosity). The overall scale has high test-retest reliability (intra-class correlation = 0.91), high internal consistency (Cronbach's alpha's = 0.78–0.91), and high convergent validity with other measures of religiosity (r's = 0.71–0.86) and the factor structure of the DUREL has now been demonstrated and confirmed in separate samples by other independent investigative teams. The DUREL has been used in over 100 published studies conducted throughout the world and is available in 10 languages.

The scale assesses (i) Organizational religious activity (ORA)- involves public religious activities such as attending religious services or participating in other group-related religious activity (prayer groups, Scripture study groups, etc., (ii) Non-organizational religious activity (NORA - consists of religious activities performed in private, such as prayer, Scripture study, watching religious TV or listening to religious radio, and (iii) Intrinsic religiosity (IR)- assesses the degree of personal religious commitment or motivation and (iv) IR has been compared to extrinsic religiosity (ER) which is a form of religiosity mainly 'for show' where religiosity is used s a means to some more important end (financial success, social status, comfort, or as a congenial social activity), rather than for religion's sake alone.

2) ***The Beck Hopelessness Scale (BHS; Beck, 1988)****:* is a 20-item self-report inventory developed by Beck that was designed to measure three major aspects of hopelessness: feelings about the future, loss of motivation, and expectations. The test is designed for adults, age 17–80. It measures the extent of the respondent's negative attitudes, or pessimism, about the future. It may be used as an indicator of suicidal risk in depressed people who have made suicide attempts. The test is multiple choices and can be administered and scored by paraprofessionals. Norms are available for suicidal patients, depressed patients, and drug abusers. Norms are available for suicidal patients, depressed patients, and drug abusers. The internal reliability coefficients are reasonably high (Pearson r = 0.82 to 0.93 in seven norm groups), but the BHS test-retest reliability coefficients are modest (0.69 after one week and 0.66 after six weeks).

3) ***The Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985):*** This scale was developed as a measure of the judgmental component of subjective well-being (SWB). The SWLS is shown to be a valid and reliable measure of life satisfaction, suited for use with a wide range of age groups and applications, which makes possible the savings of interview time and resources compared to many measures of life satisfaction.

Besides, the high convergence of self- and peer-reported measures of subjective well-being and life satisfaction provide strong evidence that subjective well-being is a relatively global and stable phenomenon, not simply a momentary judgment based on fleeting influences. Though scoring has some cut-offs to be used as benchmarks- extremely satisfied, satisfied, slightly satisfied, neutral, slightly dissatisfied, dissatisfied, and extremely dissatisfied. Participants indicate how much they agree or disagree with each of the 5 items using a 7-point scale that ranges from 7 strongly agree to 1 strongly disagree. The analysis of the scale's reliability showed good internal consistency ($\alpha = 0.74$) among the Mexican adults and also found high internal consistency ($\alpha = 0.77$) among the targetted population in the pilot study.

4) ***The Resilience Scale (RS; Gail M.Wagnild and Heather M. Young, 1993):*** The Resilience Scale (RS), developed by Wagnild and Young (1993), is a 25-item self report questionnaire to identify the degree of individual resilience. The items of the Resilience scale were selected to reflect five interrelated components of resilience: equanimity (a balanced perspective of one's life and experiences); perseverance (the act of persistence despite adversity or discouragement); self-reliance (a belief in oneself and one's abilities); meaningfulness (the realization that life has a purpose); and existential aloneness (the realization that each person's life path is unique). The respondents are asked to state the degree to which they agree or disagree with each item on a 7-point Likert-type scale from 1 (strongly disagree) to 7 (strongly agree). All items are positively scored. The possible total scores thus range from 25 to 175 with higher scores reflecting higher resilience. The resilience scale had shown excellent internal consistency of .89 among undergraduate nursing students, and almost the same ($\alpha = .84$) was found in the targeted population through the pilot study.

5) ***The DASS-21 (Lovibond & Lovibond, 1995):*** The DASS-21 is a self-report questionnaire consisting of 21 items, 7 items per subscale: depression, anxiety and stress. Each of the three DASS-21 scales contains 7 items, divided into subscales with similar content. The DASS-21 is based on a

dimensional rather than a categorical conception of psychological disorder. The assumption on which the DASS-21 development was based (and which was confirmed by the research data) is that the differences between the depression, anxiety and stress experienced by normal subjects and clinical populations are essentially differences in degree. Participants are asked to score every item on a scale from 0 (did not apply to me at all) to 3 (applied to me very much). Sum scores are computed by adding up the scores on the items per (sub) scale and multiplying them by a factor of 2. Sum scores for the total DASS-total scale thus range between 0 and 120, and those for each of the subscales may range between 0 and 42. Cut-off scores of 60 and 21 are used for the total DASS score and the depression subscale respectively. These cut-off scores are derived from a set of severity ratings, proposed by Lovibond and Lovibond. Scores greater than 60 (for DASS-total) and greater than 21 (for the depression subscale) are labelled as "high" or "severe". The present study employed only the depression sub-scale.

6) ***Socio-Demographic Profile*** **(Fanai, M.L. (2021):** The Socio Demographic profile constructed by the researcher (Fanai, 2021) for the present study contained socio-demographic variables such as age, sex, parent's occupation, family size, number of a sibling, monthly income of the family, house living condition, parent's marital status of the sample, etc for screening of the desired sample as per design of the study.

7) ***Informed Consent Form*** **(Fanai, M.L. (2021):**The informed consent form is constructed by the research scholar (Fanai, M.L. 2021) for the present study to inform about the purpose of the study, expected participation of the participants, assurance of no harm to the participant, and has participated solely on free will and may leave at any time, and assurance of confidentiality on all personal responses; which is also taken as mandatory for fulfillment of research per APA ethical standard (2014) UGC regulation for Ph D (2019).

Design of the Study

The design of the study was 2 x 2 factorial designs that 240 high school students consisting of 120 High Religious Samples (60 High Religious Male Samples and 60 Low Religious Male Samples) and 120 Low Religious Samples (60 Low Religious Male Samples and 60 Low Religious Female Samples) to examine the significant difference on Hopelessness, Life Satisfaction, Resilience and Depression between low religious and high religious samples, to examine examine the significant difference on the dependent variables between Male and Female Samples, to find any significant difference among the groups, any relationship between the dependent variables, any significant independent effect and interaction effect of 'Religiosity and Gender' on the dependent variables and and examine the prediction of Religiousity on Hopelessness, Life Satisfaction, Resilience and Depression among the samples.

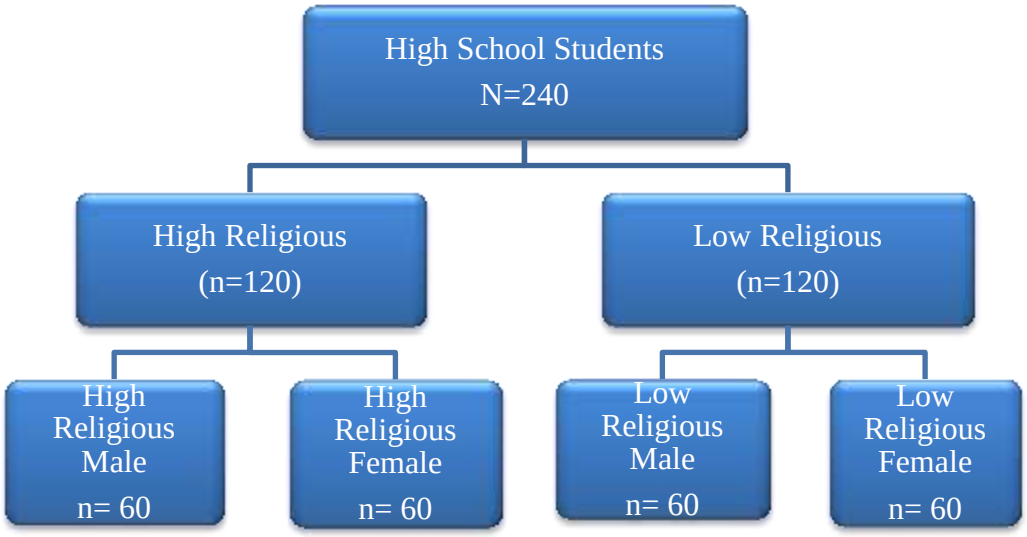


Fig-1: Diagram representing the design of the study.

Procedure

The Psychological tools were selected to be used in the study were: The Duke University Religion Index (DUREL; Koenig et al., 1997); The Beck Hopelessness Scale (BHS; Beck, 1988); The Satisfaction with Life Scale (Diener et al., 1985), The Resilience Scale (Wagnild& Young, 1993); and The DASS 21 (Lovibond &

Lovibond, 1995), and necessary permission was taken from the author or authorities. Since the participants understood English well, translation of the scale in Mizo was not needed but the Psychometric adequacy of the scales was checked through a Pilot study of the study which provided reliability (Cronbach Alpha) higher than .76 in all scales for the targeted population. Then, the scale was multiplied for administration to the samples.

Then, selection of the sample was done in phase wise. Firstly, identification of High Schools located in Aizawl was identified from the lists of High School from School Education Department, Government of Mizoram. Secondly, the researcher approached the school authorities one by one to get permission to conduct the Psychological scales. Thirdly, the researcher identified students from the selected schools, gave information about the purpose of the study, expected participation, time taken, assurance of confidentiality of their personal identity, and request for their willingness to participate in the study as subject. Only those who were willing to participate were included in the study.

The researcher administered the DUKE University Religion Index to all students of the classes; approximately more than 900 students were initiated, after which only 240 Mizo High School students who scored high (300 students) and low (300 students) on religiousity scales (M± 5) were screened out for further study. The 600 selected students were again screened on their socio-demographic variables in trying to control extraneous variables which can influence the results. For the final inclusion, 240 Mizo students were selected to meet the design of the study, and for further psychological evaluations. Again, the selected samples were informed about the purpose of the study, the expectation of participation in the study, and also ensure confidentiality of their identity as per ethical standards (APA 2014), made them clear any time they can leave if they wish, and only those who gave consent were included in the sample. Rapport formation and a careful explanation of instructions for completing the questionnaires were done with due consideration. All the prescribed administration procedures laid down by each scale were strictly followed. Then the Psychological tools were administered to the participants in individual conditions.

The response sheet was carefully checked to detect any missing or incomplete answers before leaving the administration set.

Scoring was done as per instruction in the manual of the psychological tests. After careful screening of the responses and removal of outliers and incomplete responses, 240 response sheets comprising of equal distribution of participants from each comparison group were made ready for further analysis.

Chapter- 5

RESULTS AND DISCUSSION

The present study entitled ***"Role of Religiosity on Hopelessness, Life Satisfaction, Resilience and Depression among High School Students"*** aimed to examine the unique contributions of adolescent's own religiosity in predicting their psychological adjustments, any significant relationship between the dependent variables, the independent effect of 'Religiosity and Gender' and their interaction effects on the dependent variables.

It was hypothesized that High Religious samples will have lower Hopelessness and Depression but higher Life Satisfaction and Resilience than low religious samples. It was also hypothesized that Male samples will have lower Hopelessness and Depression but higher Life Satisfaction and Resilience than Female samples. It was hypothesized that there will be a significant difference between High Religious Male Samples, Low Religious Male Samples, High Religious Female Samples and Low Religious Female Samples on the level of Hopelessness, Life Satisfaction, Resilience and Depression. It was also hypothesized that there will be a significant relationship between Hopelessness, Life Satisfaction, Resilience and Depression. It was also expected that 'religiosity and gender' will have a significant independent effect on Hopelessness, Life Satisfaction, Resilience and Depression. It was also expected that there will be significant interaction effect of 'religiosity and gender' on Hopelessness, Life Satisfaction, Resilience and Depression. It was expect that Religiosity will have significant prediction on Hopelessness, Life Satisfaction, Resilience and Depression among the samples.

To achieve the objectives and hypotheses put forth, 240 participants comprising 120 Male and 120 Female High School Students consisting of equal representation of High Religiosity and Low Religiosity having equally matched socio-demographic profiles, selected from different high schools located in Aizawl city by following multi-stage random sampling method. The age group of the participants was between 13-16 years.

The Duke University Religion Index (DUREL; Koenig et al., 1997); The Beck Hopelessness Scale (BHS; Beck, 1988); The Satisfaction with Life Scale (Diener et al., 1985) The Resilience Scale (Wagnild and Young, 1993); and The

DASS 21 (Lovibond & Lovibond, 1995), Socio-Demographic Profile (Fanai, 2021), and Informed Consent Form (Fanai, 2021) were employed for psychological evaluation to the samples. The administration was done with due care to the instructions provided in the manual and APA (2014).

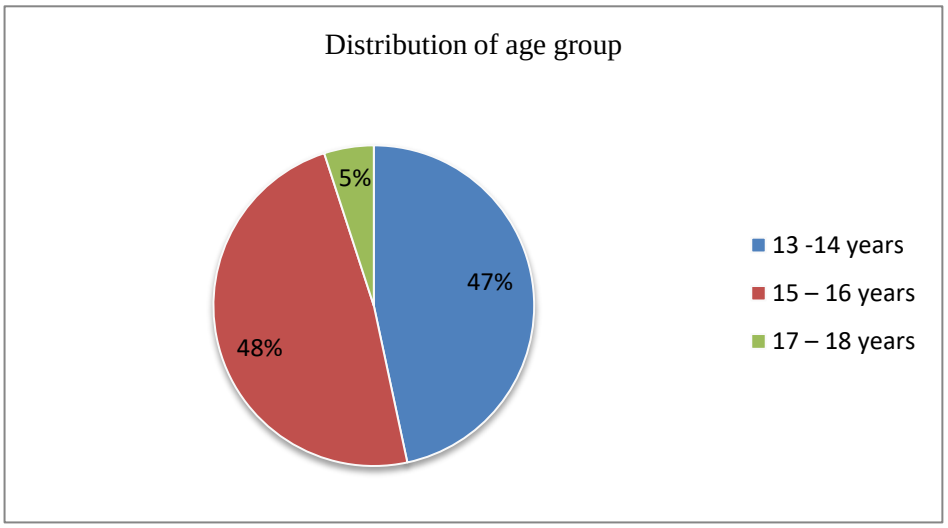
1. **Checking of Raw Data:** The raw data collected from the samples were check for missing (unresponsive) and outlier (exceedingly high or law than others), and not found missing or outlier, and ready for further analysis.

2. **Sample Characteristics:** The sample consists of 240 High School Students consisting of 120 Male School Students (60 High Religious and 60 Low Religious) and 120 Female School Students (60 High Religious and 60 Low Religious) who were permanent dwellers and born in Aizawl city, as showed under Table-1.

Table-1: Showing demographic variables (age groups, family size, sibling order, mother's occupation, father's occupation, parent's marital status, family income, participation in church activities, Sunday school attendance and family devotion) distribution among the samples (High School Students).

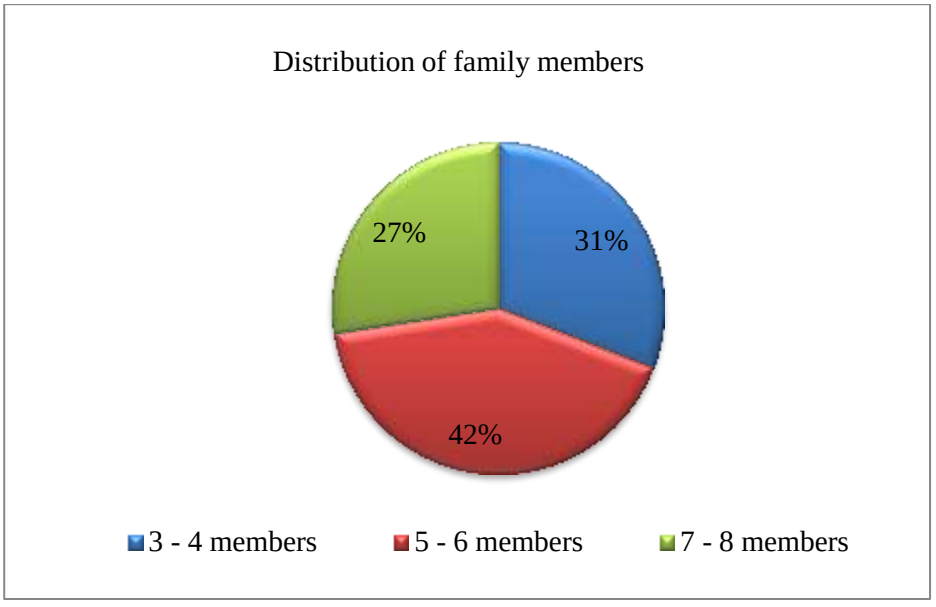
1	**Distribution of age group**				
	13 -14 years		15 – 16 years		17 – 18 years
	112 (46.6%)		116 (48.3%)		12 (5%)
2	**Distribution of family size**				
	3 - 4 members		5 -6 members		7 - 8 members
	74 (30.8%)		100 (41.16%)		66(27.5%)
3	**Distribution of sibling order**				
	1 – 2 siblings		3 – 4 siblings		5 – 6 siblings
	88 (36.6%)		120(50%)		32 (13.3%)
4	**Distribution of mother's occupation**				
	Govt. servant		Private		Unemployed
	180 (75%)		24 (10%)		36 (15%)
5	**Distribution of father's occupation**				
	Govt. servant		Private		Unemployed
	146 (60.8%)		186 (35.8%)		8 (3.3%)
6	**Distribution of parent's marital status**				
	Married	Divorced	Widow	Widower	Deceased parents
	188 (78.3%)	14 (5.8%)	20 (8.3%)	12 (5%)	6 (2.5%)
7	**Distribution of family monthly income**				
	5000	5000 - 15000	15000 - 30000	30000 - 50000	50000 - 80000	80000 above
	8 (3.3%)	14 (5.8%)	32 (13.3%)	60 (25%)	62 (25.8%)	52 (21.6%)
8	**Distribution of participation in church activities**				
	Never	Sometimes	Often	Always	
	4 (1.6%)	30 (12.5%)	178 (74.1%)	28 (11.6%)	
9	**Distribution of Sunday School attendance**				
	Never	Sometimes	Often	Always	
	4 (1.6%)	8 (3.3%)	18 (7.5%)	210 (87.5%)	
10	**Distribution of family devotion**				
	Never	Sometimes	Often	Always	
	6 (2.5%)	4 (10%)	124 (51.6%)	86 (35.8%)	

Figure -2: Showing the distribution of age group of High School Students.



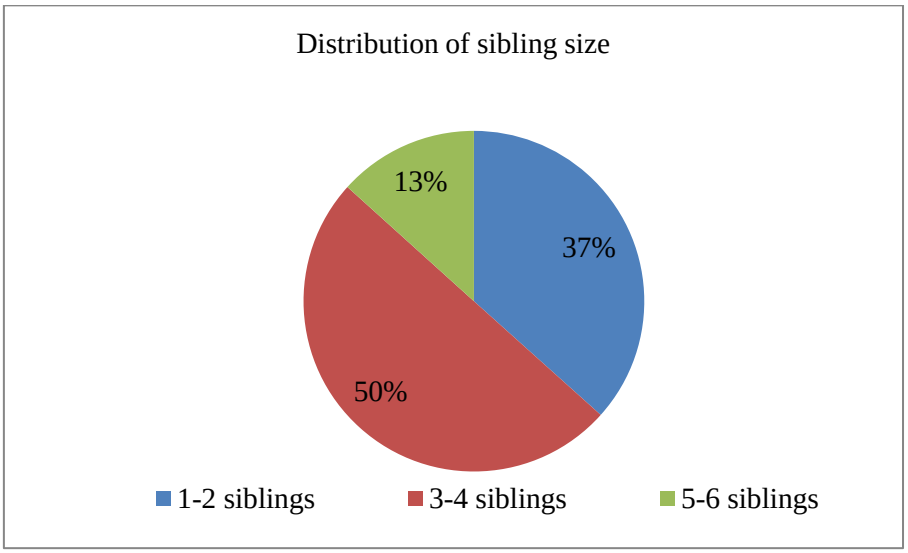
The distribution of age group of the samples showed that 47% were 13-14 years, 48% were 15-16 years, and 5% were 17-18 years *(Figure-2).*

Figure -3: Showing the distribution of family size of High School Students.



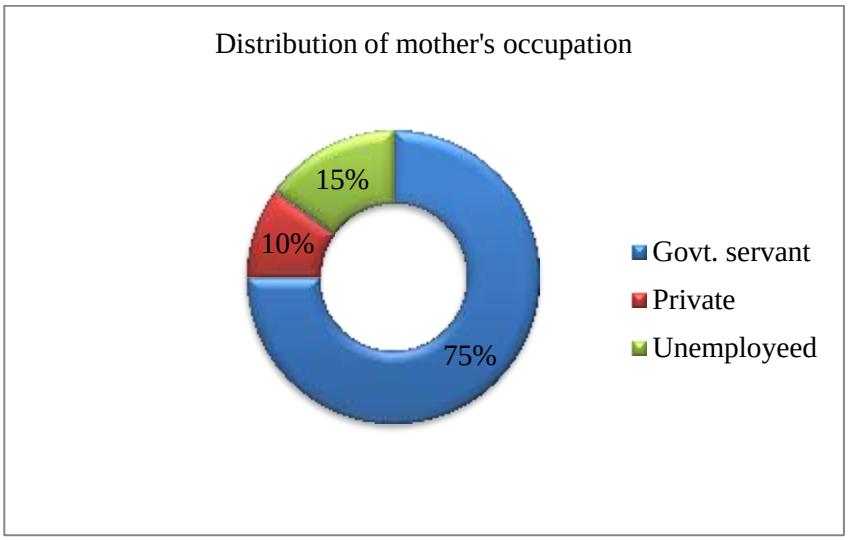
The distribution of the family size of the samples showed that 12% were having 3 family members, 18% had 4 family members, 24% had 5 family members, 18% have 6 family members, 16% had 7 family members and 12% had 8 family members *(Figure-3).*

Figure -4: Showing the distribution of sibling size of High School Students.



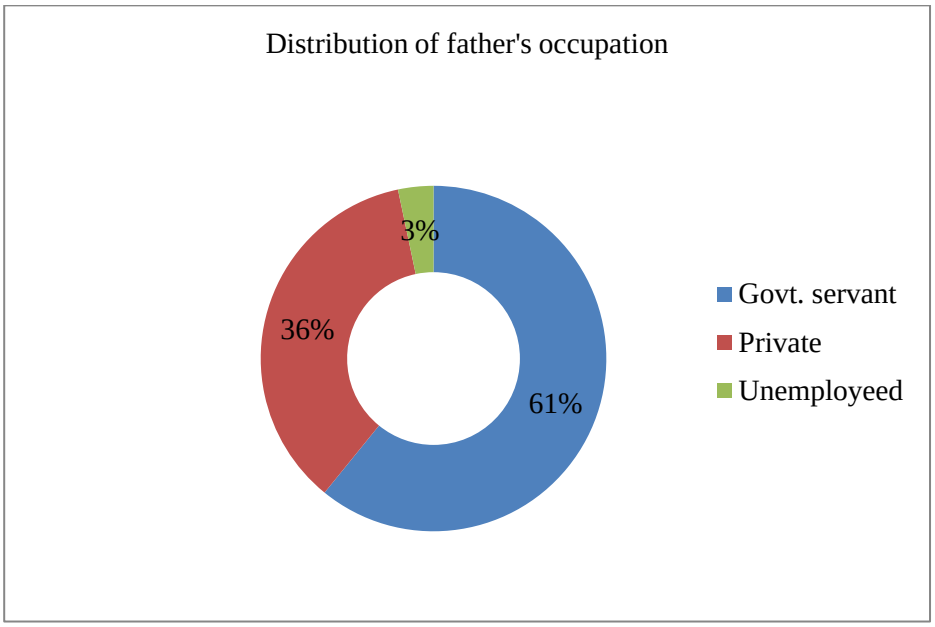
The distribution of the sibling size of the samples showed that 37% had 1-2 siblings, 50% had 3-4 siblings and 13% of the sample had 5-6 siblings *(Figure-4)* indicating that 3-4 sibling sizes were highest among the High School Students.

Figure -5: Showing the distribution of mother's occupation of High School Students.



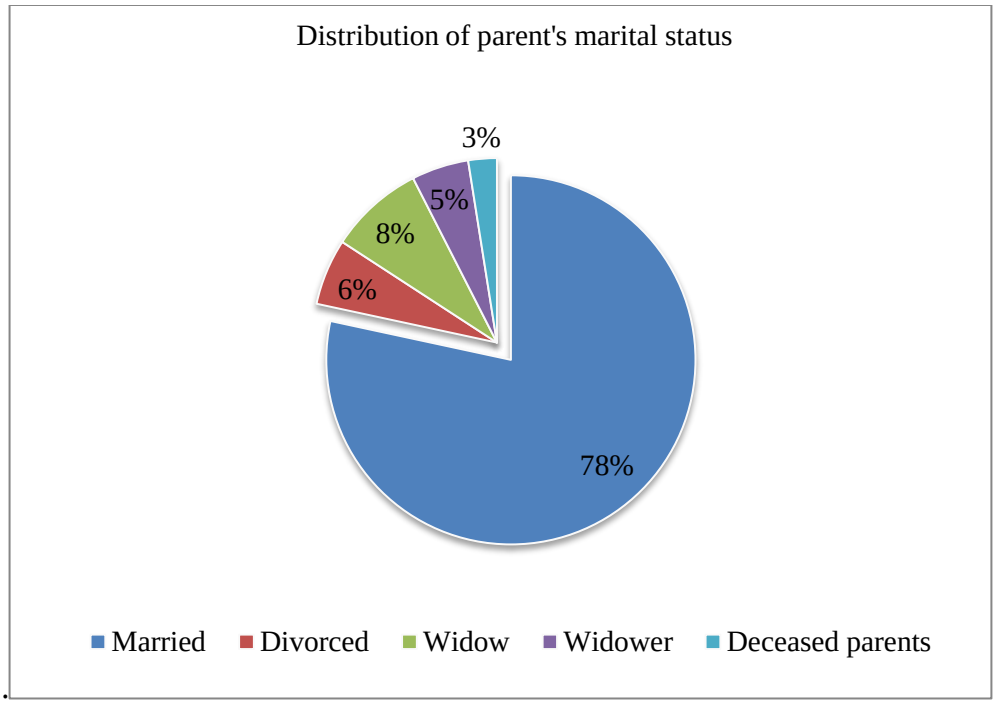
The distribution of mother's occupations of the samples has shown that 75% were Government servants, 10% were working in private and 15% were unemployed *(Figure-5)*. Research suggests that maternal unemployment can substantially affect the mental health of adolescents (Kuhn et al., 2022).

Figure -6: Showing the distribution of father's occupation of High School Students.



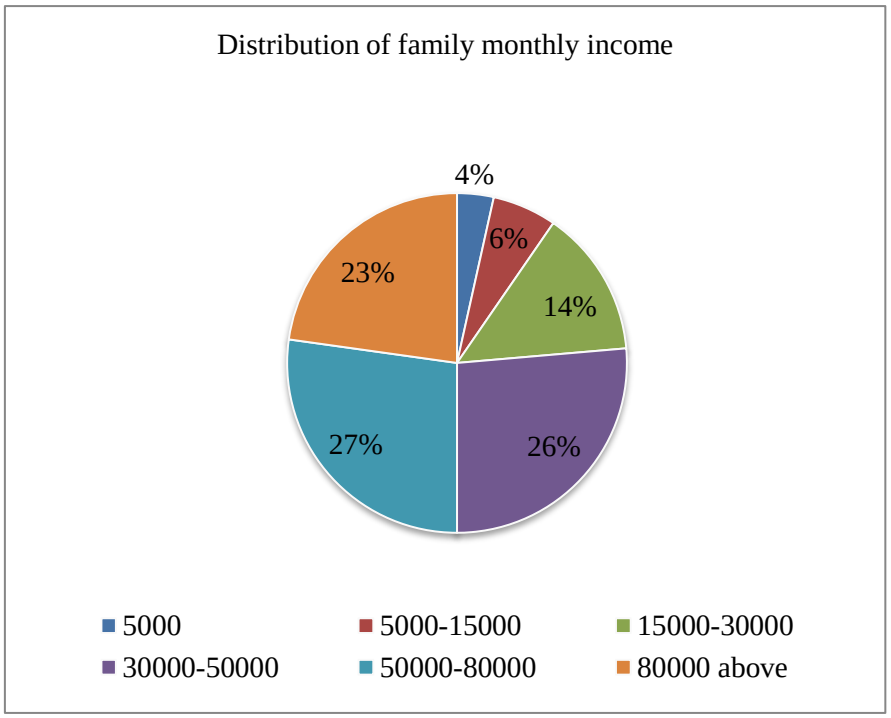
The distribution of the father's occupation of the samples has shown that 61% were Government servants, 36% were working in private and 3% were unemployed *(Figure-6)*. This implies that the stress and financial uncertainty resulting from unemployment may adversely impact the mental well-being of adolescents (Kuhn et al., 2022).

Figure -7: Showing the distribution of parent's marital status of High School Students.



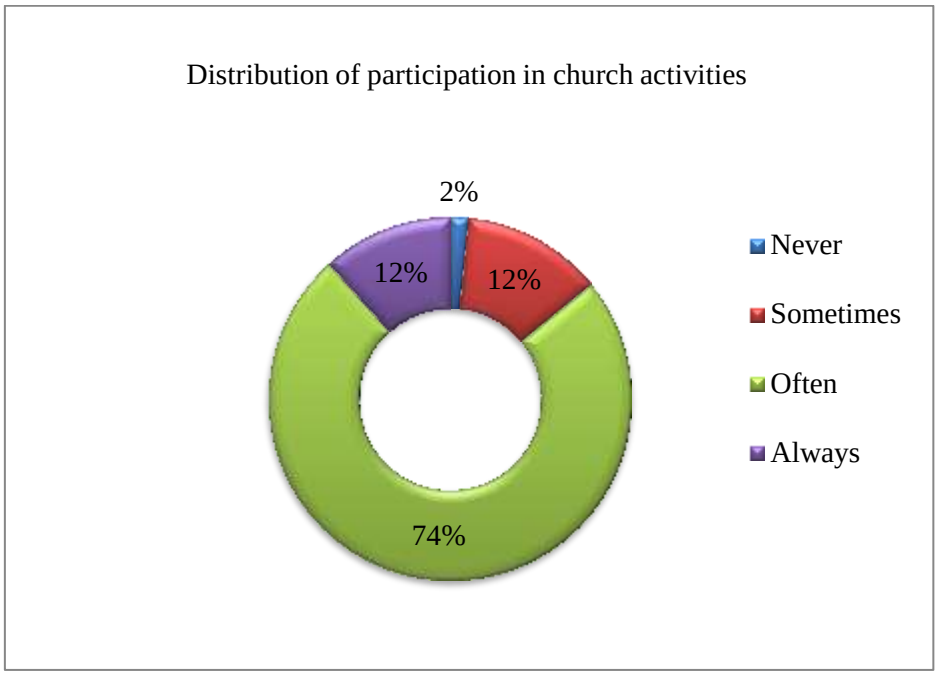
The distribution of parent's marital status of the samples showed that 80% were married, 6% were divorced, 8% were widow, 5% were widower and 3% belonged to deceased parents *(Figure-7)* which conveys that bereaved adolescents experience worsened psychological state, increased aggression and an increased risk for self-harm (Denny,2021).

Figure -8: Showing the distribution of family monthly income of High School Students.



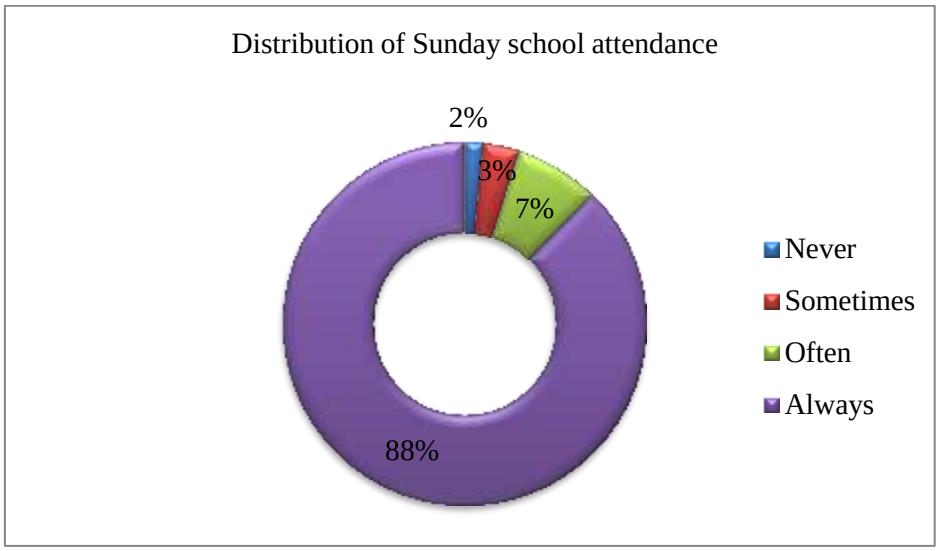
The distribution of family monthly income of the samples had shown that 4% were below 5000, 6% were between 5000-15000, 14% were between 15000-30000, 26% between 30000-50000, 27% were between 50000-80000 and 23% were above 80000 *(Figure-8).*

Figure -9: Showing the distribution of participation in church activities among High School Students.



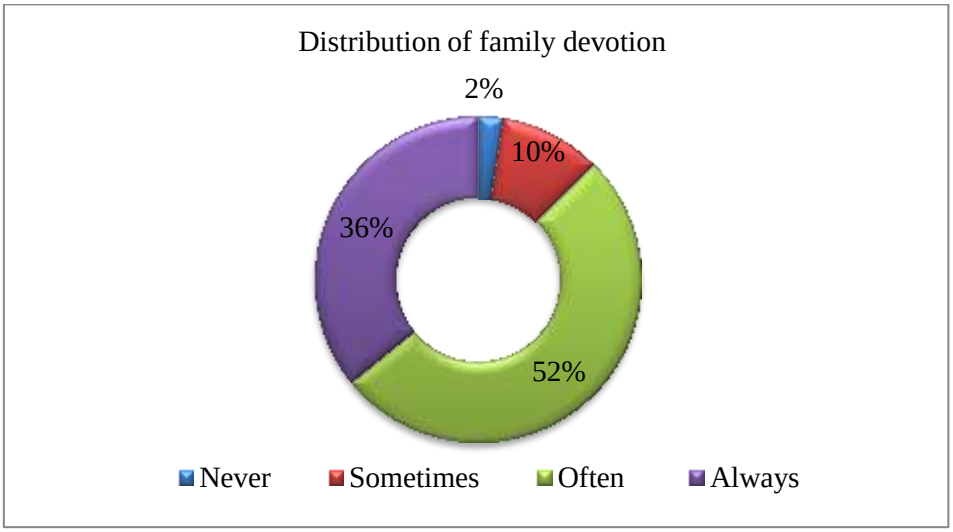
The distribution of participation of church activities showed that 2% of the samples never participated in church activities, 12% showed sometimes, 74% showed often and 12% showed always *(Figure-9)*. Research has demonstrated that individuals who frequently participate in worship services experience lower levels of depression compared to those who seldom attend (Idler, 1987; Koenig, 1995; Koenig et al., 1997; Pressman et al., 1990).

Figure -10: Showing the distribution of Sunday school attendance of High School Students.



The distribution of Sunday school attendance showed that 2% of the samples never attended Sunday school, 3% showed sometimes, 7% showed often and 88% shoed always *(Figure-10)* which conveys that attending Sunday school regularly can significantly influence an adolescent's level of religiosity.

Figure -11: Showing the distribution of family devotion of High School Students.



The distribution of family devotion showed that 2% of the samples never had family devotion, 10% showed sometimes, 52% showed often and 36% showed always *(Figure-11)* which conveys that parental religiosity, including their beliefs

and practices, can significantly influence youth, particularly during neurodevelopmentally intricate stages like adolescence (Brooks et al., 2022).

3. Checking of the Psychometric Properties of the Psychological Scales

The study employed psychological scales which were originally developed and constructed for another culture and therefore, it becomes necessary to ensure the scales are acceptable for the current population under study (Witkin & Berry,1975) as such the psychometric test was done to verify the trustworthiness of the scales for the population under study. The reliability of the scales was analyzed using Cronbach's Alpha to check the psychometric adequacy among the samples.

Reliability test: The result in ***Table-2*** revealed the reliability coefficients (Cronbach's Alpha) of the scales over the two levels of analysis (Male Samples and Female Samples). The internal consistency of the scales was found to be highly reliable for Religiosity (α = .87), Hopelessness (α = .86), Life Satisfaction (α = .90), Resilience (α = .81) and Depression (α = .85) demonstrated the trustworthiness of the psychological scales for the targeted population.

Homogeneity test: To check the homogeneity of variances of the scales, Browne Forsythe tests were employed. Results in ***Table-2***, the Browne Forsythe tests revealed non-significant in all psychological scales which indicated that the parametric statistics assumption has been met and may be employed in further analysis to meet the objectives of the study.

A normality test: Descriptive statistics including the mean, SD, Kurtosis and Skewness (***Table- 2***) revealed the normality of the present study as non was higher or lower than ± 2 which also indicated the fulfillment of the parametric statistics for choosing appropriate statistics.

Table -2: Showing the Psychometric adequacy (Mean, SD, Kurtosis, Skewness, (reliability and validity) of the psychological scales between Males (n=120) and Females (n=120), and the whole samples (N=240).

Groups	Statistics	Religiosity	Hopelessness	Life Satisfaction	Resilience	Depression
Male samples	Mean	14.20	26.64	27.09	51.16	21.81
	SD	3.72	3.63	3.88	5.59	3.57
	Kurtosis	-0.87	-0.63	0.53	0.65	-0.98
	Skewness	-0.62	0.67	-0.79	-0.72	-0.89
Female Samples	Mean	12.51	32.06	21.64	46.30	26.04
	SD	2.82	3.19	2.92	4.72	3.43
	Kurtosis	-0.68	-0.87	-0.95	-0.92	0.65
	Skewness	-0.85	0.99	-0.85	-0.96	-0.68
Reliability (Cronbach Alpha)		.87	.86	.90	.81	.85
Homogeneity test (Brown Forsythe)		.130	.093	.084	.112	.096

The results of the study were presented and discussed by objectives sequence as follows:

Objective -1: To examine the significant difference on Hopelessness, Life Satisfaction, Resilience and Depression between High Religious and Low Religious samples.

Descriptive statistics and independent t-tests were calculated to examine the difference between low religious and high religious samples on levels of hopelessness, life satisfaction, resilience and depression which was presented in ***Table-3***. The results provided that:

(i) On Hopelessness: High religious samples scored lower than low religious samples (M=27.36, 30.75; t=-8.15 p>.01) and significant at .01 level on Hopelessness. This finding was supported by previous research showing that higher levels of religiosity are linked to lower personal distress and are significantly

associated with greater life satisfaction and reduced feelings of hopelessness (Ringdal, 1996; King & Shafer, 2013). Additionally, a meta-analysis by Yonker et al., (2012) found that spirituality and religiosity positively influence psychological outcomes in adolescents and young adults.

(ii) On Life Satisfaction: High religious sample scored higher than low religious samples (M=26.48, 22.84; t= 7.50; p>.01) and significant at .01 level on Life satisfaction. The current finding aligns with previous studies suggesting that religious individuals typically report greater life satisfaction (Diener et al., 1999; Hackney & Sanders, 2003; Koenig et al., 2001). Similarly, earlier researchers also demonstrated that high levels of religiosity have been associated with improved well-being (Smith et al., 2003), and research indicates that highly religious individuals tend to live longer than those who are less religious (McCullough et al., 2000).

(iii) On Resilience: High religious samples scored higher than low religious samples (M=50.77, 47.22; t= 2.43; p>.01) and significant at .01 level on Resilience. Numerous studies have examined the relationship between spirituality or religiosity and resilience, yielding similar findings. Manning (2013) described spirituality as "a path to resilience," while Smith et al., (2012) suggested that religiosity or spirituality can enhance resilience. Individuals with higher levels of spirituality or religiosity are likely to demonstrate greater resilience. Previous research has also indicated that religiosity and spirituality can promote resilience during adolescence (Briggs et al., 2011; Kasen et al., 2012) and reduce the risk of anxiety, depression, suicidality, and substance use (Dew et al., 2008; Kasen et al., 2012).

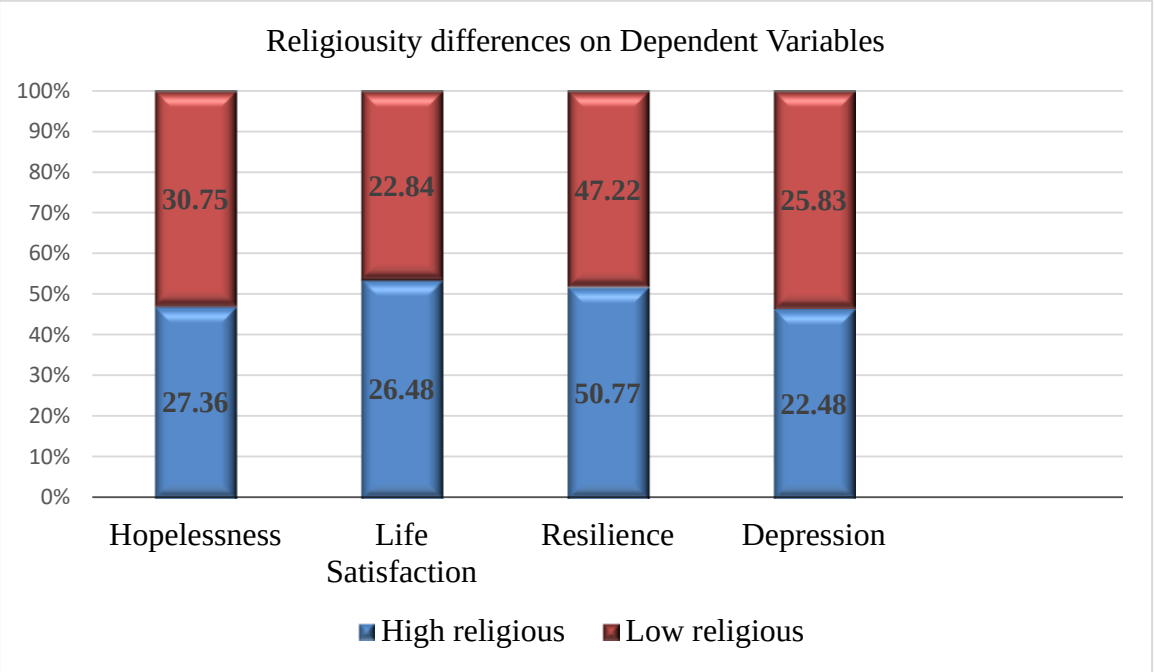
(iv) On Depression: The high religious sample scored lower than the low religious samples (M=22.48, 25.83; t= 8.53; p>.01) and significant at .01 level on Depression. This finding is consistent with research indicating that adolescents with higher levels of personal and familial religiosity tend to exhibit greater self-esteem and better psychological functioning (Ball et al., 2003). Similarly, Stearns et al., (2018) observed that individuals with high levels of religiosity reported lower levels of depression.

Table-3: Showing the descriptive statistics and significant Mean Difference (independent t-test) between High Religious (n=120) and Low Religious Samples (n=120) on Hopelessness, Life Satisfaction Resilience and Depression Variables (N=240).

Sex groups	Statistics	Hopelessness	Life satisfaction	Resilience	Depression
High religious	Mean	27.36	26.48	50.77	22.48
	SD	4.19	4.84	5.46	3.06
	Kurtosis	-0.99	-0.84	-0.83	-0.97
	Skewness	-0.85	0.85	0.92	0.82
Low religious	Mean	30.75	22.84	47.22	25.83
	SD	4.25	3.667	6.22	4.01
	Kurtosis	-0.85	-0.970	-0.86	-0.78
	Skewness	0.84	-0.748	-0.82	-0.85
t-test between high and low religious (independent t-test)		-8.15; (.003)	7.50; (.002)	2.43; (.002)	8.53; (.003)

The results presented in ***Table 3*** suggested accepting ***Hypothesis no 1*** of the study that: High Religious samples will have lower Hopelessness and Depression but higher Life Satisfaction and Resilience than Low Religious samples.

Figures -12: Showing the Mean Difference between High Religious (n=120) and Low Religious Samples (n=120) on Hopelessness, Life Satisfaction Resilience and Depression Variables (N=240).



Objective -2: To examine the significant difference on Hopelessness, Life Satisfaction, Resilience and Depression between Male and Female samples.

Descriptive statistics and independent t-tests were employed to discern any significant difference between male and female samples on dependent variables as shown in ***Table -4***, and discussed as under:

(i) On Hopelessness: The mean scores on Hopelessness showed that male samples scored lower than female samples (M= 26.64; 32.06; t= -17.08; p<.01) at .01 significant level. The finding of the study aligned with previous research done by Labelle et al., (2013) who discovered that hopeless females were twice as likely as hopeless males to report suicidal ideation, even after accounting for depression. Kashani et al., (1989) conducted a study investigating levels of hopelessness among adolescents, revealing that females tended to exhibit higher levels of hopelessness

compared to their male counterparts. This finding suggests potential gender differences in how young individuals experience and process feelings of despair and negativity about the future.

(ii) On Life Satisfaction: The mean scores on Life Satisfaction showed that male samples scored higher than female samples (M= 27.09; 21.64; t= 13.28; p<.01) at .01 significant level. The finding supports previous research on gender differences in psychological well-being, suggesting that males generally score higher on indicators of psychological well-being and life satisfaction than females. Carmel and Nigavekar (2007) found that women scored lower than men on psychological well-being measures. Goldbeck et al., (2007) observed that male adolescents consistently reported higher levels of life satisfaction compared to their female peers.

(iii) On Resilience: The mean scores on Resilience showed that male samples scored higher than female samples (M= 51.16; 46.30; t= 4.58; p<.01) at .01 significant level. The finding is consistent with previous research indicating that males exhibit greater resilience than females (Erdogan et al., 2014; Bahadir, 2009; Sürücü & Bacanli, 2010). Studies on various populations using similar measures of resilience have consistently reported higher resilience levels among boys (Campbell-Sills et al., 2009; VicHealth, 2015). While this could partly be attributed to reporting bias, with males potentially being more inclined to present themselves as strong under stress, other research employing different methods of measuring resilience has also found significantly higher resilience levels in males (Bonanno et al., 2007).

(iv) On Depression: The mean score on Depression showed that male samples scored lower than female samples (M=21.81, 26.04; t= 11.82; p<.01) at .01 significant level. The finding is in line with previous research which consistently indicates that males report experiencing lower levels of depression compared to females (Sigmon et al., 2005). Reviewing gender-related research, most previous studies suggest that adolescent females are at a higher risk of developing depression compared to males (Garber, 2002; Ay & Save, 2004). Research indicates that girls report higher levels of depressive symptoms than boys (Dishman et al., 2006; Hjemdal et al., 2011; Moksnes, Moljord, Espnes, & Byrne, 2010), with depressive

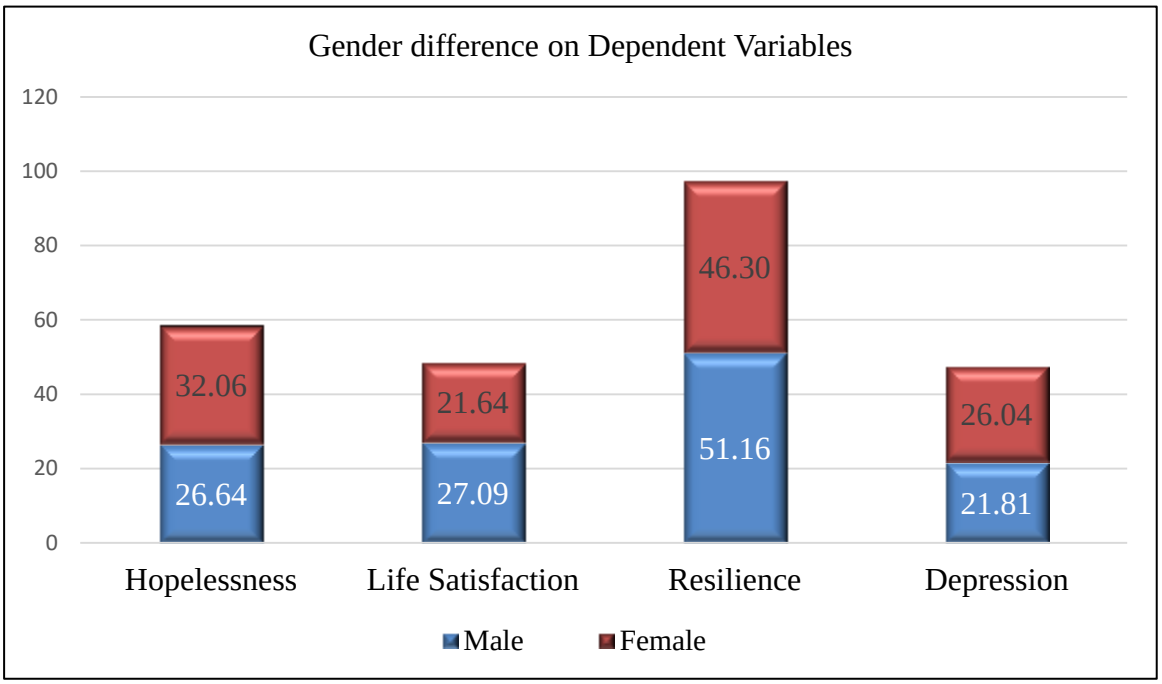
symptoms and disorders showing a notable increase among girls during mid-adolescence (Dishman et al., 2006; Hjemdal et al., 2011; Moksnes et al., 2010; Motl et al., 2004).

Table -4: Showing the descriptive statistics and significant Mean Difference (independent t-test) between Male Samples (n=120) and Female Samples (n=120) on Hopelessness, Life Satisfaction Resilience and Depression (N=240).

Groups	Statistics	Hopelessness	Life satisfaction	Resilience	Depression
Male samples	Mean	26.64	27.09	51.16	21.81
	SD	3.63	3.88	5.59	3.57
	Kurtosis	-0.63	0.53	0.65	-0.98
	Skewness	0.67	-0.79	-0.72	-0.89
Female Samples	Mean	32.06	21.64	46.30	26.04
	SD	3.19	2.92	4.72	3.43
	Kurtosis	-0.87	-0.95	-0.92	0.65
	Skewness	0.99	-0.85	-0.96	-0.68
Total Samples	Mean	29.05	24.66	48.99	24.15
	SD	3.84	4.16	5.78	3.46
	Kurtosis	-0.83	-0.83	-0.76	-0.64
	Skewness	0.82	0.89	0.83	0.82
t-test between males and female(independent t-test)		-17.08; .001	13.28; .001	4.58; .001	11.82; .002

The results presented in ***Table 4*** suggested accepting ***Hypothesis no 2*** of the study that: Male Samples will have lower Hopelessness and Depression but higher Life Satisfaction and Resilience than Female Samples.

Figure -13: Showing Male (n=120) and Female samples (n=120) differences on dependent variables (Hopelessness, Life Satisfaction, Resilience and Depression) among the samples (N=240).



Objective 3: To examine any significant difference between High Religious Male Samples, Low Religious Male Samples, High Religious Female Samples and Low Religious Female Samples on Hopelessness, Life Satisfaction, Resilience and Depression.

Descriptive statistics and Post hoc Mean Comparision were calculated to expose any significant difference between high-religious male samples, Low-religious male samples, High-religious female samples, and Low-religious female samples on Hopelessness, Life Satisfaction, Resilience and Depression; results were presented in ***Table – 5*** (mean differences) and ***Table-6*** (post hoc Mean Comparisons) , and discussed as under:

(i) High Religious Male Samples scored lowest on Hopelessness (M = 24.38) and Depression (M = 22.98) but scored highest on Resilience (M = 53.97) and Life Satisfaction (M = 29.98). This finding is in line with previous research indicating that

religious belief can help protect against depression (Bonelli et al., 2012) and may even reduce the likelihood of its onset (Koenig et al., 2012). Similar findings also suggested that religiosity serves as a protective factor against negative psychological outcomes in youth, such as depression. Factors like the "perceived importance of religion" (Sinha et al., 2007), "relational spirituality" (Wright et al., 1993), and the "meaningfulness of religion" have all been associated with reduced levels of depression in young people.

The finding is in line with previous studies done by (Koenig, 1998) who found statistically significant relationships between higher levels of religious involvement and greater life satisfaction, happiness, improved mood, or higher morale. Religiosity is thought to influence mental and physical well-being both directly and indirectly (Seybold & Hill, 2001; Miller & Thoresen, 2003). Overall, religiosity has been consistently reported to positively correlate with well-being, including life satisfaction and happiness (Argyle, 2000).

(ii) Low Religious Male Samples scored lowest on Life Satisfaction (M = 22.97) and Depression (M = 28.67) but scored highest on Hopelessness (M = 30.33) and Resilience (M = 47.57). This finding aligns with prior research, including the meta-analysis by Bonelli et al., (2012), which highlighted that the impact of religiosity on mental health is influenced by individual experiences of faith and the larger sociocultural context in which religious beliefs are practiced. These elements emphasize the intricate relationship between religiosity and depression, showcasing how personal and external factors interact to shape mental health outcomes.

(iii) High Religious Female Samples scored lowest on Depression (M = 25.25) and Hoplessness (M = 26.17) but scored highest on Life Satisfaction (M = 27.72) and Resilience (M = 50.23). The finding is consistent with previous research which stated that a strong relationship has been observed between religiosity and depression levels (Smith et al., 2003), though the degree of this relationship may vary significantly depending on regional, national, and continental contexts (Dein, 2006). Previous research has also shown that religion is positively linked to mental health in

adolescents and serves as a significant predictor of lower depression levels (Sanders et al., 2015).

Similarly, Stearns et al., (2018) reported that individuals with higher levels of religiosity experienced lower depression levels. Additionally, studies by Moreira-Almeida et al. (2006) found that, in most well-conducted research, greater religiosity was associated with improved psychological well-being, including life satisfaction, happiness, positive affect, and higher morale, as well as reduced depression, suicidal thoughts and behaviors, and drug or alcohol use and abuse.

This finding is consistent with previous research by Chavers (2013), which examined the relationships between spirituality, religiosity, mindfulness, personality, and resilience and revealed significant associations among religiosity, spirituality and resilience.

(iv) Low Religious Female Samples scored lowest on Life Satisfaction (M = 19.52) and Depression (M = 29.72) and scored highest on Hopelessness (M = 33.78) and Resilience (M = 44.20). The findings of this study align with previous research, which has shown that women with low religious engagement and religiosity tend to experience higher levels of emotional distress, depression, and hopelessness. Hays and Oxley (2014) specifically examined the role of spirituality, religiosity, and religion in mental health and found that resilience was less effective in women with low religious involvement.

Similar findings by Pargament et al., (2000) who examined the impact of religiosity on mental health found that higher levels of religiosity can help reduce depression and increase resilience, particularly during difficult circumstances. However, for individuals with low levels of religiosity, the absence of religious practices and beliefs may be linked to greater hopelessness and lower resilience.

Table- 5: Showing the Mean difference for High Religious Male samples(HRMS), Low Religious Male Samples(LRMS), High Religious Female Samples (HRFS) and Low Religious Female Samples (LRFS) on Hopelessness, Life Satisfaction Resilience and Depression Variables (N=240).

	Mean				
Scales	**HRMS**	**LRMS**	**HRFS**	**LRFS**	**Total Samples**
Hopelessness	24.38	30.33	26.17	33.78	28.66
Life Satisfaction	29.98	22.97	27.72	19.52	25.04
Resilience	53.97	47.57	50.23	44.20	48.99
Depression	22.98	28.67	25.25	29.72	26.65

Post hoc Mean comparisions between four groups on dependent variables (Table-6) and discussed as under:

(i) On Hopelessness: High religious male samples scored significantly lower (M = 24.38) on hopelessness than low religious male samples (M = 30.33) at 0.01 level (F = -5.95; p = <0.01) and also significantly lower than high religious female samples (M = 24.38; 26.17; F = -3.34; p = <0.01) and also lower than low religious female samples (M = 24.38; 33.78; F = -9.40; p = <0.01). Low religious male samples scored higher (M = 30.33) on hopelessness than high religious female samples (M = 26.17) at 0.01 level (F =2.62; P = <0.01) but lower than low religious female samples (M = 30.33; 33.78, F = -3.45; p = <0.01). High religious female sample scored significantly lower on hopelessness than low religious female samples (M = 26.17; 33.78; F = -6.06; p <0.01).

The finding is consistent with previous research indicating that spirituality and religiosity are often linked to improved mental health, including lower levels of depression, anxiety, stress, suicidal thoughts, and substance use (Moreira-Almeida et al., 2014). Religious teachings frequently promote resilience and perseverance, and

adolescents who embrace these values may be better prepared to navigate life's challenges without experiencing hopelessness.

Research on the relationship between religiosity and hopelessness has identified strong associations. Religious beliefs and coping mechanisms can significantly alleviate hopelessness, particularly in those experiencing depression or challenging life events. A meta-analysis of decades of research demonstrated that religiosity frequently correlates with reduced depressive symptoms and, as a result, lower levels of hopelessness. This protective effect is attributed to the ability of religious practices to provide meaning, foster social support, and inspire hope in the face of adversity (Bonelli et al., 2012).

(ii) On Life Satisfaction: High religious male samples scored significantly higher (M = 29.98) on life satisfaction than low religious male samples (M = 22.97) at 0.01 level (F = 1.56; p = <0.01) and also significantly higher than high religious female samples (M = 29.98; 27.72; F = .60; p = <0.01) and also higher than low religious female samples (M = 29.98; 19.52; F = 2.05; p = <0.01). Low religious male samples scored lower (M = 22.97) on life satisfaction than high religious female samples (M = 27.72) at 0.01 level (F =-2.56; P = <0.01) but higher than low religious female samples (M = 22.97; 19.52, F = -.96; p = <0.01).High religious female sample scored significantly higher than low religious female samples (M = 27.72; 19.52; F = .48; p <0.01).

This finding is supported by earlier research showing that higher levels of religiosity are associated with improved well-being (Smith et al., 2003) and that individuals with strong religious beliefs tend to live longer than those who are less religious (McCullough et al., 2000). Abdel-Khalek and Lester (2010) examined the relationship between religiosity, subjective well-being; which includes happiness, life satisfaction, love of life, and physical and mental health; and psychopathology, such as anxiety and depression. Their study found that students reporting higher religiosity also experienced greater well-being.

Research has consistently shown that individuals with high levels of religiosity tend to score higher on life satisfaction measures. This positive association is often attributed to the psychological, social, and emotional benefits provided by religious beliefs and practices. Lim and Putnam (2010) found that religious involvement is linked to greater life satisfaction, primarily mediated by the social networks built through religious communities. Ferriss (2002) observed that religiosity enhances perceived quality of life and life satisfaction by providing meaning, purpose, and a supportive community

(iii) On Resilience: High religious male samples scored significantly higher (M = 53.97) on resilience than low religious male samples (M = 47.57) at 0.01 level (F = 5.68; p = <0.01) and also significantly higher than high religious female samples (M = 53.97; 50.23; F = 3.42; p = <0.01) and also higher than low religious female samples (M = 53.97; 44.20; F = 8.95; p = <0.01). Low religious male samples scored lower (M = 47.57) on resilience than high religious female samples (M = 50.23) at 0.01 level (F =-2.26; P = <0.01) but higher than low religious female samples (M = 47.57; 44.20, F = 3.26; p = <0.01). High religious female sample scored significantly higher than low religious female samples (M = 50.23; 44.20; F = 5.53; p <0.01).

The result aligns with the findings of several researchers who have highlighted the role of spiritual and religious beliefs in enhancing resilience (Brewer-Smyth & Koenig, 2014). Studies have shown that high levels of religiosity can serve as a significant resilience factor within specific populations (Dilber et al., 2016). Smith et al., (2012), suggested that while resilience does not necessarily require spirituality or religiosity, individuals with spiritual or religious beliefs are likely to exhibit higher levels of resilience.

Similar findings by Koenig et al., (2012) observed that religious individuals often exhibit greater resilience due to the emotional and spiritual support derived from their faith and community, which fosters optimism and persistence in overcoming challenges. Pargament et al., (1998) underscored the role of religious coping mechanisms, such as seeking spiritual guidance and reframing stressful situations through a faith-oriented lens, in strengthening resilience during times of crisis. Bonelli et al., (2012) also highlighted that religiosity promotes resilience by

instilling a sense of purpose, offering moral direction, and providing psychological tools to navigate hardships effectively

(iv) On Depression: High religious male samples scored significantly lower (M = 22.98) on depression than low religious male samples (M = 28.67) at 0.01 level (F = 4.64; p = <0.01) and also significantly lower than high religious female samples (M = 22.98; 25.25; F = 3.51; p = <0.01) and also lower than low religious female samples (M = 22.98; 29.72; F = 7.57; p = <0.01). Low religious male samples scored higher (M = 28.67) on depression than high religious female samples (M = 25.25) at 0.01 level (F =-2.34; P = <0.01) but lower than low religious female samples (M = 28.67; 29.72, F = 3.62; p = <0.01). High religious female sample scored significantly lower on depression than low religious female samples (M = 25.25; 29.72; F = 5.42; p <0.01).

The finding is consistent with previous studies done by (Moreira-Almeida et al., 2014) who also found that religiosity is generally linked to better mental health outcomes, such as lower levels of depression, anxiety, stress, suicidal ideation, and substance abuse. Similar findings have been observed in other studies, which suggest that religious involvement often provides protective benefits against mental health issues. Research consistently highlighted that religiosity offers individuals coping strategies, a sense of purpose, and social support, all of which contribute to improved psychological well-being (Pargament, 1997; Koenig et al., 2012).

Table 6: Showing Significant Mean difference (Post hoc multiple Comparision; Scheffe) between the four groups (HRMS=High Religious Male Samples, LRMS= Low Religious Male Samples, HRFS=High Religious Female Samples and LRFS= Low Religious Female Samples) on Hopelessness, Life Satisfaction, Resilience and Depression (N=240).

Dependent Variable	**Groups**			
Hopelessness		LRMS	HRFS	LRFS
	HRMS	-5.95*	-3.34*	-9.40*
	LRMS	1	2.62*	-3.45*
	HRFS		1	-6.06*
Life Satisfaction		LRMS	HRFS	LRFS
	HRMS	1.56*	.60*	2.05*
	LRMS	1	-2.56*	-.96*
	HRFS		1	.48*
Resilience		LRMS	HRFS	LRFS
	HRMS	5.68*	3.42*	8.95*
	LRMS	1	-2.26*	3.26*
	HRFS		1	5.53*
Depression		LRMS	HRFS	LRFS
	HRMS	4.64*	3.51*	7.57*
	LRMS	1	-2.34*	3.62*
	HRFS		1	5.42*

*= The mean difference significant at the .01 level.

The results presented in ***Table-5*** and ***Table-6*** suggested accepting ***Hypothesis no 3*** of the study.

Objective -4: To explore any significant relationship between Hopelessness, Life Satisfaction, Resilience and Depression.

The Pearson Correlation was employed to demonstrate the significant relationship between Hopelessness, Life Satisfaction, Resilience and Depression which were presented in ***Table -7*** and discussed below:

(i) Life Satisfaction had a significant negative relationship with Depression ((r = -.56, p < .01) and Hopelessness (r = -.41, p < .01) whereas a significant positive relationship with Resilience (r = .57, p < .01). Research indicates that higher levels of

psychological well-being are associated with reduced depression (Bhullar et al., 2014). Factors such as life satisfaction, happiness, hopefulness, and self-efficacy have been linked to various positive outcomes, including lower stress levels and reduced incidence of mental health issues (Natvig et al., 2003; Gilman & Huebner, 2006; Valois et al., 2004; Schiffrin & Nelson, 2010; Siddique & D'Arcy, 1984).

The finding supports earlier studies which showed a significant negative correlation between higher levels of subjective well-being and perceived depression (Li et al., 2023), indicating that greater subjective well-being is linked to reduced perceived depressive disorders. Additionally, subjective well-being appears to play a particularly important role in mitigating self-rated depression among older adults (Li et al., 2023). Furthermore, findings by Oktan (2008) and Karairmak (2007) suggest that adolescents with higher life satisfaction also exhibit greater resilience. These findings are consistent with the results of this study.

(ii) Depression has a significant positive relationship with Hopelessness ($r = .43$, $p < .01$) at a .01 level but a significant negative relationship with Resilience ($r = -.59$, $p < .01$) at .01 level. Similar findings indicate that hopelessness is linked to depressive symptoms, suicidal ideation, and other clinical conditions (Beck et al., 1990; 1998). Likewise, Greene (1989) examined the connection between depression and hopelessness, concluding that hopelessness is a significant predictor of depression. Research consistently demonstrates that individuals with higher resilience levels tend to report lower rates of depression, anxiety, and other mental health disorders (Hu et al., 2015).

(iii) Hopelessness had a significant negative relationship with Resilience ($r = -.42$, $p < .01$) at a .01 level. Similar findings suggest that hopelessness is a key factor in predicting resilience, with the results indicating that as individuals' levels of hopelessness increase, their levels of resilience tend to decrease (Masten, 1994; Mandleco& Perry, 2000; Capella & Rhona, 2001; Smith, 2009).

Table -7: Showing the significant relationship (Pearson's Correlation) between Life Satisfaction, Depression, Hopelessness and Resilience for the whole samples (N=240).

Dependent Variables	Life Satisfaction	Depression	Hopelessness	Resilience
Life Satisfaction	1			
Depression	-.56**	1		
Hopelessness	-.41**	.43**	1	
Resilience	.57**	-.59**	-.42**	1

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

The results presented in ***table-7*** revealed a significant negative correlation between Hopelessness, Life Satisfaction and Resilience and a positive relation between Life Satisfaction and Resilience; Depression and Hopelessness which supported the ***Hypothesis no-4*** of the present study.

Objective -5: To discern any significant independent effect of 'Religiosity and Gender' on Hopelessness, Life Satisfaction, Resilience and Depression.

One Way ANOVA was used to calculate the independent effect of 'Religiosity' and 'Gender'on Hopelessness, Life Satisfaction, Resilience and Depression. Results were presented in ***Table -8*** and discussed as follows:

(i) Independent Effect of 'Religiousity'and 'Gender' on Hopelessness:

(a) Religiousity effect on hopelessness- The results of the study showed that Religiosity had a significant independent effect on Hopelessness with an effect size of 22 % (F=66.56; μ =0.22). The finding was supported by earlier researcher which demonstrated the significant role of religiosity in reducing feelings of hopelessness

by offering individuals a framework of meaning, purpose, and optimism (Koenig et al., 2001),

(b) Gender effect on hopelessness- Gender had a significant independent effect on Hopelessness with an effect size of 35 %(F=291.97; μ =0.35). The finding is consistent with previous reaserch which explored gender-based differences in how adolescents respond emotionally to stress. The study found that males are more likely to express stress through externalizing behaviors, such as aggression, rather than internalizing it. This tendency to externalize emotional distress could explain why males often report lower levels of hopelessness compared to females Burton et al., (2009).

(ii) Independent effect of 'Religiosity'and 'Gender' on Life Satisfaction

(a) Religiousity effect on Life Satisfaction-Religiosity had a significant independent effect on Life Satisfaction with an effect size of 19% (F=496.54; μ =0.19).The current finding aligns with previous research suggesting that religious individuals tend to have higher levels of life satisfaction (Diener et al., 1999; Hackney & Sanders, 2003; Koenig et al., 2001). Lee (2007) observed that religious support was linked to reduced depression and greater life satisfaction. Similarly, the Australian Unity Index Report (2008) found that among religious individuals, stronger religious beliefs and practices were associated with higher life satisfaction and overall well-being.

(b) Gender effect on Life Satisfaction- Gender had a significant independent effect on Life Satisfaction with an effect size of 43 %(F=176.60; μ =0.43). Regarding gender differences in psychological well-being, research supports the idea that males generally score higher on well-being indicators compared to females. For instance, Carmel and Nigavekar (2007) found that women scored lower than men on psychological measures of well-being.

(iii) Independent Effect of 'Religiosity'and 'Gender' on Resilience

(a) Religiosity effect on Resilience- Religiousity had a significant independent effect on Resilience with an effect size of 22 %(F=67.66; μ =0.22).Previous research has

indicated that religiosity in adolescents fosters resilience by offering social support, aiding adaptive coping mechanisms, and providing meaning and purpose during challenging times (Kim et al., 2011). Additionally, many scholars have emphasized the role of spiritual and religious beliefs in enhancing resilience (Brewer-Smyth & Koenig, 2014).

(b) Gender effect on Resilience-Gender had a significant independent effect on Resilience with an effect size of 31 %(F=165.25; μ =0.31). Research has demonstrated that males generally exhibit greater resilience than females (Erdogan et al., 2014; Bahadir, 2009; Sürücü &Bacanlı, 2010). Other population studies have also observed higher resilience among boys (Campbell-Sills et al., 2009; VicHealth, 2015). Previous studies using different methods to measure resilience have similarly reported significantly higher resilience levels in males (Bonanno et al., 2007).

(iv) Independent effect of 'Religiosity' and 'Gender' on Depression

(a) Religiousity effect on Depression-Religiosity had a significant independent effect on Depression with an effect size of 23 %(F=72.64; μ =0.23).Research indicates that religiosity is positively linked to mental health in adolescents and serves as a significant predictor of reduced depression levels (Sanders et al., 2015). Doolittle and Farrell (2004) discovered that spirituality and religiosity were positively correlated with intrinsic beliefs, such as faith in a higher power, the value of prayer, and finding meaning during adversity, while showing a negative association with depression.

(b)Gender effect on Depression- Gender had a significant independent effect on Depression with an effect size of 37% (F=139.37; μ =0.37).Research has emphasized that gender differences in depression prevalence begin to manifest during adolescence (Hankin & Abramson, 2001). Similarly, other studies have noted the emergence of such differences between males and females around ages 11 to 13 (Cicchetti & Toth, 1998). Findings also show a higher prevalence of depression among women compared to men (Essau et al., 2010; Kendler et al., 2014; Pratt et al., 2014).

Table -8: Showing the Independent effect (One-way ANOVA) of 'Religiosity and Gender' on Hopelessness, Life Satisfaction, Resilience and Depression for the whole samples (N=240).

Dependent Variables	Independent Variables	Sum of Squares	Mean Square	F	Sig.	Eta Squared
Hopelessness	Religiousity	690.20	690.20	66.56	0.00	0.22
	Gender	1739.96	1739.96	291.97	0.00	0.35
Life Satisfaction	Religiousity	1915.35	1915.35	496.54	0.00	0.19
	Gender	1764.28	1764.28	176.60	0.00	0.43
Resilience	Religiousity	756.15	756.15	67.66	0.00	0.22
	Gender	1399.87	1399.87	165.25	0.00	0.31
Depression	Religiousity	670.00	670.00	72.64	0.00	0.23
	Gender	1058.22	1058.22	139.37	0.00	0.37

The results portrayed in ***Tables- 8*** showed that 'Religiosity and Gender' had a significant independent effect on all dependent variables which supported ***Hypothesis no-5*** of the study and suggested accepting it.

Objective- 6: To study the interaction effect of 'Religiosity and Gender' on Hopelessness, Life Satisfaction, Resilience and Depression.

The Two Way ANOVA was employed to demonstrate the interaction effect of 'Religiosity and Gender' on Hopelessness, Life Satisfaction, Resilience and Depression among the samples. The results evinced the significant interaction effect which was presented in ***Table- 9,*** and discussed as under:

(i) Interaction effect of 'Religiosity and Gender' on Hopelessness: The results revealed that the interaction effect of 'Religiosity and Gender' was found significant on Hopelessness with an effect size of 42 % ($F=744.34$; $\mu =0.42$) and significant at .01 level. The results revealed that high religious males showed a lower level of hopelessness. The current findings align with research conducted by Wong et al., (2006), who reviewed studies on adolescents and found that the majority (90%)

indicated a positive association between higher levels of religiosity or spirituality and improved mental health. The existential aspects of religiosity and spirituality demonstrated the strongest connection with mental health, with this relationship being more pronounced in males and older adolescents compared to females and younger adolescents.

(ii) Interaction Effect of 'Religiosity and Gender' on Life Satisfaction: The results demonstrated that 'Religiousity and Gender' had a significant interaction effect on Life Satisfaction with an effect size of 48 % (F=517.85; μ =0.48) and significant at .01 level. Research on the interaction between religiosity and gender in relation to life satisfaction is limited. However, existing studies have shown that religiosity is linked to subjective well-being (Dunbar, 2021, 2022; Steger & Frazier, 2005; Tiliouine et al., 2009) and is a predictor of improved mental health (Hoogeveen et al., 2022; Mohr et al., 2006; Moreira-Almeida et al., 2006). This association has been observed in both adult populations (AbdAleati et al., 2016; Malinakova et al., 2020) and adolescents (Cotton et al., 2006; Estrada et al., 2019; Fruehwirth et al., 2019).

Religiosity is commonly reported to have a positive correlation with well-being, including aspects such as life satisfaction and happiness (Argyle, 2000). Research by Ismail (2012) examined the connection between religiosity and psychological well-being, revealing a strong positive association between religiosity and life satisfaction.

(iii) Interaction Effect of 'Religiosity and Gender' on Resilience: The results indicated that 'Religiosity and Gender' had a significant interaction effect on Resilience with an effect size of 37 %(F=714.03; μ =0.37) and significant at .01 level. Although studies directly related to the present findings are limited, the results align with prior research indicating that religion and spirituality can promote resilience during adolescence (Briggs et al., 2011; Kasen et al., 2012). These factors have also been shown to reduce the risk of anxiety, depression, suicidality, and substance use (Dew et al., 2008; Kasen et al., 2012). Additionally, evidence suggests

that high levels of religiosity may serve as a potential resilience factor within specific populations (Dilber et al., 2016).

(iv) Interaction Effect of 'Religiosity and Gender' on Depression: The result showed that the interaction effect of 'Religiosity and Gender' on Depression was significant at .01 level with an effect size of 41 % (F=653.76; μ =0.41).The finding is in line with research showing that individuals with high levels of religiosity tend to report lower levels of depression (Stearns et al., 2018). Similarly, a meta-analysis by Yonker et al., (2012) revealed that spirituality and religiosity positively impact psychological outcomes in adolescents and young adults.

Table - 9: Showing the Interaction effect (Two-way ANOVA) of 'Religiosity and Gender' on Hopelessness, Life Satisfaction, Resilience and Depression for the whole samples (N=240).

Dependent Variables	Interaction effect	Sum of Squares	df	Mean Square	F	Sig.	Eta Squared
Hopelessness	Religiousity x Gender	2856.41	3	952.14	744.34	0.00	0.42
Life Satisfaction	Religiousity x Gender	3595.75	3	1198.58	517.85	0.00	0.48
Resilience	Religiousity x Gender	3076.98	3	1025.66	714.03	0.00	0.37
Depression	Religiousity x Gender	2557.55	3	852.51	653.76	0.00	0.41

The results in ***Table- 9*** revealed that there was a significant interaction effect of 'Religiosity and Gender' on Hopelessness, Life Satisfaction, Resilience and Depression which accepted ***Hypothesis no-6*** of the study.

Objective-7: To examine the prediction of Religiosity on Hopelessness, Life Satisfaction, Resilience and Depression among the samples.

The linear regression analysis was employed to determine the prediction of Religiosity on Hopelessness, Life Satisfaction, Resilience and Depression. The results were presented in ***Table-10***, and discussed as under:

Results revealed that Religiosity predicted 22 % of Hopelessness; 19 % of Life Satisfaction; 22 % of Resilience and 23% of Depression.

(i) Prediction of Religiosity on Hopelessness

The results showed that Religiosity predicted 22% of Hopelessness. The finding is consistent with earlier research which demonstrated that religious belief is a significant predictor of reduced depression levels (Maton, 1989; McIntosh et al., 1993; Presman et al., 1990) and lower levels of hopelessness (Carson et al., 1990; Young et al., 1996).

(ii) Prediction of Religiosity on Life Satisfaction

The finding of the study has shown that Religiosity predicted 19 % of Life Satisfaction. Previous studies by Ismail (2012) found a strong positive correlation between religiosity and life satisfaction, further highlighting the connection between religiosity and psychological well-being. Similar studies have also indicated that religiosity is linked to improved psychological well-being, a positive self-concept, and better physical health among adolescents (Donahue & Benson, 1995; Ellison, 1991; Oleckno&Blacconiere, 1991). A meta-analysis by Moreira-Almeida et al., (2006) found a significant association between religious practices and mental health indicators such as life satisfaction, positive emotions, and high morale further demonstrated that religiosity reduces the likelihood of engaging in risky behaviors.

(iii) Prediction of Religiosity on Resilience

The finding of the study has shown that Religiosity predicted 22% of Resilience.The findings align with extensive research indicating that resilience is linked to various factors, including coping skills, self-efficacy, optimism, social support, adaptability, religious and spiritual beliefs, positive emotions, self-esteem, and a sense of meaning and purpose in life (Helmreich et al., 2017). Earier research

findind also identified spirituality and religiosity as important sources of resilience Kim and Esquivel (2011).

(iv) Prediction of Religiosity on Depression

The finding of the study has shown that Religiosity predicted 23% of Depression. The finding was supported by earlier research which showed a strong link between higher levels of religiosity or spirituality and better mental health, including lower levels of depression (Wong et al., 2006). Consistent with this, Stearns et al., (2018) reported that individuals with high religiosity also exhibited lower levels of depression.

Depression is frequently studied in relation to religiosity and spirituality, as it is a prevalent mental health condition often linked to feelings of hopelessness and loss of meaning (Dein, 2006). Koenig et al., (2012), in their comprehensive review of the literature on religiosity/spirituality and depression, concluded that religiosity and spirituality might help mitigate life stress, potentially preventing the onset of depression or reducing its duration when it occurs.

Table-10: Showing the prediction (Regression analysis) of Religiosity on Hopelessness, Life Satisfaction, Resilience and Depression for the whole samples (N=240).

Predictor	Criterion	R^2 Change	F Change	df2	Sig. F Change	Durbin-Watson
Religiousity	Hopelessness	.22	66.56	238	0.00	0.04
	Life Satisfaction	.19	56.27	238	0.00	0.06
	Resilience	.22	67.66	238	0.00	0.04
	Depression	.23	72.64	238	0.00	0.04

The results in ***Table-10*** revealed the significant prediction of Religiosity on the dependent variables, suggested acceting ***Hypothesis no-7*** of the study.

Chapter- 6

SUMMARY AND CONCLUSION

The present study entitled ***"Role of Religiosity on Hopelessness, Life Satisfaction, Resilience and Depression among High School Students"*** aimed to study the level of religiosity conditions among High School Students in Aizawl City. The study focused on some of the factors of mental health such as hopelessness, life satisfaction, resilience and depression.

It was hypothesized that High Religious samples will have lower Hopelessness and Depression but higher Life Satisfaction and Resilience than low religious samples. It was also hypothesized that Male samples will have lower Hopelessness and Depression but higher Life Satisfaction and Resilience than Female samples. It was hypothesized that there will be a significant difference between High Religious Male Samples, Low Religious Male Samples, High Religious Female Samples and Low Religious Female Samples on the level of Hopelessness, Life Satisfaction, Resilience and Depression. It was also hypothesized that there will be a significant relationship between Hopelessness, Life Satisfaction, Resilience and Depression. It was also expected that 'Religiosity and Gender' will have a significant independent effect on Hopelessness, Life Satisfaction, Resilience and Depression. It was also expected that there will be significant interaction effect of 'Religiosity and Gender' on Hopelessness, Life Satisfaction, Resilience and Depression. It was expect that Religiosity will have significant prediction on Hopelessness, Life Satisfaction, Resilience and Depression among the samples.

To achieve the research objectives and hypotheses put forth, 240 participants comprising 120 Male and 120 Female High School Students consisting of equal representation of High Religiosity and Low Religiosity having equally matched socio-demographic profiles were selected from Aizawl city by using a multi-stage random sampling method. The age group of the participants was between 13-16 years.

Four psychological scales were used to measure the variables of interest:
i) The Duke University Religion Index (DUREL; Koenig et al., 1997); ii) The Beck Hopelessness Scale (BHS; Beck, 1988); iii) The Satisfaction with Life Scale (Diener

et al., 1985) iv) The Resilience Scale (Wagnild and Young, 1993); and v) The DASS 21 (Lovibond & Lovibond, 1995).

Subject-wise scores on the specific item of the scales were separately prepared and analyzed to check their psychometric adequacy for measurement purposes across the samples. The psychometric adequacies of the behavioral measures were analyzed by employing SPSS 23 (Statistical Package for Social Sciences). To check the psychometric adequacy of each scale used in the target population i) Reliability coefficients (Cronbach's Alpha) ii) Descriptive statistics consisting of Mean, SD, Skewness and Kurtosis were included for comparison of the test scores between the groups.

The first objective was to examine the significant difference on Hopelessness, Life Satisfaction, Resilience and Depression between low religious and high religious samples. Results depicted that High Religious samples scored lower on Hopelessness and Depression and higher on Life Satisfaction and Resilience than Low Religious samples.

This finding is consistent with the results of previous studies which indicated that religiosity has been shown to protect against negative psychological outcomes in youth, such as depression, the perceived importance of religion (Sinha et al., 2007), "relational spirituality" (Wright et al., 1993), and the "meaningfulness of religion" have all been associated with lower levels of depression in youth. Studies have shown that religiosity positively influences prosocial behavior, social skills, psychological well-being, and life satisfaction (Abdollahzadeh Rafi et al., 2020; Bjorck et al., 2019; Fariddanesh& Rezaei, 2019; Yonker et al., 2012).

Studies done by Koenig et al., (2001) also found that religiosity plays a significant role in reducing feelings of hopelessness by offering individuals a framework of meaning, purpose, and optimism.

The second objective was to examine the significant difference on Hopelessness, Life Satisfaction, Resilience and Depression between Male and Female Samples. Results indicated that Male Samples scored lower on Hopelessness and Depression but higher on Life Satisfaction and Resilience than Female Samples.

Similar studies done by Burton et al., (2009) explored gender-based differences in how adolescents respond emotionally to stress and found that males are more likely to express stress through externalizing behaviors which could explain why males often report lower levels of hopelessness compared to females.

Research exploring gender difference on resilience indicated that males generally exhibit higher resilience than females (Erdogan et al., 2014; Bahadir, 2009; Sürücü & Bacanli, 2010). Piccalilli and Wilkinson (2000) conducted research on gender differences in depression, focusing on identifying risk factors contributing to these differences. Their findings highlighted that girls are more likely to experience depression than boys.

The third objective was to examine the level of Hopelessness, Life Satisfaction, Resilience and Depression between the four groups (High Religious Male Samples, Low Religious Male Samples, High Religious Female Samples and Low Religious Female Samples). Results indicated that High religious male samples depicted a lower level of hopelessness and depression and higher level of Life Satisfaction and Resilience than Low Religious Male Samples, High Religious Female Samples and Low Religious Female Samples

The finding is consistent with previous studies done by Wright et al., (1993) who examined the relationship between church attendance, the perceived meaningfulness of religion, and depressive symptoms in adolescents. The findings indicated that adolescents who frequently attended church and found religion meaningful exhibited fewer depressive symptoms. This research highlights the potential protective effect of religiosity against mental health challenges like depression and hopelessness among adolescents.

The fourth objective was to explore any significant relationship between Hopelessness, Life Satisfaction, Resilience and Depression. The results revealed a significant positive relationship between Life Satisfaction and Resilience; Depression and Hopelessness and a significant negative correlation between Hopelessness, Life Satisfaction and Resilience. Studies have indicated that resilience tends to increase in

alignment with improvements in life satisfaction. Karairmak (2007) demonstrated a positive correlation between resilience and life satisfaction.

Earlier research has identified a strong link between hopelessness and depressive symptoms, as well as suicidal ideation and other clinical conditions (Beck & Beck et al., 1990; 1998). Greene (1989) investigated the interplay between depression and hopelessness, concluding that while hopelessness is a significant predictor of depression, its influence diminishes when depression reaches severe levels.

Research has revealed a significant inverse relationship between adolescents' life satisfaction and hopelessness. As life satisfaction increases, levels of hopelessness tend to decrease. This outcome aligns with findings that life satisfaction is associated with positive perceptions and outcomes in life (Diener & Seligman, 2002), while hopelessness correlates with negative consequences such as pessimistic future expectations, feelings of helplessness, and an inability to resolve problems effectively (Beck et al., 1974; Dilbaz& Seber, 1993; Abramson et al., 1989). It has been proposed that when individuals face significant stress and lack adequate resilience or coping resources, the emergence of hopelessness is a likely outcome (Hjemdal et al., 2012).

The fifth objective was to discern any significant independent effect of ‘Religiosity and Gender’ on Hopelessness, Life Satisfaction, Resilience and Depression. The result showed that ‘Religiosity and Gender’ had a significant independent effect on Hopelessness, Life Satisfaction, Resilience and Depression. Results revealed that Religiosity and Gender had a significant independent effect on Hopelessness with an effect size of 22 %, 35 %. Life Satisfaction with an effect size of 19 %, 43 %. Resilience with an effect size of 22 %, 31 %. Depression with an effect size of 23 %, 37 % which accepted the third hypothesis.

Research indicates that religiosity positively impacts adolescent mental health, serving as a key predictor of reduced depression levels (Sanders et al., 2015). Studies have highlighted the emergence of gender differences in depression rates

during adolescence, highlighting that females are generally more prone to depressive symptoms compared to males (Hankin & Abramson, 2001). These findings suggest that both religiosity and gender play crucial roles in shaping mental health outcomes during this developmental stage.

The sixth objective was to study the interaction effect of 'Religiosity and Gender' on Hopelessness, Life Satisfaction, Resilience and Depression. The results revealed that there was a significant interaction effect of 'Religiosity and Gender' on Hopelessness, Life Satisfaction, Resilience and Depression. Results demonstrated that the interaction effect of 'Religiosity and Gender' was found significant on Hopelessness with an effect size of 42 %, Life Satisfaction 48 %, Resilience 37 % and Depression 41 % which accepted the fourth hypothesis. Studies have indeed indicated that high level of religiosity can act as a potential resilience factor in the specific population (Dilber*et al*., 2016).

The seventh objective was to examine the prediction of Religiosity on Hopelessness, Life Satisfaction, Resilience and Depression among the samples. Results revealed that Religiosity predicted 22% of Hopelessness; 19% of Life Satisfaction; 22% of Resilience and 23% of Depression.

Similar findings suggest that that individual who reported high levels of religiosity also reported lower levels of depression (Stearns et al., 2018). Depression is often selected as the phenomenon of interest in relationship to religiosity/ spirituality because it is a common mental disorder and is often associated with loss of hope and meaning (Dein, 2006).

Limitations of the study

The study was done cautiously controlling the possible effect of extraneous variables and contributed valuable new knowledge to the existing literature but it was not free from limitations; (i) The sample size used in the study was not large enough to effectively represent the targeted population which may specify not big enough to generalize to the whole targeted population although it provides a sense of insight for the future research; (ii) A more systematic and comprehensive empirical cross-

examination of responses such as conducting qualitative interviews, longitudinal studies, or employing mixed-methods approaches to gain a more in-depth understanding of the issue; (iii) Inclusion of more demographic information which could have added more interesting information in order to control extraneous variables from the focused independent variables and dependent variables; (iv) Factor related to the school environment, teachers, and peer group could have been included in the study as they may be expected to play an important part in an adolescent's behavior.

Suggestions for further studies

The study emphasizes the importance of improving future research by encouraging the replication of its findings in these areas;(i) Bigger sample size and a wider range of participants would have contributed more knowledge about the impact of religiosity on adolescents; (ii) Future research could benefit from a more structured and thorough empirical exploration, incorporating methods such as qualitative interviews, longitudinal studies, or mixed-methods approaches. These strategies would allow for a deeper and more nuanced understanding of the relationships and dynamics involved, providing richer insights into the topic; (iii) The inclusion of additional demographic details could have enriched the study by providing more nuanced insights and ensuring better control over extraneous variables that might influence the relationship between the primary independent and dependent variables; (iv) Adolescence is a transformative phase marked by substantial development and challenges. Addressing these issues requires fostering a supportive environment, ensuring access to mental health resources, and providing positive guidance from parents, caregivers, and educational institutions. Future research could explore strategies to strengthen these support systems, examining their effectiveness in promoting resilience, life satisfaction, and mental well-being during this critical stage of life.

Significance of the study

The results of the study illustrated revealed that High Religious samples had lower hopelessness and depression compared to low religious samples and higher life

satisfaction and resilience than Low Religious samples. The results may explain the importance of religiosity in promoting mental health of adolescent.

The results provided the significant difference between male and female samples on hopelessness, life satisfaction, resilience and depression which demonstrated that male samples had higher life satisfaction and resilience whereas lower hopelessness and depression compared to female samples which highlighted the need of specific attention on female adolescent including psychological cares and intervention.

The results of the study illustrated revealed a significant difference among the four groups- High religious male samples scored significant lower on depression and hopelessness and significantly higher on life satisfaction and resilience than Low religious male samples, High religious female samples and Low religious female samples. The results provided the important role of religiosity in the psychological function of adolescent.

The results provided a significant positive relationship between life satisfaction and resilience; depression and hopelessness and a significant negative correlation between hopelessness, life satisfaction and resilience. The study provided bases for framing psychological cares and interventions for adolescent.

The independent effect and interaction effect of 'Religiosity and 'Gender' was elucidated by this study, and may be utilized to make a strategy for the prevention and intervention of mental health in adolescent.

Adolescence is a pivotal period marked by significant biological, cognitive, and social changes as individual's transition from childhood to adulthood. This phase involves physical and neurobiological maturation, fostering increased psychological awareness and social interactions. Given these challenges, it's essential to focus on adolescent mental health through coordinated efforts at various levels to ensure better outcomes for young people.It is a developmental stage that bridges childhood and adulthood, marked by spiritual growth and preparation for life. In essence, this stage is marked by heightened emotions, both positive and negative, and intense reactions

to experiences (Yörükoğlu, 1993). Furthermore, individuals may experience a loss of self-confidence and feelings of hopelessness during this time (Yörükoğlu, 1992).

Adolescents today face numerous mental health challenges influenced by factors such as academic stress, social media, family dynamics, and the complexities of a rapidly changing world. These pressures have contributed to rising rates of anxiety, depression, and other mental disorders among young people. The World Health Organization (WHO) reports that one in seven adolescents aged 10-19 experiences a mental disorder, accounting for 15% of the global disease burden in this age group. Key conditions include depression, anxiety, and behavioral disorders.

Understanding the relationship between religiosity and adolescent mental health necessitates examining external influences such as school and community factors, which play a pivotal role in shaping adolescents' values, self-esteem, and social relationships. Schools and communities often provide environments that either reinforce or challenge individual beliefs.

In conclusion, the present study highlighted the role of Religiosity on Hopelessness, Life Satisfaction, Resilience and Depression among High School Students contributed new insight and understanding to the available literature, and it highlighted the role of religiousity in promoting mental health issues and psychological functions of adolescents which need urgent attention for designing a psychological intervention. It also highlighted that integrating religiosity into prevention and intervention strategies could be effective in addressing mental illnesses among adolescents, promoting protective factors like resilience and life satisfaction while mitigating hopelessness and depression.It highlighted religiosity as a vital component of adolescent mental well-being, addressing the psychological challenges typical of this developmental stage.Understanding how religiosity impacts mental health across genders and cultural contexts enables tailored approaches for more effective support.It underscored the dual nature of religiosity, with both positive and negative mental health outcomes, offering a nuanced framework for addressing spiritual and emotional needs.

Importantly, in the context of Mizo society, where Christianity and religious life are deeply embedded in daily routines, community structures, and value systems**,** this study gains particular relevance. For the majority of adolescents in Mizoram, religious beliefs, church participation, and spiritual teachings are not peripheral but central to their worldview, social life, and moral development. The results of this research therefore resonate strongly within this cultural setting, where religiosity shapes not only individual behavior but also community expectations and coping mechanisms.

This research facilitates further exploration for deeper investigation into the connections between faith, cultural identity, and psychological well-being within the context of Mizoram. It lays the groundwork for recognizing how the deeply rooted religious life of the Mizo people can be harnessed to positively influence adolescent mental health. At the same time, it recognizes that religiosity has a complex nature as overly rigid or guilt-based religious experiences may, in some cases, lead to emotional difficulties. Understanding this complexity is essential for creating balanced, culturally sensitive, and effective mental health approaches**.**

This research paves the way for deeper investigation into the connections between faith, cultural identity, and psychological well-being within the context of Mizoram. It lays the groundwork for recognizing how the deeply rooted religious life of the Mizo people can be harnessed to positively influence adolescent mental health. At the same time, it recognizes that religiosity has a complex nature as overly rigid or guilt-based religious experiences may, in some cases, lead to emotional difficulties. Understanding this complexity is essential for creating balanced, culturally sensitive, and effective mental health approaches**.**

APPENDICES

APPENDIX–I

INFORMED CONSENT FORM (Fanai, M.L. 2021)

The following questions will be used solely for research purposes, and any identifying information about participants will be kept confidential to the fullest extent possible. All information collected during this study will be treated with strict confidentiality. Your identity will remain anonymous, and any data collected will be stored securely. Only the researchers involved in this study will have access to the data, and the findings will be reported in aggregate form without any personally identifiable information. You can withdraw from the study at any time without providing a reason. If you have any questions, or concerns, or would like more information about this study, please feel free to ask.

Participant's signature_____

Date and time:_____

APPENDIX–II

DEMOGRAPHIC PROFILE FORM (Fanai, M.L. 2021)

1.	Gender :
2.	Age:
3.	Class :
4.	Address :
5.	Place of birth :
6.	Mothers Occupation: Govt Servant / Private / Unemployed
7.	Fathers Occupation: Govt Servant / Private / Unemployed
8.	Parent's marital status: Married( ) Divorced( )Widow ( )Widower( ) Deceased parents ( )
9.	Type of family: Nuclear family ( ) Joint family ( )
10.	Sibling size :
11.	Family size:
12.	Residential condition : Owned ( ) Rented ( )
13.	Family monthly income: i) 5000 ii) 5000 -15000 iii) 15000-30000 iv) 30000-50000 v) 50000 above
14	Do you attend Sunday school? i) Never ( ) ii) Sometimes ( ) iii) Often ( ) iv) Always ( )
15	Do you have family devotion? i) Never ( ) ii) Sometimes ( ) iii) Often ( ) iv) Always ( )

APPENDIX - III

THE DUKE RELIGION INDEX (DUREL: Koenig et al., 1997)

1. **How often do you attend church or other religious meetings? (ORA)**
   a- Never
   b- Once a year or less
   c- A few times a year
   d- A few times a month
   e- Once a week
   f- More than once/week

2. **How often do you spend time in private religious activities, such as prayer, meditation or Bible study? (NORA)**
   a- Rarely or never
   b- A few times a month
   c- Once a week
   d- Two or more times/week
   e- Daily
   f- More than once a day

The following section contains 3 statements about religious belief or experience. Please mark the extent to which each statement is true or not true for you.

3. **In my life, I experience the presence of the Divine. (i.e., God) – (IR)**
   a- Definitely not true
   b- Tends not to be true
   c- Unsure
   d- Tends to be true
   e- Definitely true of me

4. **My religious beliefs are what really lie behind my whole approach to life. - (IR)**
   a- Definitely not true
   b- Tends not to be true
   c- Unsure
   d- Tends to be true
   e- Definitely true of me

5. **I try hard to carry my religion over into all other dealings in life. –(IR)**
   a- Definitely not true
   b- Tends not to be true
   c- Unsure
   d- Tends to be true
   e- Definitely true of me

APPENDIX –IV

BECK HOPELESSNESS SCALE (BHS; Beck, 1988)

Instruction:The questionnaire consists of 20 statements. Please read the statements carefully one by one. If the statements describe your attitude for the past week including today, indicate 'True' below the column next to the statement. If the statements do not describe your attitude, indicate 'False' below the column next to the statement. Please be sure to read each statement carefully.		**TRUE**	**FALSE**
1.	I look forward to the future with hope and enthusiasm.		
2.	I might as well give up because there is nothing I can do about making things better for myself.		
3.	When things are going badly, I am helped by knowing that they cannot stay that way forever.		
4.	I can't imagine what my life would be like in ten years.		
5.	I have enough time to accomplish the things I want to do.		
6.	In the future, I expect to succeed in what concerns me most.		
7.	My future seems dark to me.		
8.	I happen to be particularly lucky, and I expect to get more of the good things in life than the average person.		
9.	I just can't get the breaks, and there's no reason I will in the future.		
10.	My past experiences have prepared me well for the future.		
11.	All I can see ahead of me is unpleasantness rather than pleasantness.		
12.	I don't expect to get what I really want.		
13.	When I look ahead to the future, I expect that I will be happier than I am now.		
14.	Things just won't work out the way I want them to.		
15.	I have great faith in the future.		
16.	I never get what I want, so it's foolish to want anything.		
17.	It's very unlikely that I will get any real satisfaction in the future.		
18.	The future seems vague and unclear to me.		
19.	I can look forward to more good times than bad times.		
20.	There's no use in really trying to get anything I want because I probably won't get it.		

APPENDIX – V

THE SATISFACTION WITH LIFE SCALE

(SWLS; Diener, Emmons,Larsen, & Griffin, 1985)

Instructions: Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your response.

- 7 - Strongly agree
- 6 – Agree
- 5 - Slightly agree
- 4 - Neither agree nor disagree
- 3 - Slightly disagree
- 2 – Disagree
- 1 - Strongly disagree

1. _____ In most ways my life is close to my ideal.
2. _____ The conditions of my life are excellent.
3. _____ I am satisfied with my life.
4. _____ So far I have gotten the important things I want in life.
5. _____ If I could live my life over, I would change almost nothing.

APPENDIX –VI

THE RESILIENCE SCALE (RS; Wagnild and Young, 1993)

Instruction: Please read the following statements. To the right of each you will find seven numbers, ranging from "1" (Strongly Disagree) on the left to "7" (Strongly Agree) on the right. Tick the number which best indicates your feelings about that statement. For example, if you strongly disagree with a statement, tick "1". If you are neutral, tick "4", and if you strongly agree, tick "7", etc.		Strongly disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly agree
1.	When I make plans, I follow through with them.	1	2	3	4	5	6	7
2.	I usually manage one way or another.	1	2	3	4	5	6	7
3.	I am able to depend on myself more than anyone else.	1	2	3	4	5	6	7
4.	Keeping interested in things is important to me.	1	2	3	4	5	6	7
5.	I can be on my own if I have to.	1	2	3	4	5	6	7
6.	I feel proud that I have accomplished things in life.	1	2	3	4	5	6	7
7.	I usually take things in stride.	1	2	3	4	5	6	7
8.	I am friends with myself.	1	2	3	4	5	6	7
9.	I feel that I can handle many things at a time.	1	2	3	4	5	6	7
10.	I am determined.	1	2	3	4	5	6	7
11.	I seldom wonder what the point of it all is.	1	2	3	4	5	6	7
12.	I take things one day at a time.	1	2	3	4	5	6	7
13.	I can get through difficult times because I've experienced difficulty before.	1	2	3	4	5	6	7
14.	I have self-discipline.	1	2	3	4	5	6	7
15.	I keep interested in things.	1	2	3	4	5	6	7
16.	I can usually find something to laugh about.	1	2	3	4	5	6	7
17.	My belief in myself gets me through hard times.	1	2	3	4	5	6	7
18.	In an emergency, I'm someone people can generally rely on.	1	2	3	4	5	6	7
19.	I can usually look at a situation in a number of ways.	1	2	3	4	5	6	7
20.	Sometimes I make myself do things whether I want to or not.	1	2	3	4	5	6	7
21.	My life has meaning.	1	2	3	4	5	6	7
22.	I do not dwell on things that I can't do anything about.	1	2	3	4	5	6	7
23.	When I'm in a difficult situation, I can usually find my way out of it.	1	2	3	4	5	6	7
24.	I have enough energy to do what I have to do.	1	2	3	4	5	6	7
25.	It's okay if there are people who don't like me.	1	2	3	4	5	6	7

APPENDIX – VII

THE DASS-21 (Lovibond & Lovibond, 1995)

Instruction: Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There is no right or wrong answers. Do not spend too much time on any statement. ***0-Never ,1-Sometimes 2-often, 3-almost always***		**Never**	**Some-Times**	**Often**	**Almost Always**
1.	I found it hard to wind down.	0	1	2	3
2.	I was aware of the dryness of my mouth.	0	1	2	3
3.	I couldn't seem to experience any positive feeling at all.	0	1	2	3
4.	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion).	0	1	2	3
5.	I found it difficult to work up the initiative to do things.	0	1	2	3
6	I tended to over-react to situations.	0	1	2	3
7.	I experienced trembling (eg, in the hands).	0	1	2	3
8.	I felt that I was using a lot of nervous energy.	0	1	2	3
9.	I was worried about situations in which I might panic and make a fool of myself.	0	1	2	3
10.	I felt that I had nothing to look forward to.	0	1	2	3
11.	I found myself getting agitated.	0	1	2	3
12.	I found it difficult to relax.	0	1	2	3
13.	I felt down-hearted and blue.	0	1	2	3
14.	I was intolerant of anything that kept me from getting on with what I was doing.	0	1	2	3
15.	I felt I was close to panic.	0	1	2	3
16.	I was unable to become enthusiastic about anything.	0	1	2	3
17.	I felt I wasn't worth much as a person.	0	1	2	3
18.	I felt that I was rather touchy.	0	1	2	3
19.	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat).	0	1	2	3
20.	I felt scared without any good reason.	0	1	2	3
21.	I felt that life was meaningless.	0	1	2	3

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ABSTRACT

ROLE OF RELIGIOSITY ON HOPELESSNESS, LIFE SATISFACTION, RESILIENCE AND DEPRESSION AMONG HIGH SCHOOL STUDENTS

AN ABSTRACT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

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ROLE OF RELIGIOSITY ON HOPELESSNESS, LIFE SATISFACTION, RESILIENCE AND DEPRESSION AMONG HIGH SCHOOL STUDENTS

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Youth is accepted as one of the most critical phases of life, a period of major physical, physiological, psychological and behavioral changes taking place with changing patterns of social interactions and relationships, laying the foundation for healthy and productive adulthood, helping to cope with the risk of health issues in later life. Numerous biological transformations such as growth in height and weight, completion of skeletal development with a rise in bone mass, sexual maturation, and alterations in body composition also take place during this period. These changes are often accompanied by significant stress influencing and affecting their relationships with their peers and adults, vulnerability to influence by peer groups and media that result in changes in perception and practice, decision-making skills and abilities with the acquisition of new emotional, cognitive and social skills.

Adolescent

The Latin word '*adolescere*,' meaning "to grow into maturity" transformed into '*adolescenc*e' refers to the transitional phase of development between childhood and adulthood (Darley et al., 1988), an individual biologically becoming adult but not fully mature emotionally. Adolescence falls between 10 and 20 years of age and is a stage of identity versus role confusion, marked by uncertainty, exploration, experimentation, and struggles with identity (Erikson (1968). They try to explore various possibilities, and failure to navigate is accompanied by a persistent identity crisis (Friedman & Schustack, 2004). Further, the coverage period was differently explained as extending from age 11 to 20 (Mahale, 1987), and 12 to 23 years (Hall, 1904) marked by turmoil and stress.

Symptoms of storm and stress in adolescence

Various symptoms of storm and stress in adolescence include conflicts with parents (Paikoff & Brooks-Gunn, 1991), mood swings (Petersen et al., 1993), risk-taking behaviors (Arnett, 1992, 1999), parental expectations for academic success, family relocations, exposure to drugs and conflict with parents (Hall, 1904).

Reasons for storm and stress in adolescence

Adolescents face challenges and life difficulties but do not receive proper guidance and support for their personal growth (Pajares & Urdan, 2006) which leads to stress and is linked to anxiety, depression, and suicidal thoughts. The common causes of adolescent turbulence include:

a) ***Biological factor-*** Adolescence is a time of physical changes, including height, weight, body composition, and circulatory and respiratory systems due to the maturation of adrenal and sex glands (Steinberg, 2013).

b) ***Environmental changes*** *(*Faustini, 2014) - home environment (Garrett-Peters et al., 2016), peer group interactions (Nelson and DeBacker, 2008), quality of the social and educational environment (Chevalier et al., 2013)

c) ***Increased independence*** - the relationship between parents and adolescents worsens as adolescents become independent (Hadiwijaya et al., 2017)

d) ***Gender identity crisis*** Erikson (1968) - puberty suppression provides adolescents with role confusion, uncertainty, exploration, experimentation, struggling with identity, and exploring various possibilities including gender reassignment (Olson et al., 2011).

Religiosity

Religiosity is a formal, institutional, outward expression of faith (Cotton et al., 2006) and encompasses practices and beliefs such as attending religious services, praying, holding theological convictions, and believing in a higher power (Iannello et al., 2019). Religiosity is an organized belief system (Muller & Dennis, 2007), encompassing shared feelings, practices, and beliefs within a cultural context (Hay, Reich & Utsch, 2006), and institutional rituals (Oman & Thoresen, 2002).

Spirituality

Spirituality is a search for meaning and purpose in life and involves a transcendent relationship with a higher being, which may not necessarily be tied to organized religion (Jenkins & Pargament, 1995).

Determinants of religiosity in Adolescent: Religious identity is shaped within the family and often functions as a family-oriented activity with participation levels being highest among families (Stolzenberg et al., 1995) which can help their relationships with their adolescent children (Wilcox, 2001). Adolescents with higher levels of religiousity in their families (Schmidt, 2003) play a crucial role in shaping adolescent achievement (Csikszentmihalyi & Schneider, 2000) by providing a sense of belonging and stable identity (Schneider & Stevenson, 1999). Mother's role is significant in shaping their children's religious and moral development including participation in religious activities and identification with religion (Bao et al., 1999).

Dependent Psychological variables

The Study aimed to explore the role of religiosity on selected psychological variables among the samples as given under.

*(i)****Hopelessness:*** Hopelessness is a belief that all possible actions may lead to an inability to summon energy or effort (Shea & Hurley, 1964). It is a negative expectation about themselves and the future (Beck, 1963), a strong predictor of suicidal behavior and accompanied by depression and other clinical conditions (Beck et al., 1990; Beck et al., 1988), It is a total absence of optimism with a feeling of powerlessness to alter them that leads to hopelessness (Abramson et al., 1989).

(ii) ***Life Satisfaction:*** Life satisfaction is a cognitive aspect of subjective well-being and a primary measure of an individual's perceived quality of life (Huebner et al., 2006).It is an overall assessment of one's life by weighing accomplishments against challenges and expectations (Diener et al., 1985; Suldo& Huebner, 2006). The factors of life satisfaction include personal fulfillment, happiness, contentment, and the degree of achievement to one's goals and desires (Landry, 2000).

(iii) ***Resilience:*** Resilience is the ability to successfully adapt in the face of trauma, tragedy, threats, or other major sources of stress (Southwick et al., 2014). The capacity to withstand hazards with minimal harm and recover effectively after

experiencing damage (Gilbert, 2010). It needs to understand the inner spirit and realize a sense of purpose (Heavy et al., 2003).

Factors of Resilience

Protective Factors: A protective factor acts as a shield against challenges, helping to reduce difficulties and promoting healthy adaptation and the development of an individual's competencies (Masten, 1994).

Social factors: Social factors encompass supportive relationships, access to resources, social support networks, community ties; and a combination of both practical and emotional support (Masten, 2007; Reinelt et al., 2015).

Psychological factors: Psychological factors include personality traits, coping mechanisms, physical and cognitive capabilities, as well as neurocognitive structures and neural reactions to stress (Feder et al., 2009; Luthar et al., 2000).

Cultural factors: Cultural resilience refers to the ability of a specific community or cultural system to withstand disruptions and adapt to changes, which include beliefs, values, and traditions that influence how individuals perceive and express resilience (Healy, 2006).

(iv) Depression: Depression is a mood disorder predisposed by both genetic and environmental risk factors and experience of stressful life events (Bouma et al., 2008; Maughan et al., 2013). Seligman (1973) called it the "common cold" of psychiatry because of its high prevalence. Depression is a mood disorder that causes a persistent feeling of sadness, loss of interest (Salik& Marwaha, 2022), emptiness, irritable mood, and changes in somatic and cognitive that significantly affect the individual’s capacity to function (Ormel et al., 2019). The DSM-5 classifies the depressive disorders into (APA, 2013):

(i) Disruptive mood dysregulation disorder

(ii) Major depressive disorder

(iii) Persistent depressive disorder (dysthymia)

(iv) Premenstrual dysphoric disorder

(v) Depressive disorder due to another medical condition

Review of Literature on Dependent Psychological Variables

This study was designed to investigate the relationship of Religiosity with Hopelessness, Life Satisfaction, Resilience and Depression, and gather literature regarding 'religiosity' and 'gender' differences effect on selected psychological variables to examine the role of religiousity in determining psychological function.

1) ***Adolescent and Religiosity:*** Adolescent religiosity impact on adolescents' adjustment varies on culture, politics, local communities, and individuals (Hardy et al., 2019). Religion is recognized as having a pivotal and influential role in life (Fisher, 2005). The self-perceived religiousity of adolescents affects their levels of school engagement and helping behaviors (Dowling et al., 2004). The high frequencies of prayer and religious reading were positively connected to volunteerism (Lam, 2002) and civic participation. Their religiousity serves as a protective factor against depression and internalized symptoms (Loveland et al., 2005).

2) ***Adolescent and Hopelessness:*** High levels of hopelessness tend to exhibit a negative mood, low adaptability, aggression, violence, and withdrawal (Kashani et al., 1991). Children with hopelessness have no positive expectations for the future but hold negative expectations that serve as a key indicator of suicidal behavior in adolescents.

3) ***Adolescent and Life Satisfaction:*** Longitudinal studies highlighted adolescents with life satisfaction linked to future externalizing and internalizing behaviors and peer victimization (Haranin et al., 2007; Martin et al., 2008) and having various family factors such as parental involvement, positive parent-child relationships, and parental social support (Ash & Huebner, 2001; Zimmerman et al., 1995).

4) ***Adolescent and Resilience:*** Resilience in adolescents is viewed as a capacity, a process to go through, and a positive and beneficial outcome (Lee et al., 2012).

Dayioglu (2008) found that males exhibit higher levels of resilience than females. Adolescents' perceived social support significantly predicts their resilience levels as girls exhibit higher resilience levels than boys (Savi-Cakar &Karatas, 2011).

5) ***Adolescent and Depression:*** Adolescent-onset depression is associated with more chronic, severe, and disabling symptoms and higher rates of suicide attempts in family history (Zisook et al., 2007). Adolescents with a major depressive disorder are more likely to exhibit irritability, anhedonia, suicidality, hypersomnia, and issues with cognitive function and circadian rest-activity rhythms (Emslie et al., 2005).

Gender Differences on Dependent Psychological Variables

Males and females differ due to a combination of genetic and environmental factors. Gender refers to the continuum of complex psychosocial self-perceptions, attitudes, social expectations behavior, lifestyles, and life experiences (Reale et al., 2023). Gender differences in religiosity, hopelessness, life satisfaction, resilience and depression are given below.

1) ***Gender Differences in Religiosity:*** Research indicates that religiosity levels vary between genders as females tend to attend church more frequently than males (Wright et al., 1993) and engage more in personal prayer (Francis & Evans, 1996). Young women seem to demonstrate stronger religious beliefs and practices compared to young men (Smith et al., 2002).

2) ***Gender Differences in Hopelessness:*** Hopelessness in females is found more reported twice than in males (Labelle et al., 2013). The hopelessness theory of depression (Stone et al., 2009) revealed that boys experienced greater hopelessness than girls, and expressed their stress with externalizing behaviors of aggression (Stone et al., 2009).

3) ***Gender Differences in Life Satisfaction:*** Studies have demonstrated that gender plays a significant role in life satisfaction as they encounter different life circumstances and life events impact in distinct ways. Earlier research has revealed

that women are generally more likely than men to experience happiness (Judge & Watanabe, 1993).

4) ***Gender Differences in Resilience:*** Males exhibit higher resilience than females (Erdogan et al., 2014; Sürücü &Bacanli, 2010) as using alternative measures have also identified significantly higher resilience levels in males (Bonanno et al., 2007).

5) ***Gender Differences in Depression:*** Gender differences in depression during adolescence start to appear between the ages of 11 and 13 (Cicchetti & Toth, 1998), and males may underreport their levels of depression (Sigmon et al., 2005) as such girls are more likely higher experience depression than boys (Piccalilli & Wilkinson, 2000).

Relationship between Dependent Psychological Variables

The relationships between observed psychological variables in this study were presented as under.

Relationship between Religiosity and hopelessness: Research demonstrated that religiosity plays a significant role in reducing feelings of hopelessness by providing a framework of meaning and purpose in life with optimism for the future (Koenig et al., 2001).

Relationship between Religiosity and life-satisfaction: Religiosity is found linked to psychological well-being, a positive self-concept, and better physical health among adolescents (Donahue & Benson, 1995; Ellison, 1991; Oleckno & Blacconiere, 1991). Religion contributes to better academic performance, educational aspirations, worldview, and optimism about the future (Regnerus et al., 2003), and has a consistent correlation with well-being among women (Koenig et al., 2012).

Relationship between Religiosity and Resilience: Religiosity is a significant source of resilience (Kim & Esquivel, 2011) that positively impacts adolescents in various ways including fostering healthy development, enhancing coping skills, improving

mental health, promoting psychological well-being, and supporting academic success (Kim & Esquivel, 2011).

Relationship between Religiosity and Depression: Religion has been found to lower the risk of depression (Miller et al., 2013), Studies showed a correlation between religiosity and mental health as religiosity buffers against stressors in ways that school activities and friendships do not (Fruehwirth et al., 2019)

Relationship between Hopelessness and Life Satisfaction: Studies have consistently found a negative correlation between hopelessness and life satisfaction, showing that higher levels of hopelessness are associated with lower life satisfaction. Hopelessness impairs the ability to enjoy life and decreases overall well-being, especially in individuals with chronic illnesses or adolescents (Beck et al., 1974).

Relationship between Hopelessness and Resilience: Research demonstrated that resilience serves as a strong predictor of hopelessness in life events of depression and anxiety (Beck et al., 1974) by strengthening an individual's capacity to adapt and cope effectively (Hjemdal et al., 2012).

Relationship between Hopelessness and Depression: Hopelessness is a key cognitive component in the development and severity of depressive symptoms (Beck et al., 974), characterized by a belief that their situations will not improve and an inability to change or control their circumstances which intensifies depressive symptoms with a cycle of negative thinking and emotional distress.

Relationship between Life Satisfaction and Resilience: Resilience has a positive effect on life satisfaction (Arslan, 2019; Yang et al., 2020), and has been considered an important cause of subjective well-being (Yildirim & Belen, 2019) which affected how they perceived, assessed, experienced, or expressed (McRae and Gross, 2020).Life satisfaction significantly predicts resilience among adolescents while preparing for exams (Oktan, 2008).

Relationship between Life Satisfaction and Depression: Research evinced that a lower level of life satisfaction is strongly associated with higher levels of depression in various aspects of their lives, such as relationships, personal achievements, and prospects, were more likely to experience symptoms of depression (Bhullar et al., 2014).

Relationship between Resilience and Depression: Individuals with greater resilience are less likely to experience depression, anxiety, and other mental health challenges. Resilient individuals maintain a more optimistic perspective, report higher levels of perceived social support, and possess strong problem-solving abilities, all of which help them manage stress effectively and sustain their mental well-being (Hu et al., 2015).

Statement of the Problem

Adolescence is a crucial developmental stage with significant physical, emotional, and psychological changes which accompanied by mental health issues such as depression, anxiety, and stress. Adolescence is a time of growth, exploration, excitement, worry and difficulties as both "the best of times and the worst of times" (Coon, 1992). In this fast-changing world today, adolescents seem to face more challenges and difficulties than previous generations (Pajares &Urdan, 2004). Stress encountered by adolescents is found linked to anxiety, depression, and suicidal thoughts (Aldwin & Greenberger, 1987; Bonner & Rich, 1987 & 1988; Wilburn &Smith (2005) while effective coping can enhance adolescents' well-being.

Research evinced that religiosity can serve as a source of emotional support, offer a sense of purpose, and provide coping mechanisms that mitigate the effects of stress, potentially reducing the risk of depression and hopelessness. Numerous studies have highlighted the role of religiosity as a protective factor during adolescence (Benson et al., 2003; Kerestesv & Youniss, 2003).

Adolescent mental health is a global concern, as estimates with that one in seven (14%) of 10–19-year-olds experience mental health conditions (WHO, 2024),

yet these remain largely unrecognized and untreated. It was estimated that depression occurs among 1.4% of adolescents aged 10–14 years, and 3.5% of 15–19-year-olds (WHO, 2024). Adolescence is a transitional period filled with unique challenges; several studies have explored the connection between religiousness and personality (Emmons & Paloutzian, 2003).

It has been recognized high mental health issues, and an increasing rate of mental illness without proper guidance and treatment are prevailing in all cultures all over the globe though religious play is significant in coping with stress not only in the adolescent period but whole life long. The researcher felt a crucial need to address adolescent mental issues, examine the role of religiousity in determining mental health conditions, and to utilize the findings for framing appropriate prevention and intervention.

Objectives: Given the available literature set the foundation for framing the objectives of the present research:

1) To examine the significant difference on Hopelessness, Life Satisfaction, Resilience and Depression between High Religious and Low Religious samples.
2) To examine the significant difference on Hopelessness, Life Satisfaction, Resilience and Depression between Male and Female samples.
3) To examine any significant difference between High Religious Male Samples, Low Religious Male Samples, High Religious Female Samples and Low Religious Female Samples on Hopelessness, Life Satisfaction, Resilience and Depression.
4) To explore any significant relationship between Hopelessness, Life Satisfaction, Resilience and Depression.
5) To discern any significant independent effect of ‘religiosity’ and ‘gender’ on Hopelessness, Life Satisfaction, Resilience and Depression.
6) To study the interaction effect of ‘religiosity and gender’ on Hopelessness, Life Satisfaction, Resilience and Depression.

7) To examine the prediction of Religiosity on Hopelessness, Life Satisfaction, Resilience and Depression among the samples.

Hypothesis: To meet the objectives of the study, the following hypotheses were framed for the present study:

1) High Religious samples will have lower Hopelessness and Depression but higher Life satisfaction and Resilience than Low Religious samples.
2) Male Samples will have lower Hopelessness and Depression but higher Life Satisfaction and Resilience than Female Samples.
3) There will be a significant difference between High Religious Male Samples, Low Religious Male Samples, High Religious Female Samples and Low Religious Female Samples on the level of Hopelessness, Life Satisfaction, Resilience and Depression.
4) There will be a significant relationship between Hopelessness, Life Satisfaction, Resilience and Depression.
5) It was expected that 'Religiosity' and 'Gender' will have a significant independent effect on Hopelessness, Life Satisfaction, Resilience and Depression.
6) There will be a significant interaction effect of 'Religiosity and Gender' on Hopelessness, Life Satisfaction, Resilience and Depression.
7) It was expected that Religiosity will have a significant prediction on Hopelessness, Life Satisfaction, Resilience and Depression among the samples.

Methods and Procedures

Sample: 240 Mizo High School Students (120 high religious and 120 low religious) were screened out from 600 students of different High Schools located in Aizawl City of Mizoram with equal representation of gender (120 male and 120 female adolescents), between 13-16 years were drawn from following multi-stage sampling procedures, selection of the high and low religiousity (M±5) was done with the Duke University Religion Index (DUREL; Koenig et al., 1997) to serve as a sample. Other

variables including age, permanent address, birthplace, family type, size of the family, place in birth order, several siblings, family income, etc were kept under control to have well-matched high and low religiousity along with male and female students using socio-demographic data and also used for cross-checking of the true representation as per the designs.

Psychological scales used: The study used the following psychological scales to measure the psychological function of the samples such as:

*i) The Duke University Religion Index (DUREL: Koenig, Parkerson & Meadow (1997):*The Duke Religion Index (DUREL) is a five-item measure of religious involvement. The overall scale has high test-retest reliability (intra-class correlation = 0.91), high internal consistency (Cronbach's alpha's = 0.78–0.91), and high convergent validity with other measures of religiosity (r's = 0.71–0.86) .

ii) The Beck Hopelessness Scale (BHS; Beck, 1988): is a 20-item self-report inventory developed by Beck that was designed to measure hopelessness: feelings about the future, loss of motivation, and expectations. The internal reliability coefficients are reasonably high (Pearson r = 0.82 to 0.93)

iii) The Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985): This scale was developed as a measure of the judgmental component of subjective well-being (SWB). The SWLS is shown to be a valid and reliable measure of life satisfaction, suited for use with a wide range of age groups and applications. It measures of subjective well-being/life satisfaction. The analysis of the scale's reliability showed good internal consistency ($\alpha = 0.74$) and high internal consistency ($\alpha = 0.77$).

iv) The Resilience Scale (RS; Gail M. Wagner and Heather M. Young, 1993): The Resilience Scale (RS), developed by Wagnild and Young (1993), is a 25-item self-report questionnaire to identify the degree of individual resilience. The resilience scale showed excellent internal consistency of .89 among undergraduate nursing

students, and almost the same (α =.84) was found in the targeted population through the pilot study.

*v) The DASS-21 (Lovibond & Lovibond, 1995):*The DASS-21 is a self-report questionnaire consisting of 21 items, 7 items per subscale: depression, anxiety and stress. Each of the three DASS-21 scales contains 7 items, divided into subscales with similar content. The overall Cronbach's alpha was 0.74, 0.66 for stress, 0.29 for anxiety and 0.52 for depression (DASS-D), anxiety (DASS-A) and stress (DASS-S), respectively. The present study employed only the depression sub-scale.

vi) Socio-Demographic Profile (Fanai, M.L, 2021): The Socio-Demographic profile constructed by the researcher (Fanai, 2021) for the present study contained socio-demographic variables such as age, sex, parent's occupation, family size, number of siblings, monthly income of the family, house living condition, parent's marital status of the sample, etc for screening of the desired sample as per design of the study.

vii) Informed Consent Form (Fanai, M.L, 2021):The informed consent form is constructed by the research scholar (Fanai, M.L. 2021) taking leads from APA ethical standard (2002, 2017) UGC regulation for Ph D (2019) for the present study. The researcher informed the participants about the purpose of the study, expected participation of the participants, assurance of no harm to the participant, and has participated solely of free will and may leave at any time, and assurance of confidentiality on all personal responses; which is also taken as mandatory for fulfillment of research per

Design of the study: The design of the study was 2 x 2 factorial designs that 240 high school students consisting of 120 High Religious Samples (60 High Religious Male Samples and 60 Low Religious Male Samples) and 120 Low Religious Samples (60 Low Religious Male Samples and 60 Low Religious Female Samples).

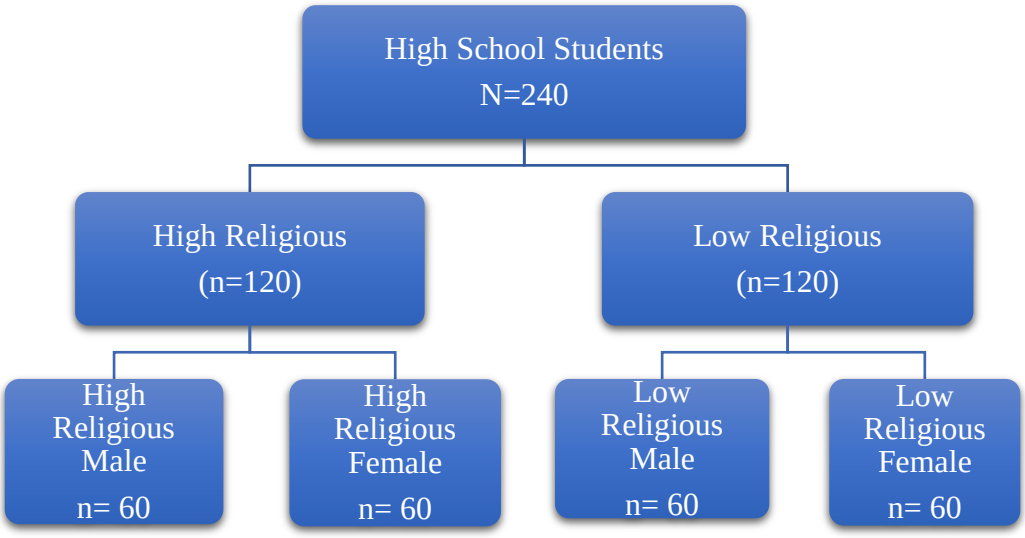

Fig-1: Diagram representing the design of the study.

Procedures: The selection of the sample was done phase-wise. Firstly, identification of High Schools located in Aizawl was identified from the lists of High Schools from the School Education Department, Government of Mizoram. Secondly, the researcher approached the school authorities one by one to get permission to conduct the psychological scales. Thirdly, the researcher identified students from the selected schools, and gave information about the purpose of the study, expected participation, time taken, assurance of confidentiality of their identity, and request for their willingness to participate in the study as subjects. Only those who were willing to participate were included in the study. Fourthly, the researcher administered the DUKE University Religion Index to all students of the classes; approximately more than 900 students were initiated. Fifthly, screening of 240 from 600 Mizo High School students who scored high (300 students) and low (300 students) on religiousity scales (M± 5) were screened out for further study. Sixthly, the final selection of 240 Mizo students was done for the design of the study, and for further psychological evaluations. The selected samples were informed about the purpose of the study, and the expectation of participation in the study, and also ensured confidentiality of their identity as per ethical standards (APA 2014), made them clear any time they could leave if they wished, and only those who gave consent were

included in the sample. Rapport formation and a careful explanation of instructions for completing the questionnaires were done with due consideration. All the prescribed administration procedures laid down by each scale were strictly followed. Then the Psychological tools were administered to the participants in individual conditions. The response sheet was carefully checked to detect any missing or incomplete answers before leaving the administration set.

Scoring was done as per instruction in the manual of the psychological tests. After careful screening of the responses and removal of outliers and incomplete responses, 240 response sheets comprising of equal distribution of participants from each comparison group were made ready for further analysis.

Results and Discussions

The Raw Data calculation was done using Microsoft Excel and SPSS and was done sequentially to meet the objectives set forth as under.

1) ***Checking Raw Data for missing and outliers:*** The raw data collected from the samples were checked for missing (unresponsive) and outlier (exceedingly high or law than others), and not found missing or outlier, and ready for further analysis.

2) ***Checking psychological scales for appropriateness:*** The study employed psychological scales which were originally developed and constructed for another culture and therefore, it becomes necessary to ensure the scales are acceptable for the current population under study (Witkin & Berry,1975) as such the psychometric test was done to verify the trustworthiness of the scales for the population under study. The reliability of the scales was analyzed using Cronbach's Alpha to check the psychometric adequacy among the samples.

Reliability test: The result in *Table-2* revealed the reliability coefficients (Cronbach's Alpha) of the scales over the two levels of analysis (Male Samples and Female Samples). The internal consistency of the scales was found to be highly reliable for Religiosity ($\alpha = .87$), Hopelessness ($\alpha = .86$), Life Satisfaction

(α = .90), Resilience (α = .81) and Depression (α = .85) demonstrated the trustworthiness of the psychological scales for the targeted population.

Homogeneity test: To check the homogeneity of the scales' variances, Browne Forsythe tests were employed. Results in Table-2 show that the Browne Forsythe tests were non-significant in all psychological scales, which indicated that the parametric statistics assumption has been met and may be employed in further analysis to meet the objectives of the study.

Normality test: Descriptive statistics, including the mean, SD, Kurtosis, and Skewness (Table 2) revealed the present study's normality as none was higher or lower than ± 2, which also indicated the fulfillment of the parametric statistics for choosing appropriate statistics.

3) ***Results presentation follows objective sequences:*** The results of the study were presented and discussed by objectives sequence as follows:

Objective -1: To examine the significant difference on Hopelessness, Life Satisfaction, Resilience and Depression between High Religious and Low Religious samples.

Descriptive statistics and independent t-tests were calculated to examine the difference between low religious and high religious samples on levels of hopelessness, life satisfaction, resilience and depression which was presented in ***Table-3***. The results provided that:

(i) On Hopelessness: High religious samples scored lower than low religious samples (M=27.36, 30.75; t=-8.15 p>.01) and significant at a .01 level on Hopelessness. This finding was supported by previous research showing that higher levels of religiosity are linked to lower personal distress and are significantly associated with greater life satisfaction and reduced feelings of hopelessness (Ringdal, 1996; King & Shafer, 2013). Additionally, a meta-analysis by (Yonker et al., 2012) found that spirituality and religiosity positively influence psychological outcomes in adolescents and young adults.

(ii) On Life Satisfaction: High religious samples scored higher than low religious samples (M=26.48, 22.84; t= 7.50; p>.01) and significant at .01 level on Life satisfaction. The current finding aligns with previous studies suggesting that religious individuals typically report greater life satisfaction (Diener et al., 1999; Hackney & Sanders, 2003; Koenig et al., 2001). Similarly, earlier researchers also demonstrated that high levels of religiosity have been associated with improved well-being (Smith et al., 2003), and research indicates that highly religious individuals tend to live longer than those who are less religious (McCullough et al., 2000).

(iii) On Resilience: High religious samples scored higher than low religious samples (M=50.77, 47.22; t= 2.43; p>.01) and significant at .01 level on Resilience. Numerous studies have examined the relationship between spirituality or religiosity and resilience, yielding similar findings. Manning (2013) described spirituality as "a path to resilience," while (Smith et al., 2012) suggested that religiosity or spirituality can enhance resilience. Individuals with higher levels of spirituality or religiosity are likely to demonstrate greater resilience. Previous research has also indicated that religiosity and spirituality can promote resilience during adolescence (Briggs et al., 2011; Kasen et al., 2012) and reduce the risk of anxiety, depression, suicidality, and substance use (Dew et al., 2008; Kasen et al., 2012).

(iv) On Depression: The high religious sample scored lower than the low religious samples (M=22.48, 25.83; t= 8.53; p>.01) and significant at .01 level on Depression. This finding is consistent with research indicating that adolescents with higher levels of personal and familial religiosity tend to exhibit greater self-esteem and better psychological functioning (Ball et al., 2003). Similarly, Stearns and colleague (2018) observed that individuals with high levels of religiosity reported lower levels of depression.

Objective -2: To examine the significant difference on Hopelessness, Life Satisfaction, Resilience and Depression between Male and Female samples.

Descriptive statistics and independent t-tests were employed to discern any significant difference between male and female samples on dependent variables as

shown in *Table -4*, and discussed as under:

(i) On Hopelessness: The mean scores on Hopelessness showed that male samples scored lower than female samples (M= 26.64; 32.06; t= -17.08; p<.01) at a .01 significant level. This finding supports earlier research findings that hopeless females were twice as likely higher in hopelessness with suicidal ideation resulting in depression (Labelle et al., 2013) as a higher level of hopelessness exhibition found in females than in male samples (Kashani et al., 1989).

(ii) On Life Satisfaction: The mean scores on Life Satisfaction showed that male samples scored higher than female samples (M= 27.09; 21.64; t= 13.28; p<.01) at a .01 significant level. The finding is consistent with available findings that gender differences in psychological well-being, usually as males score higher than females (Carmel & Nigavekar, 2007) as male adolescents consistently reported higher levels of life satisfaction compared to their female peers (Goldbeck et al., 2007).

(iii) On Resilience: The mean scores on Resilience showed that male samples scored higher than female samples (M= 51.16; 46.30; t= 4.58; p<.01) at a .01 significant level. The earlier research indicated that males' exhibit greater resilience than females (Erdogan et al., 2014; Sürücü &Bacanli, 2010) even other measurements of resilience have consistently yielded higher resilience levels among boys (Campbell-Sills et al., 2009; VicHealth, 2015). .

(iv) On Depression: The mean score on Depression showed that male samples scored lower than female samples (M=21.81, 26.04; t= 11.82; p<.01) at a .01 significant level. The earlier research finding consistently indicates that males report experiencing lower levels of depression compared to females (Sigmon et al., 2005) as adolescent females are at a higher risk of developing depression compared to males (Ay & Save, 2004) with a notable increase during mid-adolescence among girls (Dishman et al., 2006; Hjemdal et al., 2011).

Objective -3: To examine any significant difference between High-Religious Male Samples, Low-Religious Male Samples, High-Religious Female Samples and Low-

Religious Female Samples on Hopelessness, Life Satisfaction, Resilience and Depression.

Descriptive statistics and Post Hoc Mean Comparison were calculated to expose any significant difference between high-religious male samples, Low-religious male samples, High-religious female samples, and Low-religious female samples on Hopelessness, Life Satisfaction, Resilience and Depression; results were presented in ***Table – 5*** (mean differences) and ***Table-6*** (post hoc Mean Comparisons) , and discussed as under:

(i) High Religious Male Samples scored lowest on Hopelessness (M = 24.38) and Depression (M = 22.98) but scored highest on Resilience (M = 53.97) and Life Satisfaction (M = 29.98). The finding indicates that religious belief can help and protect against depression (Bonelli et al., 2012), and reduce the likelihood of its onset (Koenig et al., 2012) which supports earlier research findings. Studies confirmed earlier research findings which proposed the perceived importance of religion (Sinha et al., 2007), relational spirituality (Wright et al., 1993), and the meaningfulness of religion were associated with reduced levels of depression in young people. The higher levels of religious involvement invite greater life satisfaction, happiness, improved mood, or higher morale(Koenig, 1998) as religiosity influences mental and physical well-being in both directly and indirectly (Seybold & Hill, 2001; Miller & Thoresen, 2003). Overall, religiosity consistently has a positive correlation with well-being, including life satisfaction and happiness (Argyle, 2000).

(ii) Low Religious Male Samples scored lowest on Life Satisfaction (M = 22.97) and Depression (M = 28.67) but scored highest on Hopelessness (M = 30.33) and Resilience (M = 47.57).This finding aligns with prior research, including the meta-analysis by Bonelli and colleague, (2012), which highlighted that the impact of religiosity on mental health is influenced by individual experiences of faith and the larger sociocultural context in which religious beliefs are practiced. These elements emphasize the intricate relationship between religiosity and depression, showcasing how personal and external factors interact to shape mental health outcomes.

(iii) High Religious Female Samples scored lowest on Depression (M = 25.25) and Hopelessness (M = 26.17) but scored highest on Life Satisfaction (M = 27.72) and Resilience (M = 50.23). The finding support earlier findings that a strong relationship has been observed between religiosity and depression levels (Smith et al., 2003) but the degree may vary depending on regional, national, and continental contexts (Dein, 2006), and is positively linked to mental health in adolescents which serves as a significant predictor of lower depression levels (Sanders et al., 2015).

(iv) Low Religious Female Samples scored lowest on Life Satisfaction (M = 19.52) and Depression (M = 29.72) and scored highest on Hopelessness (M = 33.78) and Resilience (M = 44.20). The finding aligned with previous researchthat women with low religious engagement and religiosity tend to experience higher levels of emotional distress, depression, and hopelessness as resilience was less effective in women with low religious involvement.

Higher levels of religiosity help reduce depression and increase resilience during difficult circumstances as low levels of religiosity and absence of religious practices are linked to greater hopelessness and lower resilience (Pargament et al., 2000).

Post-Hoc Mean comparisions between four groups on dependent variables (Table-6): Post-hoc analysis is to identify specific groups or variables that significantly impact the outcomes by offering a clearer picture of what drives the results.

(i) On Hopelessness: High religious male samples scored significantly lower (M = 24.38) on hopelessness than low religious male samples (M = 30.33) at 0.01 level (F = -5.95; p = <0.01) and also significantly lower than high religious female samples (M = 24.38; 26.17; F = -3.34; p = <0.01) and also lower than low religious female samples (M = 24.38; 33.78; F = -9.40; p = <0.01).Low religious male samples scored higher (M = 30.33) on hopelessness than high religious female samples (M = 26.17) at 0.01 level (F =2.62; P = <0.01) but lower than low religious female samples (M = 30.33; 33.78, F = -3.45; p = <0.01).The high-religious female sample scored

significantly lower on hopelessness than low religious female samples (M = 26.17; 33.78; F = -6.06; p <0.01).

The finding is consistent with other research indicating that spirituality and religiosity are often linked to improved mental health, including lower levels of depression, anxiety, stress, suicidal thoughts, and substance use (Moreira-Almeida et al., 2014) as religious teachings promote resilience and perseverancewho embrace these religious values have better preparation to navigate life's challenges without experiencing hopelessness.

(ii) On Life Satisfaction: High religious male samples scored significantly higher (M = 29.98) on life satisfaction than low religious male samples (M = 22.97) at 0.01 level (F = 1.56; p = <0.01) and also significantly higher than high religious female samples (M = 29.98; 27.72; F = .60; p = <0.01) and also higher than low religious female samples (M = 29.98; 19.52; F = 2.05; p = <0.01).Low religious male samples scored lower (M = 22.97) on life satisfaction than high religious female samples (M = 27.72) at 0.01 level (F =-2.56; P = <0.01) but higher than low religious female samples (M = 22.97; 19.52, F = -.96; p = <0.01).High religious female sample scored significantly higher than low religious female samples (M = 27.72; 19.52; F = .48; p <0.01).

This finding is supported by earlier research showing that higher levels of religiosity are associated with improved well-being (Smith et al., 2003), tend to live longer than those who are less religious (McCullough et al., 2000). examined the relationship between religiosity, subjective well-being; which includes happiness, life satisfaction, love of life, and physical and mental health; and psychopathology, such as anxiety and depression. Their study found that students reporting higher religiosity also experienced greater well-being.

Research has consistently shown that individuals with high levels of religiosity tend to score higher on life satisfaction measures. This positive association is often attributed to the psychological, social, and emotional benefits provided by religious beliefs and practices. Lim and Putnam (2010) found that religious

involvement is linked to greater life satisfaction, primarily mediated by the social networks built through religious communities. Ferriss (2002) observed that religiosity enhances perceived quality of life and life satisfaction by providing meaning, purpose, and a supportive community

(iii) On Resilience: High religious male samples scored significantly higher (M = 53.97) on resilience than low religious male samples (M = 47.57) at 0.01 level (F = 5.68; p = <0.01) and also significantly higher than high religious female samples (M = 53.97; 50.23; F = 3.42; p = <0.01) and also higher than low religious female samples (M = 53.97; 44.20; F = 8.95; p = <0.01).Low religious male samples scored lower (M = 47.57) on resilience than high religious female samples (M = 50.23) at 0.01 level (F =-2.26; P = <0.01) but higher than low religious female samples (M = 47.57; 44.20, F = 3.26; p = <0.01).High religious female sample scored significantly higher than low religious female samples (M = 50.23; 44.20; F = 5.53; p <0.01).

The result aligns with the findings of several researchers who have highlighted the role of spiritual and religious beliefs in enhancing resilience (Brewer-Smyth & Koenig, 2014). Studies have shown that high levels of religiosity can serve as a significant resilience factor within specific populations (Dilber et al., 2016). Smith and colleague (2012) suggested that while resilience does not necessarily require spirituality or religiosity, individuals with spiritual or religious beliefs are likely to exhibit higher levels of resilience.

Similar findings also observed that religious individuals often exhibit greater resilience due to the emotional and spiritual support derived from their faith and community, which fosters optimism and persistence in overcoming challenges (Koenig et al., 2012). The role of religious coping mechanisms, such as seeking spiritual guidance and reframing stressful situations through a faith-oriented lens, helps in strengthening resilience during times of crisis (Pargament et al., 1998). Religiosity promotes resilience by instilling a sense of purpose, offering moral direction, and providing psychological tools to navigate hardships effectively (Bonelli et al., (2012).

(iv) On Depression: High religious male samples scored significantly lower (M = 22.98) on depression than low religious male samples (M = 28.67) at 0.01 level (F = 4.64; p = <0.01) and also significantly lower than high religious female samples (M = 22.98; 25.25; F = 3.51; p = <0.01) and also lower than low religious female samples (M = 22.98; 29.72; F = 7.57; p = <0.01).Low religious male samples scored higher (M = 28.67) on depression than high religious female samples (M = 25.25) at 0.01 level (F =-2.34; P = <0.01) but lower than low religious female samples (M = 28.67; 29.72, F = 3.62; p = <0.01).High religious female sample scored significantly lower on depression than low religious female samples (M = 25.25; 29.72; F = 5.42; p <0.01).

The finding is consistent with previous studies done by (Moreira-Almeida et al., 2014) who also found that religiosity is generally linked to better mental health outcomes, such as lower levels of depression, anxiety, stress, suicidal ideation, and substance abuse. Similar findings have been observed in other studies, which suggest that religious involvement often provides protective benefits against mental health issues. Research consistently highlighted that religiosity offers individuals coping strategies, a sense of purpose, and social support, all of which contribute to improved psychological well-being (Pargament, 1997; Koenig et al., 2012).

Objective -4: To explore any significant relationship between Hopelessness, Life Satisfaction, Resilience and Depression.

The Pearson Correlation was employed to demonstrate the significant relationship between Hopelessness, Life Satisfaction, Resilience and Depression which were presented in ***Table -7*** and discussed below:

(i) Life Satisfaction had a significant negative relationship with Depression ((r = -.56, p < .01) and Hopelessness (r = -.41, p < .01) whereas a significant positive relationship with Resilience (r = .57, p < .01). Research indicates that higher levels of psychological well-being are associated with reduced depression (Bhullar et al., 2014). Factors such as life satisfaction, happiness, hopefulness, and self-efficacy have been linked to various positive outcomes, including lower stress levels and

reduced incidence of mental health issues (Natvig et al., 2003; Gilman & Huebner, 2006; Valois et al., 2004; Schiffrin& Nelson, 2010; Siddique & D'Arcy, 1984).

The finding supports earlier studies which showed a significant negative correlation between higher levels of subjective well-being and perceived depression (Li et al., 2023), indicating that greater subjective well-being is linked to reduced perceived depressive disorders. Additionally, subjective well-being appears to play a particularly important role in mitigating self-rated depression among older adults (Li et al., 2023). Furthermore, findings by Oktan (2008) and Karairmak (2007) suggest that adolescents with higher life satisfaction also exhibit greater resilience. These findings are consistent with the results of this study.

(ii) Depression has a significant positive relationship with Hopelessness ($r = .43$, $p < .01$) at a .01 level but a significant negative relationship with Resilience ($r = -.59$, $p < .01$) at .01 level. Similar findings indicate that hopelessness is linked to depressive symptoms, suicidal ideation, and other clinical conditions (Beck et al., 1990; 1998). Likewise, Greene (1989) examined the connection between depression and hopelessness, concluding that hopelessness is a significant predictor of depression. Research consistently demonstrates that individuals with higher resilience levels tend to report lower rates of depression, anxiety, and other mental health disorders (Hu et al., 2015).

(iii) Hopelessness had a significant negative relationship with Resilience ($r = -.42$, $p < .01$) at a .01 level. Similar findings suggest that hopelessness is a key factor in predicting resilience, with the results indicating that as individuals' levels of hopelessness increase, their levels of resilience tend to decrease (Masten, 1994; Mandleco & Perry, 2000; Capella & Rhona, 2001; Smith, 2009).

Objective -5: To discern any significant independent effect of ‘Religiosity and Gender’ on Hopelessness, Life Satisfaction, Resilience and Depression.

One Way ANOVA was used to calculate the independent effect of 'Religiosity' and 'Gender 'on Hopelessness, Life Satisfaction, Resilience and Depression. Results were presented in ***Table -8*** and discussed as follows:

(i) Independent Effect of 'Religiousity' and 'Gender' on Hopelessness:

(a) Religiousity effect on hopelessness- The results of the study showed that Religiosity had a significant independent effect on Hopelessness with an effect size of 22 % (F=66.56; μ =0.22). The finding was supported by earlier researcher which demonstrated the significant role of religiosity in reducing feelings of hopelessness by offering individuals a framework of meaning, purpose, and optimism (Koenig et al., 2001),

(b)Gender effect on hopelessness- Gender had a significant independent effect on Hopelessness with an effect size of 35 %(F=291.97; μ =0.35).The finding is consistent with another research finding which explored gender-based differences in responding emotionally to stress that males are more likely to express stress through externalizing behaviors such as aggression, and explain why males report lower levels of hopelessness compared to females (Burton et al., 2009).

(ii) Independent effect of 'Religiosity' and 'Gender' on Life Satisfaction

(a) Religiousity effect on Life Satisfaction-Religiosity had a significant independent effect on Life Satisfaction with an effect size of 19% (F=496.54; μ =0.19).The finding aligns with previous research that religious individuals tend to have higher levels of life satisfaction (Diener et al., 1999; Koenig et al., 2001) as religious support was linked to reduced depression and greater life satisfaction (Lee., 2007). Similarly, the Australian Unity Index Report (2008) found that individuals with strong religious beliefs and practices had higher life satisfaction and overall well-being.

(b) Gender effect on Life Satisfaction- Gender had a significant independent effect on Life Satisfaction with an effect size of 43 %(F=176.60; μ =0.43). Research

evidenced gender differences in psychological well-being that males generally score higher on well-being compared to females (Carmel & Nigavekar, 2007).

(iii) Independent Effect of 'Religiousity' and 'Gender' on Resilience

(a) Religiosity effect on Resilience- Religiousity had a significant independent effect on Resilience with an effect size of 22 %(F=67.66; μ =0.22). The findings supported earlier research findings that religiosity in adolescents fosters resilience (Kim et al., 2011), and the role of religious beliefs in enhancing resilience (Brewer-Smyth & Koenig, 2014).

(b) Gender effect on Resilience-Gender had a significant independent effect on Resilience with an effect size of 31 %(F=165.25; μ =0.31). The findings demonstrated that males generally exhibit greater resilience than females (Erdogan et al., 2014; Sürücü &Bacanlı, 2010) as higher resilience prevails among boys (Campbell-Sills et al., 2009; VicHealth, 2015) even using different methods to measure resilience reported significantly higher resilience levels in males (Bonanno et al., 2007).

(iv) Independent effect of 'Religiosity' and 'Gender' on Depression

(a) Religiousity effect on Depression-Religiosity had a significant independent effect on Depression with an effect size of 23 %(F=72.64; μ =0.23). The finding got support from earlier research that religiosity is positively linked to mental health in adolescents and serves as a significant predictor of reduced depression levels (Sanders et al., 2015). Some other researchers also discovered that religiosity was positively correlated with faith in a higher power, the value of prayer, and finding meaning during adversity while showing a negative association with depression (Doolittle& Farrell, 2004).

(b)Gender effect on Depression-Gender had a significant independent effect on Depression with an effect size of 37% (F=139.37; μ =0.37).Results emphasized gender differences in depression prevalence start to manifest during adolescence (Hankin & Abramson, 2001) at different times for males and females around ages 11

to 13 (Cicchetti & Toth, 1998), higher prevalence of depression in women compared to men (Essau et al., 2010; Kendler et al., 2014).

Objective- 6: To study the interaction effect of 'Religiosity and Gender' on Hopelessness, Life Satisfaction, Resilience and Depression.

The Two Way ANOVA was employed to demonstrate the interaction effect of 'Religiosity and Gender' on Hopelessness, Life Satisfaction, Resilience and Depression among the samples. The results evinced the significant interaction effect which was presented in ***Table- 9,*** and discussed as under:

(i) Interaction effect of 'Religiosity and Gender' on Hopelessness: The results revealed that the interaction effect of 'Religiosity and Gender' was found significant on Hopelessness with an effect size of 42 % ($F=744.34$; $\mu =0.42$) and significant at .01 level. The results revealed that highly religious males showed a lower level of hopelessness which was the same line with the majority (90%) indicating a positive association between higher levels of religiosity with improved mental health (Wong et al.,2006).

(ii) Interaction Effect of 'Religiosity and Gender' on Life Satisfaction: The results demonstrated that 'Religiousity and Gender' had a significant interaction effect on Life Satisfaction with an effect size of 48 % ($F=517.85$; $\mu =0.48$) and significant at .01 level. Research on the interaction between religiosity and gender on life satisfaction is limited. However, existing studies have shown that religiosity is linked to subjective well-being (Dunbar, 2021),and improves mental health (Hoogeveen et al., 2022; Moreira-Almeida et al., 2006)in both adult populations (Malinakova et al., 2020) and adolescents (Cotton et al., 2006; Fruehwirth et al., 2019).

(iii) Interaction Effect of 'Religiosity and Gender' on Resilience: The results indicated that 'Religiosity and Gender' had a significant interaction effect on Resilience with an effect size of 37 %($F=714.03$; $\mu =0.37$) and significant at a .01 level. Research studies covering the religiousity and gender on resilience have found

to be limited but have constancy with prior research which indicated that religion promotes resilience during adolescence (Briggs et al., 2011; Kasen et al., 2012) and reduces the risk of anxiety, depression, suicidality, and substance use (Dew et al., 2008; Kasen et al., 2012). Additionally, high levels of religiosity may serve as a potential resilience factor (Dilber et al., 2016).

(iv) Interaction Effect of 'Religiosity and Gender' on Depression: The result showed that the interaction effect of 'Religiosity and Gender' on Depression was significant at a .01 level with an effect size of 41 % (F=653.76; μ =0.41).The finding is in line with earlier research showing that individuals with high levels of religiosity tend to report lower levels of depression (Stearns et al., 2018), and religiosity positively impacts psychological outcomes in adolescents and young adults (Yonker et al.,2012).

Objective-7: To examine the prediction of Religiosity on Hopelessness, Life Satisfaction, Resilience and Depression among the samples.

The linear regression analysis was employed to determine the prediction of Religiosity on Hopelessness, Life Satisfaction, Resilience and Depression. The results were presented in ***Table-10***, and discussed as under:

Results revealed that Religiosity predicted 22 % of Hopelessness; 19 % of Life Satisfaction; 22% of Resilience and 23% of depression.

(i) Prediction of Religiosity on Hopelessness: The results showed that Religiosity predicted 22% of Hopelessness. The finding is in consistent with earlier research findings which demonstrated that religious belief is a significant predictor, reduced depression levels (Maton, 1989; McIntosh et al., 1993) and lower levels of hopelessness (Carson et al., 1990; Young et al., 1996).

(ii) Prediction of Religiosity on Life Satisfaction: The finding of the study has shown that Religiosity predicted 19 % of Life Satisfaction. This finding supports earlier studies that a strong positive correlation was between religiosity and life

satisfaction, highlighting the connection between religiosity and psychological well-being as religiosity is linked to improved psychological well-being, a positive self-concept, and better physical health among adolescents (Donahue & Benson, 1995; Ellison, 1991). A meta-analysis showed a significant association between religious practices and mental health indicators such as life satisfaction, positive emotions, and high morale further demonstrating that religiosity reduces the likelihood of engaging in risky behaviors.

(iii) Prediction of Religiosity on Resilience: The finding of the study has shown that Religiosity predicted 22% of Resilience. The findings support previous research indicating that resilience is linked to coping skills, self-efficacy, optimism, social support, adaptability, religious and spiritual beliefs, positive emotions, self-esteem, and a sense of meaning and purpose in life (Helmreich et al., 2017) as religiosity is an important source of resilience (Kim & Esquivel, 2011).

(iv) Prediction of Religiosity on Depression: The finding of the study has shown that Religiosity predicted 23%. The result is consistent with other research findings which showed a strong link between higher levels of religiosity and better mental health including lower levels of depression (Wong et al., 2006) individuals with high religiosity also exhibited lower levels of depression (Stearns et al., 2018). Depression is often linked to feelings of hopelessness and loss of meaning (Dein, 2006), religiosity might help mitigate life stress, potentially preventing the onset of depression or reducing its duration when it occurs (Koenig et al., 2012).

The results in ***Table-10*** revealed the significant prediction of Religiosity on the dependent variables, suggesting accepting ***Hypothesis no-7*** of the study.

Summary and Conclusion

The present study entitled ***"Role of Religiosity on Hopelessness, Life Satisfaction, Resilience and Depression among High School Students"*** aimed to examine the level of religiosity conditions among High School Students in Aizawl City, and its effect on hopelessness, life satisfaction, resilience and depression.

The results indicated the ‘level of religiosity’ and ‘gender’ single influence and together influence at an acceptable level on hopelessness, life satisfaction, resilience and depression. Hopelessness and depression move in the same direction as increase and decrease together at acceptable levels as life satisfaction and resilience have the same direction but life satisfaction and resilience move in opposite directions with depression and hopelessness. Post hoc Mean comparison highlighted the four groups’ differences in observed dependent variables that the high religious group of males and females had higher life satisfaction and resilience but lower hopelessness and depression than the lower religious group of male and female groups. ‘Religiosity and Gender’ had significant independent and interaction effect on the dependent variables. Religiousity predicted hopelessness; life satisfaction; resilience and depression at acceptable levels. The overall results provided answers to all objectives set forth and accepted hypotheses of the study.

Significance of the study

The results of the study revealed that High Religious samples had lower hopelessness and depression compared to low religious samples and higher life satisfaction and resilience than Low Religious samples. The results may explain the *importance of religiosity in promoting the mental health* of adolescents.

The results provided the significant difference between male and female samples on hopelessness, life satisfaction, resilience and depression which demonstrated that male samples had higher life satisfaction and resilience with lower hopelessness and depression compared to female samples which highlighted the need for *specific attention for female adolescent* including psychological cares and intervention.

The results of the study revealed a significant difference among the four groups- High religious males and High religious females had higher life satisfaction and resilience with lower hopelessness and depression than low-religious male and female groups. A similar trend was found that males showed higher life satisfaction

and resilience while lower hopelessness and depression than female groups. Results highlighted *the crucial role played by religiousity in controlling dependent variables*.

The results provided a significant positive relationship between life satisfaction and resilience; depression and hopelessness and a significant negative correlation between hopelessness, life satisfaction and resilience. The study *provided bases for framing psychological cares and interventions for adolescent.*

The independent effect and interaction effect of 'Religiosity and 'Gender' was elucidated by this study, and *may be utilized to make a strategy for the prevention and intervention of mental health in adolescent.*

The religiosity predicted positive (life satisfaction and resilience) and negative (hopelessness and depression) at acceptable levels in the targeted population which demonstrated the determinant factors of religiousity on the psychological functions of an individual *explaining religiousity can be exploited for intervention strategy.*

In conclusion, the present study highlighted the role of religiosity on hopelessness, life satisfaction, resilience and depression among High School Students contributed new insight and understanding to the available literature and also highlighted the role of religiousity in promoting mental health issues and psychological functions of adolescents which need urgent attention for designing a psychological intervention. It also highlighted that integrating religiosity into prevention and intervention strategies could be effective in addressing mental illnesses among adolescents, promoting protective factors like resilience and life satisfaction while mitigating hopelessness and depression. It emphasized religiosity as a vital component of adolescent mental well-being, addressing the psychological challenges typical of this developmental stage. Understanding how religiosity impacts mental health across genders and cultural contexts enables tailored approaches for more effective support. It underscored the dual nature of religiosity, with both positive and negative mental health outcomes, offering a nuanced framework for addressing spiritual and emotional needs.

Limitations of the study

The study was done cautiously controlling the possible effect of extraneous variables and contributed valuable new knowledge to the existing literature but it was not free from limitations; (i) The sample size used in the study was not large enough to effectively represent the targeted population which may specify not big enough to generalize to the whole targeted population although it provides a sense of insight for the future research; (ii) A more systematic and comprehensive empirical cross-examination of responses such as conducting qualitative interviews, longitudinal studies, or employing mixed-methods approaches to gain a more in-depth understanding of the issue; (iii) Inclusion of more demographic information which could have added more interesting information in order to control extraneous variables from the focused independent variables and dependent variables; (iv) Factor related to the school environment, teachers, and peer group could have been included in the study as they may be expected to play an important part in an adolescent's behavior.

Suggestions for further studies

The study emphasizes the importance of improving future research by encouraging the replication of its findings in these areas;(i) inclusion of a bigger sample size and a wider range of participants would have contributed more knowledge about the impact of religiosity on adolescents; (ii) Future research could benefit from a more structured and thorough empirical exploration, incorporating methods such as qualitative interviews, longitudinal studies, or mixed-methods approaches. These strategies would allow for a deeper and more nuanced understanding of the relationships and dynamics involved, providing richer insights into the topic; (iii) The inclusion of additional demographic details could have enriched the study by providing more nuanced insights and ensuring better control over extraneous variables that might influence the relationship between the primary independent and dependent variables; (iv) Adolescence is a transformative phase marked by substantial development and challenges. Addressing these issues requires

fostering a supportive environment, ensuring access to mental health resources, and providing positive guidance from parents, caregivers, and educational institutions. Future research could explore strategies to strengthen these support systems, examining their effectiveness in promoting resilience, life satisfaction, and mental well-being during this critical stage of life.

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