

Maternal Depression and the Intergenerational Transmission of Religion

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Abstract: This study tests the hypothesis that maternal depression (major depressive disorder; MDD) decreases rates of the intergenerational transmission of religiosity from mother to offspring and attenuates the beneficial qualities of religiosity in offspring. Depression was assessed using semistructured clinical interviews; religiosity was assessed based upon the personal importance of religion, frequency of attendance at religious services, and religious denomination. Results suggest that (1) maternal depression attenuates the intergenerational transmission of religion; (2) in the presence of maternal depression, offspring were more likely to have MDD at 10-year follow-up when mother-offspring were concordant on religious importance; and (3) in the absence of maternal depression, offspring were less likely to have MDD at 10-year follow-up when mother-offspring were concordant on attendance. Thus, in the presence of maternal depression, transmission of religious attendance is no longer associated with decreased likelihood of offspring MDD, whereas transmission of religious importance is associated with increased likelihood of offspring depression.

Key Words: Religion, intergenerational, depression, transmission.

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This study tests the hypotheses that maternal depression potentially decreases rates of the intergenerational transmission of religiosity (defined broadly in the literature to include religious beliefs, practices, and denomination) and may attenuate the beneficial qualities of religiosity in offspring. The study focuses specifically on mothers and offspring because rates of maternal transmission have been

shown to exceed rates of paternal transmission to offspring (Acock and Bengston, 1978; Dudley and Dudley, 1986).

Children of depressed parents are at increased risk for major depression, physical health problems, anxiety disorders, and alcohol dependence compared with children whose parents are not depressed (Downey and Coyne, 1990; Hammen et al., 1987; Kramer et al., 1998; Nomura et al., 2002; Orvaschel et al., 1988; Weissman et al., 1987, 1997). Higher levels of maternal depressive symptoms have been shown to predict more aggressive and hostile behaviors in toddlers (Leadbeater et al., 1996; Lyons-Ruth, 1992). Children of depressed mothers have also been shown to have high rates of disruptive behaviors, anxiety disorders, and attention deficit disorder (Hammen et al., 1987; Warner et al., 1999). In addition to clinical symptomatology, children of depressed parents also display more academic deficits and impaired social functioning and competence throughout their lives, and adjustment difficulties (Downey and Coyne, 1990). Children of mothers with unipolar depression have been shown to have greater severity of behavioral and emotional problems compared with children of bipolar mothers, chronic medically ill mothers, and normal mothers (Hammen et al., 1987).

INTERGENERATIONAL TRANSMISSION OF RELIGION

The intergenerational transmission of religiosity, as measured by concordance of mother-offspring religiosity, has been shown to protect against offspring major depressive disorder (MDD; Miller et al., 1997). In a study of offspring of mothers with and without MDD, the authors showed that daughters with mother-offspring concordance of denomination were 71% less likely to have MDD compared with daughters without mother-offspring concordance of denomination. Sons with mother-offspring concordance of religious denomination were 84% less likely to have MDD compared with sons without mother-offspring concordance of denomination (Miller et al., 1997). The intergenerational transmission of religiousness has been shown to occur despite the presence of offspring depression and parental opiate use (Miller et al., 1997, 2001); however, the relative rates of

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transmission by maternal depression status have yet to be established.

CONDITIONS ASSOCIATED WITH TRANSMISSION OF RELIGIOSITY

Previous research suggests some degree of transmission of religiosity from mothers to offspring to be normative, such that parental religiosity has been shown to predict religiosity in offspring across a range of dimensions (Myers, 1996; Wan-Ning et al., 1999). De Vaus (1983) showed a strong association between maternal religious values and offspring religious activities among 375 mothers and their adolescent children. In the same study, uniquely parental religious values strongly predicted adolescent church attendance and not other social influences like peer group influences, type of school, and socioeconomic factors. Parental church attendance and parental personal importance of religion both were positively associated with adolescent church attendance, religious importance, and adolescent concept of a Supreme Being, G-d (Dudley and Dudley, 1986).

Children who reported their parents (who were religious) to be more nurturing were more religious on dimensions of attendance, belief, and devotional practice (Nelsen, 1980). Maternal transmission of religiousness (church attendance, religious denomination, and the concept of G-d) is greater when the adolescent perceives the parent as accepting and supportive (Wan-Ning et al., 1999). Numerous studies have shown that the child's closeness to the parent was an important predictor of the child's religious institutional belonging, private spiritual devotion, and greater religious commitment in religious families (Ozorak, 1989; Thomas, 1988). A longitudinal study conducted with 1133 adolescents showed that emotionally supportive relationship with mother predicted transmission of private religiosity to the child. Positive connection with mother contributed to public religious practice as much as did family religious practice, with specific items measuring mother-child connection being (1) I tell mother about problems, (2) I can count on mother, (3) I can go to mother for advice, and (4) I share my feelings with my mother (Litchfield et al., 1997). Furthermore, greater maternal warmth was associated with daughter's beliefs being more similar to her perception of how important religion was to her mother, and to her own devotional practices being more similar to her perceptions of her mother's devotional practices (Okagaki and Bevis, 1999). Hoge et al. (1982) have shown that religious families with good parental-child relationship and less parental-child conflict had greater transmission of religion to the offspring.

DEPRESSION AND RELIGIOUS TRANSMISSION

The dimensions that facilitate the intergenerational transmission of religion (maternal warmth, support, nurturance, less conflict) have been shown to be deficient in

the presence of maternal depression. Depressed mothers have been observed to be more negative in interactions with their children as they displayed more critical, disapproving, and less nurturing and supporting behaviors than mothers without depression (Blatt and Homann, 1992; Gordon et al., 1989; Lovejoy, 1991). Depressed mothers also have been observed to be less responsive to their children and to have more negative interactions with their children (more conflict characterized by maternal criticism, lack of support, and excessive use of authority; Chiariello and Orvaschel, 1995). The reciprocal communication process with children often is disrupted by maternal depression, which eventuates frequently in insecure attachment style (Kaslow et al., 1994; Radke-Yarrow et al., 1985). Furthermore, depressed mothers were more likely to negatively evaluate their child, disapprove of the child, and become irritable quickly when interacting with the child, and had difficulties maintaining attention to the child (Chiariello and Orvaschel, 1995). These findings suggest that maternal depression may interfere with parental skills and with the mother's ability to relate to her child, and therefore may interfere with her ability to transmit religion. It is also possible that the protective qualities of concordance of religion will be attenuated by maternal depression. Mother-offspring concordance of denomination has been shown to be protective against offspring depression (Miller et al., 1997); however, the protective and risk factors of concordance of religiosity by maternal depression status were not established.

In this study, we investigate the following questions among a sample of depressed and nondepressed mothers and their offspring: (1) do lower rates of religious transmission occur from depressed mothers compared with nondepressed mothers, and, (2) in the presence of transmission, does maternal depression attenuate the beneficial qualities of religion in the offspring?

METHODS

The data for this study come from a 10-year follow-up study on offspring of depressed and nondepressed mothers (Weissman et al., 1997).

Participants

Subjects were parents and offspring who participated in a 10-year follow-up study of offspring at high and low risk for depression. An extensive description of the sample has been published elsewhere (Miller et al., 1997; Weissman et al., 1997). Depressed mothers had been treated at a depression clinic and received a lifetime diagnosis of primary MDD on the basis of at least three independent Schedule for Affective Disorders and Schizophrenia-Lifetime (SADS-L; Endicott and Spitzer, 1978) interviews and the modified Research Diagnostic Criteria, which requires an episode of

MDD of duration of at least 4 weeks and resulting in impairment in a major social role. Nondepressed mothers were drawn from a longitudinal community sample (Weissman and Myers, 1978) followed since 1974 and reinterviewed with the SADS-L on at least two occasions before their initial participation.

In this study, we looked at mother-offspring dyads. At time 1 (1982), the original sample of 91 mothers and 220 offspring were independently assessed for a lifetime history of MDD using the SADS-L, and the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS; Orvaschel et al., 1982). Mothers were asked to report on their religious denomination at Time 1 assessment. Two years later, at time 2 (1984), the sample was reassessed using the same methods as at time 1. Ten years later (1992), 84% of those offspring who were interviewed at time 1 were interviewed at time 10. There was no significant difference in the attrition rate of probands or offspring by maternal status (Weissman et al., 1997). One hundred fifty-eight offspring (now adults) and their mothers were again independently assessed for depression using the SADS-L and asked to report on the three questions on religiosity from the demographic section of the SADS-L. Refer to Table 1 for sample demographics and rates of religiosity of offspring and mothers at 10-year follow-up.

Measures

The SADS-L was used to assess maternal and offspring religiosity based on (1) degree of importance (highly important, moderately important, slightly important, or not at all important) at time 10; (2) frequency of attendance at church, synagogue, or other religious service (at least once a week or more, about once a month, about once or twice a year, less than once a year, never) at time 10; and (3) current religious denomination at time 1 and again at time 10. Maternal and offspring report on religious importance and attendance at time 10 were used to establish concordance. We used religious denomination as reported by mother at time 1 and offspring at time 10 to establish concordance of the denomination the child was raised by, and his current identified denomination. Time 1 maternal lifetime clinical status (MDD versus no MDD) was assessed using the SADS-L structured clinical interview (Endicott and Spitzer, 1978), which yielded Research Diagnostic Criteria. The K-SADS was used to assess time 1 offspring lifetime clinical status (MDD versus no MDD), which yielded a DSM-III diagnosis. Time 10 offspring diagnosis of MDD was based on the presence or absence of an episode of MDD between time 1 and time 10. The Diagnostic Schedule for Affective Disorders and Schizophrenia Modified for the Anxiety Disorders (SADS-LA; Mannuzza et al., 1986) was used to assess time 10 offspring (now adults) clinical status, which yielded a DSM-III-R

TABLE 1. Demographics and Rates of Religiosity of Offspring and Mothers at 10-Year Follow-Up (Time 10)

	Offspring (N = 158)	Mothers (N = 158)
Age		
M	27.43	54.80
SD	4.69	6.70
SES (1–5; Hollingshead) ^a		
M	3.24	3.24
SD	1.12	1.12
Denomination ^b		
Protestant	20.9% (29/139)	20.3% (25/123)
Catholic	66.2% (92/139)	75.6% (93/123)
Spiritual but not religious	7.9% (11/139)	4.1% (5/123)
Atheist/agnostic	5.0% (7/139)	—
Attendance at religious events		
At least weekly	22.8% (36/158)	50.0% (67/134)
Monthly	15.2% (24/158)	17.2% (23/134)
Once or twice a year	35.4% (56/158)	12.7% (17/134)
Less than once a year	3.2% (5/158)	8.2% (11/134)
Never	23.4% (37/158)	11.9% (16/134)
Importance of religion		
Highly important	22.8% (36/158)	69.4% (93/134)
Moderately important	44.3% (70/158)	28.4% (38/134)
Slightly important	22.2% (35/158)	1.5% (2/134)
Not important at all	10.8% (17/158)	.7% (1/134)
MDD ^c	46.2% (73/158)	54.4% (86/158)

^aSES at time 1.

^bMaternal denomination at time 1; offspring denomination at time 10.

^cMaternal MDD at time 1; offspring MDD between time 1 and time 10 (i.e., 10 yr later). Met criteria for MDD using the SADS.

diagnosis. Clinical interviewers' assessment of offspring diagnosis was blind and independent of maternal diagnosis.

Maternal parenting style was measured by the Parental Bonding Index (PBI). The PBI was developed by Parker et al. (1979) and is a widely used 25-item self-report which includes dimensions of care and overprotection in parenting behavior. The PBI was completed by the offspring reporting on their own mother, and by each mother reporting on her offspring, both in time 1 and in time 10. We used both maternal report on her child and offspring report on his/her mother at time 1. The PBI has been found to be an important predictor of onset of illness in the offspring of depressed and nondepressed parents (Fendrich et al., 1990). Time 1 maternal socioeconomic status (SES) was based on maternal report, which was categorized according to the Hollingshead (1965) 5-point, two-factor index, which combines occupation and level of education into one score ranging from 1 to 5. Refer to Table 2 for a summary of mother and offspring measures at time 1 and at time 10.

TABLE 2. Mother and Offspring Measures at Time 1 and at Time 10

	Time 1	Time 10
Mothers		
Depression status	SADS-L	
Religiosity	Religious Denomination ^a	● Religious importance
Mother-child bond	PBI-mother report on child	● Religious attendance
SES	Hollingshead	
Offspring		
Depression status	K-SADS	SADS-LA ^b
Religiosity		● Religious denomination ● Religious importance ● Religious attendance
Mother-child bond	PBI-child report on mother	

^aConcordance of denomination between mother-offspring was measured by maternal report of denomination at time 1 and offspring report at time 10. Concordance of attendance and importance was based on mother and offspring report at time 10.

^bOffspring 10-year follow-up MDD status was based on the presence or absence of an episode of MDD between time 1 and time 10.

Data Analysis and Significance

Analyses were first conducted to establish rates of depression, religiosity, and demographics in mothers and offspring using χ^2 tests for dichotomous outcome and *t* tests for continuous outcome. χ^2 Tests were conducted examining rates of offspring’s depression outcome at 10-year follow-up by maternal depression (time 1). *t* Tests for independent means examining age of offspring and SES were conducted. To examine patterns of religious transmission between mother and offspring by maternal depression, data was then stratified by maternal depression (MDD) status at time 1. Pearson correlations between maternal religiosity and offspring religiosity at time 10 (child grown up) on the importance of religiosity and attendance at religious services were conducted.

Three mother-offspring concordance variables (concordance of importance, concordance of attendance, concordance of denomination) were constructed (1 = concordant, 0 = not concordant). For example, if an offspring reported being Protestant and a mother reported being Protestant, mother-offspring were concordant on denomination and given a score of 1. Logistic regression was conducted predicting concordance of religion variables (importance, attendance, denomination) by maternal depression status. All analyses were repeated controlling for time 1 maternal report on the PBI, offspring report on the PBI, and SES.

RESULTS

Rates of Offspring Depression Outcome at 10-Year Follow-Up

As compared with offspring of nondepressed mothers, offspring of depressed mothers (as diagnosed at time 1) were significantly more likely to have MDD between time 1 and time 10 (31.9% [23/72] versus 58.1% [50/86]; $\chi^2[1] = 10.82$; $p < 0.001$).

Intergenerational Transmission of Religion by Maternal MDD Status

Overall, the findings support the hypothesis that there was a differential transmission of religiosity by maternal MDD status. Pearson correlations between mother and offspring religiosity by maternal time 1 MDD status are presented in Table 3. Offspring and maternal religiosity (attendance and importance) were significantly associated if mothers had no MDD at time 1 but were not significantly associated if mother had time 1 MDD.

Concordance of Religiosity and Offspring MDD Status at 10-Year Follow-Up by Maternal MDD at Time 1

Forty-eight mother-offspring pairs were concordant on importance. Ninety-four percent (45/48) of these pairs reported religion was moderately to highly important. Forty-nine mother-offspring pairs were concordant on attendance at religious services. Of the concordant pairs on attendance, 53% (26/49 pairs) indicated they attended services more than once a week and 6% (3/49 pairs) indicated they attended at

TABLE 3. Pearson Correlations Between Mother Religiosity and Offspring Religiosity at 10-Year Follow-up (Time 10) by Maternal Depression Status at Time 1

	No maternal MDD (N = 72)		Maternal MDD (N = 86)	
	Maternal attendance	Maternal importance	Maternal attendance	Maternal importance
Offspring attendance	.44**	.06	.19	.28*
Offspring importance	.23	.33**	.07	.15

* $p < 0.05$; ** $p < 0.01$.

least once a month. Eighty-five pairs were concordant on denomination. Of the concordant pairs on denomination, 87% (74/85 pairs) reported they were Catholic, whereas 13% (11/85 pairs) reported they were Protestant.

The association between concordance of religiosity and offspring 10-year follow-up depression status (MDD between time 1 and time 10) is presented in Table 4. Offspring who were concordant on attendance were 83% less likely to have MDD between time 1 and time 10 when the mother had no time 1 MDD (OR = .17; 95% CI = .04–.81; $p < 0.05$). However, in the presence of time 1 maternal MDD, concordance of attendance was no longer associated with decreased likelihood of offspring depression. In addition, compared with a mother who did not have time 1 MDD, an offspring of a mother who had time 1 MDD was 3.81 times more likely to have MDD between time 1 and time 10 if concordant on importance (OR = 3.81; 95% CI = 1.12–13.01; $p < 0.05$). These results remained significant when controlling for those risk factors associated with offspring's MDD, namely maternal PBI, offspring PBI, and family SES (Table 4).

DISCUSSION

Our analyses suggest that (1) maternal depression attenuates the intergenerational transmission of religion; (2) in the presence of maternal depression, offspring were more likely to have MDD at 10-year follow-up when mother-offspring were concordant on religious importance; and (3) in the absence of maternal depression, offspring were less likely to have MDD at 10-year follow-up when mother-offspring were concordant on attendance. Thus, maternal depression attenuated the rates of religious transmission and the beneficial qualities (a decreased rate of offspring MDD) of the intergenerational transmission of religion.

Intergenerational Transmission of Religion by Maternal MDD Status

This study examines the impact of maternal depression on the intergenerational transmission of three dimensions of religiosity: (1) importance of religion, (2) attendance at religious services and events, and (3) religious denomination. Specifically, the findings showed that there was maternal-

TABLE 4. Multivariate Analysis of the Association Between Concordance of Religiosity and Offspring MDD at 10-Year Follow-Up (MDD Episodes Between Time 1 and Time 10) by Maternal MDD at Time 1

	No maternal MDD (N = 72)		Maternal MDD (N = 86)	
	OR	95% CI	OR	95% CI
Concordance				—
Importance	.72	.15–3.35	3.81	1.12–13.01*
Attendance	.17	.04–.81*	1.25	.40–3.90
Denomination	2.85	.53–15.32	.00	.00–1.54E+17
Concordance controlling for maternal PBI				
Importance	1.52	.23–10.14	5.77	.82–40.44†
Attendance	.09	.01–.68*	2.37	.38–14.67
Denomination	1.61	.21–12.17	.00	.00–4.80E+38
Affection	1.13	.89–1.41	1.16	.91–1.49
Overprotection	1.04	.86–1.27	.99	.83–1.19
Concordance controlling for child PBI				
Importance	.80	.16–4.01	10.66	2.10–54.18***
Attendance	.11	.02–.66**	2.35	.54–10.31
Denomination	3.43	.52–22.95	.00	.00–3.1E+17
Affection	1.14	.96–1.36	.90	.79–1.02
Overprotection	1.04	.91–1.19	.90	.82–.99*
Concordance controlling for family SES				
Importance	.81	.16–3.97	4.13	1.15–14.77*
Attendance	.17	.03–.83*	1.04	.32–3.37
Denomination	2.73	.49–15.04	.00	.00–9.6E+16
SES	.78	.37–1.61	1.24	.78–1.98

† $p < 0.10$; * $p < 0.05$; ** $p < 0.01$; *** $p < 0.005$.

offspring transmission of importance and attendance, with specificity by dimension, among nondepressed mothers, but no maternal-offspring transmission among depressed mothers.

Previous research has shown that the transmission of religiosity from mothers to offspring is normative, such that parental religiosity has been shown to predict religiosity in offspring across a range of dimensions (Myers, 1996; Wan-Ning et al., 1999). However, these studies have focused on nonclinical samples. The current study focuses exclusively on mothers with DSM-III-R diagnosis of MDD and their offspring and matched controls. This study has shown that exclusively among offspring of mothers with MDD, transmission of religiosity may be less likely. Maternal depression attenuates maternal traits that have been shown to facilitate the intergenerational transmission of religion, and therefore, maternal depression may also attenuate the transmission of religiosity.

Previous research has shown that the optimal conditions of religious transmission are parental nurturance, acceptance, support, and close relationship (Litchfield et al., 1997; Nelsen, 1980; Ozorak, 1989; Thomas, 1988; Wan-Ning et al., 1999). Family conflict, on the other hand, either between parent and child or between the spouses, has been shown to inhibit transmission of religious values (Clark and Worthington, 1987). In families in which the mother is depressed, the child-mother relationship may be characterized by greater conflict and less nurturance, closeness, and support, which then interfere with the transmission of religion. Depressed mothers have been observed to be more negative in interactions with their children as they displayed more critical, disapproving, and less nurturing and supporting behaviors than mothers without depression (Blatt and Homann, 1992; Gordon et al., 1989; Lovejoy, 1991), a style of mothering previously shown to be inversely associated with the intergenerational transmission of religion (Clark and Worthington, 1987).

Concordance of Religiosity and Offspring 10-Year Follow-Up MDD Status by Maternal MDD at Time 1

This study examined the association between mother-offspring concordance of religiosity and offspring depression status. Uniquely among offspring of depressed mothers, concordance of importance of religiousness was associated with increased likelihood of offspring depression at 10-year follow-up (as measured by MDD between time 1 and time 10). Among offspring of nondepressed mothers, however, concordance of religious attendance was associated with decreased likelihood of offspring depression at 10-year follow-up. One potential explanation for these findings is that in the presence of maternal depression, concordance signals strong identification or

enmeshment with an unhealthy mother, which has shown to be associated with internalizing psychological and emotional problems in offspring such as depression (Barber and Buehler, 1996; Salzman, 1996). Enmeshment has been shown to be associated with mothers who are controlling and overprotective (Barber and Buehler, 1996), yet findings in this study remained significant when controlling for mother-offspring attachment and maternal control as reported by both mother and child on the PBI. It therefore appears unlikely that attachment style or enmeshment accounts for the increased risk for depression in offspring.

Another possible explanation for the depressogenic effect of transmission of importance in offspring could be that the child may confuse religiosity as expressed through the mother with the mother's depression. Cognitive schemas of helplessness, self-criticism, and external locus of control are common in depressed individuals (Dunkley and Blankstein, 2000; Herman-Stahl and Peterson, 1999; Njus and Brockway, 1999; Steer et al., 1989). Low self-worth, guilt, and exaggerated responsibility for others are depressive symptoms often identified in depressed individuals (Aube et al., 2000; Zahn-Waxler et al., 1991). It could be that the offspring confuses cognitive schemas associated with maternal depression (feeling guilty, being critical, having external locus of control, feelings of low self-worth) with maternal religiosity, and that religion in depressed mothers takes on a depressing form. As such, the offspring picks from the mother depressive religiosity, and his/her sense of religious importance may focus on depressogenic traits such as guilt and external locus of control.

Heggen and Long (1991) have argued that specifically for women, religion can discourage self-expression and encourages submissiveness and lack of mastery. In the presence of maternal depression, a child may be more likely to internalize these values from the mother, which are associated with maternal depressive symptoms. The religion and depression may become one entity. In addition, an offspring of a depressed mother may distort religious other-centered understandings of services, empathy, and altruism (Bridges and Spilka, 1992) with the depressive symptoms of the mother.

Transmission of attendance to offspring has been shown to be protective against offspring substance abuse (Miller et al., 2001). Attendance at religious services has been shown to be protective against depression in adolescents (Wright et al., 1993) and in adults age 65 and older (Koenig et al., 1997). It is possible that transmission of attendance signals strong ties with the community (church) and greater social support. It is also possible that a child who is concordant on attendance had greater interaction with mother through religious activities (such as going to church). Greater social support and frequent interaction with mother through religious activities may be protective against offspring de-

pression. However, our findings indicate that the benefits transmission of attendance may have in children of nondepressed mothers (decreased rates of offspring MDD) are no longer beneficial in the presence of maternal depression. Consistent with this finding, concordance of attendance has been shown to be protective against alcohol intake in offspring to nonopiate-addicted parents; however, for offspring of an opiate-addicted parent, this finding was no longer significant (Miller et al., 2001). Parental pathology seems to attenuate the protective qualities of concordance of attendance. In the presence of maternal depression, greater mother-child interaction and greater ties with the religious community may not offer adequate support sufficient to protect the child against depression.

Limitations of Current Study

This study examines the association between the intergenerational transmission of religiosity as measured at time 10, and offspring MDD status during this 10-year period, in a sample of depressed and nondepressed mothers. It is possible that in depressed women, religiosity may have changed over the years, and that maternal report on time 10 religiosity does not fully represent her religious activities and beliefs between time 1 and time 10, when the child was growing up. This study does not allow for examination of mother-child religious activities during the 10-year period in which the offspring may have developed MDD. Therefore, the impact of mother-child religiosity on the child's development of depression is unclear, as are the mechanisms involved in this process. Further longitudinal research is needed to understand the risk and protective factors associated with religious transmission in the presence of maternal psychopathology. Furthermore, the majority of this sample reported they were Catholic. These findings, therefore, should not be generalized to individuals from diverse religious backgrounds.

CONCLUSION

These overall findings suggest that maternal depression impacts the intergenerational transmission of religiosity and that mother-offspring concordance of religiosity is associated with increased likelihood of offspring MDD. Treatment of children at high risk for depression potentially might benefit from the differentiation between religious values and maternal depressive symptoms.

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