The Effects of Self-Monitoring and Religious Self-Discrepancies on Negative Affect

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Western Kentucky University

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THE EFFECTS OF SELF-MONITORING AND
RELIGIOUS SELF-DISCREPANCIES ON
NEGATIVE AFFECT

A Thesis
Presented to
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Western Kentucky University
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Of the Requirements for the Degree
Master of Arts

By
John Robert Parker B.A.

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THE EFFECTS OF SELF-MONITORING AND RELIGIOUS SELF-DISCREPANCIES ON NEGATIVE AFFECT

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According to Higgins’s (1987) self-discrepancy theory, an individual’s self-esteem is based upon fulfilling one’s self-expectations or the expectations of significant others (e.g., spouse or parent). Failure to live up to these expectations results in greater levels of depression, anxiety, and lower self-esteem.

Previous research has also found that those low in Snyder and Gangestad’s (1986) self-monitoring construct are more influenced by their own expectations, while those high in self-monitoring are more influenced by others’ expectations. It was predicted that Christians who are low in self-monitoring will have greater levels of depression and anxiety and lower self-esteem if they fail to fulfill their own religious expectations, whereas Christians who are high in self-monitoring would have greater levels of depression and anxiety and lower self-esteem if they fail to meet the religious expectations of significant others.

As predicted, for low self-monitors actual:ideal religious self-discrepancies led to increased negative affect, but actual:other discrepancies did not. For high self-monitors, however, neither actual:ideal nor actual:other self-discrepancies led to increased negative affect.
The Effects of Self-Monitoring and Religious Self-Discrepancies on Negative Affect

Much of the research examining interactions between religious motivation and low-self esteem or depression has yielded inconclusive results. Therefore, further research is necessary to examine why some very religious individuals are happy, healthy, content, and well-adjusted while other equally religious individuals are depressed and despairing. For this study, Higgins’s (1987) self-discrepancy theory and Snyder and Gangestad’s (1986) construct of self-monitoring were used to predict anxiety and depression among Christians. According to self-discrepancy theory, individuals’ self-esteem is based on fulfilling either one’s self-expectations or the expectations of significant others (e.g., parents or spouse). When one fails to fulfill the expectations that are more important, greater anxiety, depression, and low self-esteem result. Previous research has also shown that self-expectations are more important for those who are low in self-monitoring, while others’ expectations are attended to more by those high in self-monitoring. From these joint considerations, it was predicted that Christians who are low in self-monitoring would experience greater depression and anxiety if they see themselves as failing to fulfill their religious self-expectations, whereas Christians who are high in self-monitoring would have greater anxiety and depression if they think they are not fulfilling the religious expectations significant others hold for them.

Self-Discrepancy Theory

Higgins’s (1987) self-discrepancy theory describes the differences between the characteristics a person has, desires, and feels should be possessed. Two main dimensions comprise self-discrepancy theory: the domains of the self and the standpoints of the self.
The domains of the self are divided into three categories. The "actual self" refers to these attributes, characteristics, beliefs, etc. that an individual believes are actually possessed. The "ideal self" are the attributes, characteristics, beliefs, etc. that an individual wishes to ideally possess. The third category, the "ought self," consists of attributes, characteristics, beliefs, etc. that an individual believes should be possessed (Higgins, 1987).

The second dimension of self-discrepancy theory, the standpoints on the self, consists of the own standpoint and the other standpoint. The own standpoint is one’s own personal perception of oneself. The other standpoint is one’s perception of how important other persons, such as a parent or spouse, see that individual (Higgins, 1987).

By organizing his theory into these two dimensions, Higgins (1987) derived six possible ways that a person can see oneself: the actual/own, ideal/own, ought/own, actual/other, ideal/other, and ought/other perspectives. Any one person can have or be influenced by one or more of these six points of view. To simplify these six viewpoints on the self, Higgins describes the actual/own and actual/other, as a person’s “self-concept,” either what one sees in one’s self (actual/own) or what someone thinks other people see in him or her (actual/other). The remaining four viewpoints are called “self-guides.” These self-guides are used to direct a person’s life. An individual will not necessarily use all four self-guides. Some will be more influenced by the ideal selves and others by the ought selves, some more by the own perspective and others by the other perspective. In the end, self-discrepancy theory essentially states that people are motivated by their self-guides to reach a state of congruency between their individual self-concepts and their individual self-guides.
A self-discrepancy occurs when there is a difference between a person’s self-concept (actual self, own or other) and self-guide (ought or ideal, own or other). Higgins (1987) states that these self-discrepancies create emotional disturbance and that the larger the self-discrepancy, the greater the emotional upset. He differentiates between the specific type of disturbance held by each type of self-guide (ideal or ought) by hypothesizing that self-discrepancies from ideal self-guides create dejection or depression-related disturbances, while self-discrepancies from ought self-guides lead to anxiety or agitation. His reasoning is that ideal self-guided people may feel as though they have not or will not achieve a certain standard. Therefore, they may feel depressed as a result of having disappointed themselves or important others and having missed positive outcomes that would have resulted from achieving that standard. When ought self-guided people, on the other hand, feel as though they have not achieved a certain standard, they may feel anxiety due to anticipated punishment or other impending negative outcomes as a result of not having achieved that standard.

Higgins (1987) states that these emotional disturbances may not occur as long as the individual with a large self-discrepancy is unaware of that discrepancy. It is the awareness that one has not achieved what one has wished for or felt obligated to achieve that creates the emotional discomfort. “The greater the magnitude and accessibility of a particular type of self-discrepancy possessed by an individual, the more the individual will suffer the kind of discomfort associated with that type of self-discrepancy” (Higgins, 1987, p. 324).

Self-discrepancies most often have been assessed by one of two measures. The Selves Questionnaire developed by Higgins, Bond, Klein, and Strauman (1986) is most
widely used. The Selves Questionnaire asks participants to list attributes for the actual, ideal, and ought selves. Test administrators then compare the attributes from the actual-self list to the attributes in the ideal-self and ought-self lists using a thesaurus to examine how well attributes match each other and assign a score to each attribute based upon the quality of that match. Discrepancy scores are then assigned by taking the difference between the total score on the actual-self list and the ideal-self or ought-self lists. The higher the discrepancy score, the greater the difference between the individual’s self-concept and self-guide. Hoge and McCarthy (1983) developed a second measure on which participants answer an eight-item scale with Likert-type responses assessing various actual-self and ideal-self attributes. Respondents indicate how true of themselves each of the items is by giving a score of 1 (not at all true) to 6 (very true). One open-ended item is included at the end of the scale for respondents to indicate further important attributes not addressed in the first eight items. Discrepancy scores are assigned by taking the difference of real-self and ideal-self ratings for each item and then calculating an average total discrepancy across all nine items.

Higgins and his colleagues have done a number of studies testing his hypotheses of self-discrepancies and the corresponding emotional disturbances. The results of the studies (Higgins, Klein, & Strauman, 1985; Higgins, Klein, & Strauman, 1987; Higgins, et al., 1986; Strauman & Higgins, 1987) are summarized by Higgins’s (1987) and lend considerable support for his theory of self-discrepancy.

Strauman and Higgins (1988) again examined self-discrepancies in two studies. They found, in support of the theory, that actual/own versus ideal/own discrepancies were uniquely related to dejection, frustration, and anger towards self and that actual/own
versus ought/other discrepancies were uniquely related to agitation and anger at others, as well as resentment (Study 1). They also found that social anxiety was related to actual/own versus ought/other discrepancies and that depressive symptoms were related to actual/own versus ideal/own discrepancies best fit the results obtained (Study 2).

Moretti and Higgins (1990) examined the ability of self-discrepancies to predict self-esteem. Participants filled out the Selves Questionnaire (Higgins et al., 1986) and Hoge and McCarthy’s (1983) measure of self-discrepancy. Self-discrepancy scores were obtained on both measures and correlated with participants’ scores on two measures of self-esteem.

Significant correlations between actual:ideal discrepancies on the Selves Questionnaire and both measures of self-esteem were observed, but similar significant relationships were not found for the Hoge and McCarthy scale and self-esteem. These findings imply that the Selves Questionnaire is a superior instrument for predicting self-esteem levels resulting from self-discrepancies. The better predictability of the Selves Questionnaire appears to be because its discrepancies are related to attributes named by the individual instead of from attributes named by another person. While there was no significant correlation found between actual-ought discrepancies and self-esteem, these results indicate that discrepancies derived from Higgins’s (1987) measure of self-discrepancy are better predictors of self-esteem level than Hoge and McCarthy’s (1983).

Self Monitoring

Whereas self-discrepancies examine the differences between what an individual is and wants to be (whether the ought or ideal self), self-monitoring examines differences in how people portray themselves to others. Snyder and Gangestad’s (1986) self-
monitoring construct was developed at much the same time as Higgins’s self-discrepancy theory. Snyder and Gangestad, like Higgins, maintain that each person has a type of inner self that is comprised of what a person actually believes and feels, like Higgins’s actual self. In addition to that inner self, most people also have multiple selves that they demonstrate in social settings, the way an actor moves from one role to another, depending on the script. The extent to which each person controls, or monitors, the self that is seen by the public is called self-monitoring (Snyder, 1987).

High self-monitors are typically very concerned about the images or selves they allow others to see. They tend to tailor the way they act, or the self they demonstrate, to their social situation. They most often act in a way to conform to the expectations of others around them. According to Snyder (1987), most people monitor their projected self to some degree, but for high self-monitors especially, doing so becomes a core way of living. On the other hand, low self-monitors are more concerned that the self they demonstrate in public is congruent with their true inner self. They are much less apt to conform to the expectations of a social situation, especially if those expectations are contrary to their own beliefs.

Snyder and Gangestad’s (1986) Self-Monitoring Scale consists of 18 items, such as, “I guess I put on a show to impress or entertain others.” They are presented as statements about how an individual’s life is led, and individuals respond whether each statement is true or false about their lives. The items are designed to assess different situationally appropriate methods of presenting the self, such as assessing how much attention is paid to monitoring social cues, controlling expressive behaviors, and shifting from one self to another when changing social situations.
Combining Self-Monitoring and Self-Discrepancy Theory

Gonnerman, Parker, Lavine, and Huff (2000) examined the extent to which self-monitoring and standpoints on the self moderate the affective states of individuals in terms of discrepancies between actual:ideal and actual:ought selves. The researchers’ hypotheses were that, for low self-monitors, only self-discrepancies from the own standpoint would be significantly related to depression and anxiety. For high self-monitors, only self-discrepancies from the other standpoint would be significantly related to depression and anxiety. The expectations were based upon the idea that if high self-monitors are most concerned about how they portray themselves to others, they would be most concerned about discrepancies from the other standpoint, while if low self-monitors are most concerned about reflecting their own ideals, they would be most concerned with discrepancies from their own standpoint.

Participants were divided into either high or low self-monitoring categories, depending on whether their score on Snyder and Gangestad’s (1986) Self Monitoring Scale fell above or below the sample’s median split. In addition to filling out the self-monitoring instrument, participants also filled out Higgins’s Selves Questionnaire, and two self-discrepancy scores (own and other perspectives) were calculated for each individual. After self-discrepancy scores were determined, the participants filled out a number of measures assessing anxiety and depression.

Gonnerman et al. (2000) evaluated the relationship between self-discrepancy and depression for the low and high self-monitors from both the own and other standpoints. The results confirmed the hypotheses. Specifically, low self-monitors had a significant relationship between discrepancies and depression only in the own standpoint, indicating
that low self-monitors are concerned with not living up to their own ought and ideal expectations. Results further indicated that high self-monitors had a stronger relationship between self-discrepancy and depression and anxiety from the other standpoint than from the own standpoint, indicating that high self-monitors are more concerned with not living up to others’ expectations.

Given the established relationships for self-monitoring and self-discrepancies with depression and anxiety, it was expected that similar self-discrepancies in an individual’s religious beliefs and motivations would similarly be related to depression and anxiety.

Religious Beliefs

Batson, Schoenrad, and Ventis’s (1993) Doctrinal Orthodoxy was designed to measure one’s belief in core Christian doctrines. The scale consists of 12 statements such as “I believe Jesus Christ is the Divine Son of God,” to which the individual responds in a Likert-type format from “strongly disagree” (1) to “strongly agree” (5). A measure of orthodoxy will be used in the current study.

Religious Motivation

Gordon Allport (1950) introduced the terms immature and mature religion to describe the way that religious individuals incorporate religion into their lives. Allport contended that as people grow from childhood to adulthood, they generally move from immaturity to maturity in most areas (intellectual, emotional, physical). However, not everyone grows in all areas. Intellectual and emotional growth do not necessarily accompany physical growth, and this is especially the case with religion. For people who are religious for most of their lives, the immature religion of childhood is generally one that is comforting and familiar, providing a basis of stability for life. As people age, they
often find the religion of childhood to be sufficient for their purposes. It is difficult and uncomfortable to challenge long held beliefs, especially when those beliefs provide the holder with positive rewards such as security or consolation. Therefore, growth of religious sentiment, as Allport calls it, may be stifled and remain immature.

Mature religion on the other hand is one that “... comes about ... by the desire that this sentiment shall not suffer arrested development ...” (Allport, 1950, p. 59). Mature religion is cultivated to reflect the positive experiences of the person holding those beliefs. It is not merely self-gratifying. Rather, a mature religion is one that allows the holder to expand interests to concepts beyond the self. It allows viewing of oneself objectively, in perspective to the rest of the world and seeing oneself as others do. It also unifies all experiences of the person into a whole; that is, it affects every aspect of the individual’s life. Mature religion is not put into use only when it serves a purpose to the individual. Instead of merely meeting needs or fulfilling desires, it provides a framework by which one’s life is led. It welcomes challenges and existential questions, and it allows growth of a nature that immature religion is unable to allow.

Allport and Ross (1967) further developed the study of religious motivation by expanding from immature and mature religion to extrinsic and intrinsic religion. The authors began their definitions of these two terms by saying, “... the extrinsically motivated person uses his [sic] religion, whereas the intrinsically motivated person lives his [sic] religion” (p. 434; italics added). The extrinsic motivation for religion is essentially immature. The person with extrinsically motivated religious beliefs holds those beliefs because they provide something or because they meet certain needs, such as security, self-assurance, or social connectedness. On the other hand, the person with
intrinsically motivated religious beliefs embraces or internalizes those beliefs. All other needs, as important as they may be, are considered less important than the religious belief. Intrinsic motivation for religion is mature.

Allport and Ross’s original scales for assessing these motivations were called Extrinsic and Intrinsic Scales of Religious Orientation. They consisted of 11 statements assessing extrinsic motivation (e.g., “What religion offers me most is comfort when sorrows and misfortune strike.”) and 9 statements reflecting intrinsic motivation (e.g., “My religious beliefs are what really lie behind my whole approach to life.”). Persons responded to each item in a Likert-type manner indicating “I definitely disagree” to “I definitely agree” (Allport & Ross, 1967, p. 436). Batson et al. (1993) slightly modified the wording on a few of the original items in order to move the Likert-type response choices from a 5-point scale to 9-point scale.

Gorsuch and Venable (1983) developed an age-universal scale to measure intrinsic and extrinsic motivation. They posited that the original scales were developed for adults, and therefore were not accurate measures for the motivations of children and adolescents. Their modified scale was found to be equally reliable and valid with children and adolescents compared to the original scales, with wording that makes it easier for children down to the fifth grade level to comprehend the statements on the scales.

An EBSCO search revealed that since their introduction, more than 375 published studies have used Allport and Ross’s scales, Gorsuch and Venable’s scale, or other derivations to assess how intrinsic and extrinsic motivations affect other behaviors or attitudes. Some examples are antihomosexual sentiment among Christians (Fulton, Gorsuch, & Maynard, 1999), religious motivation in middle-age (Kivett, 1979), religion
and rationality (Watson, Milliron, Morris, and Hood, 1994), spiritual and psychological well-being (Genia, 1996), and depressive symptoms (Maltby & Day, 2000).

Batson and Ventis’s (1982) introduction of quest motivation created a third major dimension in the study of religious motivation. Quest motivation, like intrinsic motivation, is mature. It also has moved from the self-gratifying nature of immature or extrinsic religion to a nature that grows and develops along with the individual. Batson defined quest motivation as “…an open-ended, responsive dialogue…” (Batson et al., 1993, p. 169) about religion. It is essentially an open-minded attitude toward change and searching for the answers to the existential questions that are part of the nature of religion. Batson & Ventis first introduced a six-item measure in 1982. McFarland (1989) developed a 10-item revision of the quest scale, and Batson et al. (1993) produced a 12-item revised scale to measure quest motivation. Many researchers have since incorporated the quest dimension into their study of religious motivation, including studies of authoritarianism and religious fundamentalism with quest (Altemeyer & Hunsberger, 1992), and relationships of religious attitudes to religious orientations (Kristensen, Pedersen, & Williams, 2001).

Religion and Self-Esteem

Most research regarding religion and self-esteem has yielded mixed results. Smith, Weigert, and Thomas (1979) found general support for a positive correlation between religious behavior in adolescents and self-esteem. However, Smith, et al. did not examine the religious motivations and also found significant results in only a portion of the sample. Most studies reviewing direct relationships between self-esteem and religious motivation have shown few or no significant results when self-esteem was correlated

Religious Self-Discrepancies

An Internet search located only one study on the relationship between self-discrepancies and religion. Lilliston and Klein (1991) examined the extent to which self-discrepancies affect the application of religious coping strategies to personal crisis. Participants completed the Selves Questionnaire. They responded to a series of religious activities that they might engage in to cope with personal crisis. The results indicated that only high actual/own:ought/own discrepancies were significantly related to religious coping strategies. Individuals with high actual:ought discrepancies from the own point of view were more likely to engage in religious activities as a coping strategy for personal crisis than those with high actual/own:ideal/own discrepancies. The implication is that individuals who are more concerned with how significant others in their lives want them to be may be more likely to use the religion of those significant others as coping tools during personal crisis.

The Current Study

The current study combined self-discrepancy theory and self-monitoring to assess the degree to which discrepancies between actual religious self-states and ideal or ought religious self-guides mediate the level of self-esteem, depression, and anxiety in Christian
individuals. No research to date to assesses how discrepancies in religious selves affect self-esteem and depression.

Based on previous findings, two specific hypotheses were posited. First, for low self-monitors, large discrepancies between actual religious self (motivations and beliefs) and ideal religious selves from the own perspective will be significantly related to greater depression and lower levels of self-esteem, but ought discrepancies from the other perspective should not lead to depression or reduced self-esteem. Second, for high self-monitors large discrepancies between actual religious self and ideal or ought religious self from the other perspective will be significantly correlated with greater depression and lower levels of self-esteem, but discrepancies from ideal religious self from one’s own perspective should not lead to depression or reduced self-esteem.

Using Amos 4.0, data were analyzed for goodness-of-fit to the structural model presented in Figures 1 and 2. Goodness-of-fit to the model was calculated separately for high and low self-monitors and for own and other perspectives. For high self-monitors, the path from religious self-discrepancy to generalized negative affect was expected to be greater for other than for own perspective. For low self-monitors, the path from religious self-discrepancy to generalized negative affect was expected to be greater for own than for other perspective.

This model assumed that the four measures of religious self-discrepancy from the own perspective would yield a generalized religious own-perspective self-discrepancy score. Similarly, it assumes that the four measures of religious self-discrepancy from the other perspective would yield a generalized religious other-perspective self-discrepancy
score. It also assumed that the three measures of negative affect (anxiety, depression, and low self-esteem) would yield a general negative affect score.
Figure 1 Hypothetical model of the effects of religious self-discrepancy (own perspective) upon negative affect.
Figure 2  Hypothetical model of the effects of religious self-discrepancy (other perspective) upon negative affect.
Method

Participants

Participants (N=227) were recruited on a volunteer basis from undergraduate and graduate classes at a mid-sized state university. One individual did not complete the survey and was removed from the sample, leaving 156 females and 70 males. Eighty-seven percent were Caucasian, 9% African-American, and 4% Hispanic, Asian, or other ethnicity. Eighty-seven percent of participants answered that they are Christians.

Measures

Self-Monitoring. Participants completed the revised version of the Self-Monitoring Scale (Appendix A; Snyder & Gangestad, 1986) designed to place an individual into either a high or low self-monitoring group. Gonnerman et al. (2000) reported a reliability (Cronbach’s alpha) coefficient of .70 for their sample of 294 college students.

Self-Esteem. The Rosenberg Self-Esteem Scale (Appendix B; Rosenberg, 1965) is designed to assess a measure of global self-esteem based on a 10-item, Likert-type format. Participants are asked to respond to various questions such as “On the whole, I am satisfied with myself,” (reverse scored) or “At times I think I am no good at all,” from strongly disagree (1) to strongly agree (5). McFarland (2002) reported an alpha of .86 for more than 200 adults and .81 for 200 college students.

Religious motivation. Six items per scale were taken from Allport & Ross’s (1967) Religious Orientation Scales, assessing extrinsic orientation (Appendix C; Allport & Ross, 1967) and intrinsic orientation (Appendix D; Allport & Ross, 1967). The
participant responds to each statement by indicating to what degree the item applies to his or her life. The measure of quest orientation (Appendix E; Batson et al., 1993), also reduced to six items, was responded to in the same manner as the extrinsic and intrinsic measures. Batson et al. (1993) reported an alpha of .72 for the extrinsic measure, .83 for the intrinsic measure, and .78 for the quest measure on a group of 424 undergraduate students, using each of the full scales.

Orthodoxy. The Doctrinal Orthodoxy Scale (Appendix F; Batson et al., 1993), also reduced to six items, was given to measure one’s belief in traditional religious doctrines, primarily from the Christian perspective. Batson et al. reported an alpha of .91 for a group of 424 undergraduate students, using the full scale.

Religious Behavior. A four-item measure of the frequency of religious behavior (Appendix G) was added to assess how often each individual engages in the activities of reading the Bible, praying, attending church, and a general statement assessing the individual’s degree of religiosity.

Depression. The depression subscale of the Hopkins Symptom Checklist (HSCL; Appendix H; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi. 1974) is an eleven-item scale assessing an individual’s recent experience of depression-related symptoms. Participants respond to each item in a Likert-type format from 1 (not at all) to 4 (extremely). Derogotis et al. (1974) reported an alpha of .86 for three separate clinical samples.

Anxiety. The anxiety subscale of the HSCL (Appendix I: Derogatis et al., 1974) is a seven-item scale assessing an individual’s recent experience of anxiety-related symptoms. Participants respond to each item in a Likert-type format from 1 (not at all) to
4 (extremely). Derogatis et al. (1974) reported an alpha of .84 for three separate clinical samples.

Procedure

Participants completed a series of questionnaires consisting of the Self-Monitoring Scale (Snyder & Gangestad, 1986), the Rosenberg Self-Esteem Scale (Rosenberg, 1965), abbreviated (six-item) versions of the Intrinsic Scale of Religious Orientation (Allport & Ross, 1967), Extrinsic Scale of Religious Orientation (Allport & Ross, 1967), Quest Scale of Religious Life Inventory (Batson, et al., 1993), Doctrinal Orthodoxy scale (Batson, et al., 1993), and Religious Behavior Scale, as well as the depression and anxiety subscales of the Hopkins Symptom Checklist (HSCL; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). Abbreviation of the extrinsic, intrinsic, quest, and orthodoxy religious measures was done in the interest of shortening the time required of a participant to complete the questionnaire. Choices for items included in the abbreviated forms were based on face validity, selecting the six items from each scale that appear to best represent its content. Participants also answered four items assessing the frequency of religious behavior.

The participants answered the Self-Monitoring Scale, Rosenberg Self-Esteem Scale, Doctrinal Orthodoxy Scale, and Depression and Anxiety Subscales once each. The participants answered the religious scales three times each: once as they actually see themselves, once as they would ideally like to be, and once as they believe significant others (parents, loved ones) would like them to be. The scales were answered in the order of the Self-Monitoring Scale, the Rosenberg Self-Esteem Scale, the four religious scales and religious behavior questions answered three times in the order of actual self, ideal
self, and other perspective, and lastly the depression and anxiety subscales. After returning the questionnaires, the participants received appropriate debriefing as to the purpose of their involvement.
Results

The sample was divided into high and low self-monitors based on criteria that scores of 10 or lower on the self-monitoring section of the survey denoted low self-monitors (n = 135) and scores of 11 or higher denoted high self-monitors (n = 91). Analysis was then done for both high and low self-monitors for both actual:ideal and actual:other discrepancies. The decision to place the cutoff score at 10 was based on the recommendation of Snyder and Gangestad’s (1986) research that 10 is most often the best score to set as the cutoff limit.

Self-discrepancy scores were calculated by summing the response values of each item in each of the five religious scales for the actual, ideal, and other perspectives. The absolute value of the difference between the actual (how one sees one’s self) and ideal (how one aspires to be) perspectives produced the actual:ideal discrepancy score on any given scale. Similarly, the absolute value of the difference between the actual and other (how one thinks others want him or her to be) perspectives produced the actual:other discrepancy score. Separate discrepancy scores were calculated for each of the five religious constructs assessed (extrinsic, intrinsic, and quest motivations, orthodoxy and religious behavior). Means, standard deviations, reliability coefficients, and correlations among variables in each of the four study groups are provided in Table 1. All scales used were found to be reliable, with alphas ranging from .71 to .88.
### Table 1
*Means, Standard Deviations, and Reliability Coefficients for Each Study Group.*

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>Rel. Alpha</th>
</tr>
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<tbody>
<tr>
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<tr>
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<td>.77</td>
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<tr>
<td><strong>Int. Act.</strong></td>
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<td>.85</td>
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<tr>
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<td>.79</td>
</tr>
<tr>
<td><strong>Orth. Act</strong></td>
<td>24.48</td>
<td>5.96</td>
<td>.88</td>
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<tr>
<td><strong>Beh. Act.</strong></td>
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<td>4.03</td>
<td>.83</td>
</tr>
<tr>
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<td>.84</td>
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<tr>
<td><strong>Anx.</strong></td>
<td>9.64</td>
<td>3.77</td>
<td>.88</td>
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Intercorrelations were conducted between all discrepancy scores for all groups. As presented in Tables 2 and 3, discrepancy scores between the five religious measures
correlated highly with each other for both the actual:ideal discrepancy (Table 2) and actual:other discrepancy (Table 3).

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Actual: Ideal Discrepancies from the Own Perspective</th>
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<tbody>
<tr>
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<tr>
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<td>Intrinsic actual:ideal</td>
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<tr>
<td>Quest actual:ideal</td>
<td>.27**</td>
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<tr>
<td>Orthodoxy actual:ideal</td>
<td>.47**</td>
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<tr>
<td>Behaviors actual:ideal</td>
<td>.41**</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Actual: Other Discrepancies from the Other Perspective</th>
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</thead>
<tbody>
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<td></td>
<td>Extrinsic</td>
</tr>
<tr>
<td></td>
<td>actual:other</td>
</tr>
<tr>
<td>Extrinsic actual:other</td>
<td>1.0</td>
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<tr>
<td>Intrinsic actual:other</td>
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<tr>
<td>Quest actual:other</td>
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<tr>
<td>Orthodoxy actual:other</td>
<td>.39**</td>
</tr>
<tr>
<td>Behavior actual:other</td>
<td>.34**</td>
</tr>
</tbody>
</table>

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

In examining the correlations between discrepancy scores, it was discovered that although all of the correlations for the quest discrepancies were significantly related to the other four discrepancies, its coefficients were consistently lower than the correlation coefficients of the Religious Behavior scale with the other four discrepancies (see Tables 2 and 3). It was therefore decided to substitute religious behavior in place of quest.
motivation when analyzing the data's fit to the models presented in Figures 1 and 2. Thus, the self-discrepancies determined using the four measures of religion used in the revised model (extrinsic and intrinsic motivation, religious orthodoxy, and frequency of religious behaviors) loaded heavily onto the latent variable of a general religious self-discrepancy.

It was additionally found, as presented in Table 4 that the three measures of negative affect were significantly correlated with each other, indicating that a generalized negative affect exists as the path analysis model assumes.

<table>
<thead>
<tr>
<th></th>
<th>Self-esteem</th>
<th>Depression</th>
<th>Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Esteem</td>
<td>1.0</td>
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<tr>
<td>Depression</td>
<td>-.41**</td>
<td>1.0</td>
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<tr>
<td>Anxiety</td>
<td>.23**</td>
<td>.60**</td>
<td>1.0</td>
</tr>
</tbody>
</table>

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

However, when analyzing the data for fit to the models presented in Figures 1 and 2, Amos 4.0 overcorrected for the anxiety and depression scales and reported an inadmissible solution due to negative variance for the depression scale, probably due to the high correlation between these two scales. After examining the data, it was decided to remove the anxiety scale from the model altogether. Rationale for this was taken from Higgins' (1987), who theorized that individuals with own perspective discrepancies are more likely to also suffer from depressive symptoms rather than anxious symptoms.
Low Self-Monitors

As shown in Figure 3, for low self-monitors in the actual:ideal analysis, the four measures of religious self-discrepancy used all contributed to the latent general religious self-discrepancy. Further, both depression and low self-esteem loaded highly on latent general negative affect as was expected. When the data were analyzed for fit to the revised model (with anxiety measure removed), the relationship between general religious self-discrepancy and general negative affect was found to be highly significant, $p < .01$. As presented in Figure 3, the data fit the presented model well. Three goodness-of-fit indices were used. Data constitute a good fit to a model when chi-square is not significant, comparative goodness-of-fit (CFI) approaches 1.0, and root mean square error of approximation (RMSEA) approaches .00.

For low self-monitors' actual:other discrepancies, the four measures of religious self-discrepancy again all contributed to the latent general religious self-discrepancy and depression and low self-esteem loaded highly on latent general negative affect. However, as presented in Figure 4, when the data were analyzed for fit to the revised model (with the anxiety measure removed), though it was found to be a good fit to the model presented, the relationship between general religious self-discrepancy and general negative affect was not significant. Therefore, a significant relationship was found between religious self-discrepancy and negative affect for low self-monitors for actual:ideal discrepancies, but not for actual:other discrepancies, supporting the first hypothesis.
Figure 3

Actual-Ideal Discrepancy and Negative Affect for Low Self Monitors

Chi-square (6, N=135) = 6.30, p = .39, CFI = .996, RMSEA = .02
Figure 3
Actual-Other Discrepancy and Negative Affect for Low Self Monitors

Chi-square (6, N = 135) = 6.30, p = .39, CFI = .996, RMSEA = .02
High Self-Monitors

For high self-monitors in the actual:ideal discrepancy analysis, the four measures of religious self-discrepancy all contributed to the latent general religious self-discrepancy. When the data were analyzed for this group, an inadmissible solution due to negative variance was found again for the depression measure. The self-esteem and depression measures were again collapsed into one single measure of negative affect (the factor scores of depression and self-esteem). Goodness-of-fit indices indicated that the data were a perfect fit to the model presented in Figure 5 (CFI = 1.00, RMSEA = .000). However, the relationship between the negative affect and religious self-discrepancy variables was not significant.

As shown in Figure 6, for high self-monitors in the actual:other discrepancy analysis, the four religious measures of religious self-discrepancy all again contributed to the latent general religious self-discrepancy. When the data were analyzed for this group, an inadmissible solution due to negative variance was found for the depression measure. By collapsing the self-esteem and depression measures into one single measure of negative affect (the factor scores of self-esteem and depression), the data were analyzed for fit to the revised model and was found to have a good fit to the model presented, though the relationship between general religious self-discrepancy and general negative affect was not found to be significant. Therefore, because there was no significant relationship found between religious self-discrepancies and negative affect for high self-monitors for either the actual:ideal or actual:other discrepancies, the second hypothesis was not supported.
Figure 5

Actual-Ideal Discrepancy and Negative Affect for High Self Monitors

Chi-square (5, N =91) = 2.14, p = .83, CFI =1 .00, RMSEA = .000
Figure 6

Actual-Other Discrepancy and Negative Affect for High Self Monitors

Chi-square (4, N=91) = 4.059, p = .398, CFI = .998, RMSEA = .03
Discussion

The purpose of the current study was to examine the effects of self-monitoring and religious self-discrepancies on levels of depression, anxiety, and self-esteem in Christian individuals. The hypotheses were that low self-monitors with large actual:ideal religious discrepancies (own perspective) would have greater depression and lower self-esteem than low self-monitors without that discrepancy, and secondly, that high self-monitors with large actual:other religious discrepancies would have greater depression and lower self-esteem than high self-monitors without that discrepancy.

Due to a better correlation between religious behavior and the remaining four measures of religious motivation than for quest motivation and the remaining four religious measures, the decision was made to substitute the religious behavior scale in place of the quest motivation scale when analyzing the data. Removal of the anxiety measure on the latent negative affect variable was necessary due to an inadmissible solution produced by the Amos program.

It was found that all four groups analyzed produced acceptable levels of goodness of fit for their respective and revised models. A significant relationship was found between religious self-discrepancies and negative affect for low self-monitors for the actual:ideal discrepancy. A similarly significant relationship was not found for low self-monitors from the other perspective, thus supporting the hypothesis that low self-monitors, who are more concerned with meeting their own expectations in religious beliefs, but who do not do so, are more likely to be depressed and have lower self-esteem than those who do not meet the expectations of others. These findings appear to be
consistent with Higgins’ theory that individuals with self-discrepancies from their own
ideals tend to be more prone to depressive symptoms. Also, these findings appear to be
consistent with the findings of Gonnerman et al. (2000), in that low self-monitors tend to
have more negative affect when they have actual:ideal discrepancies rather than
actual:other discrepancies.

Significant relationships between religious self-discrepancies and negative affect
for high self-monitors were not found for either the own:other or the own:ideal
perspectives. This indicates that although high self-monitors in this sample may show
signs of depression and low self-esteem and may have religious self-discrepancies, these
two states are not related. Whatever causes negative affect in high self-monitors, it is not
religious discrepancies either from one’s own ideals or from the expectations of
significant others. These findings are contrary to the results reported by Gonnerman et al.
(2000), in that high self-monitors with self-discrepancies from the other perspective did
have more instances of negative affect, whereas the current study did not find this to be
the case.

In finding a relationship between religious self-discrepancies and negative affect
from the own perspective for low self-monitors, it is then reasonable to assume that this
may be an area to address with the depressed, religious client who seeks treatment from a
clinician. Due to the correlational nature of the data, we cannot assume that a religious
self-discrepancy causes greater depression and lowered self-esteem. It is possible that an
individual who is depressed would choose to abandon the religious beliefs that have been
held up to that point. However, it seems illogical that someone would actually do this.
Instead, it makes more sense that a person who has abandoned the religious beliefs might
feel some greater sense of depression or lower self-esteem. Regardless of the direction of causality, where there is a relationship between the two, the clinician has another area from which to approach treatment.

There are perhaps several reasons as to why the second hypothesis was not confirmed. One reason may be the wording of the questions on the survey regarding the other perspective. Our survey asked the participants to report how they thought their parents and others close to them would want them to believe. We did not address the concept of anticipated peer approval in the general sense, only from the point of view of those closest to the participants. It may be that high self-monitors are more concerned with fulfilling the expectations of a larger peer group or of society in general than just the expectations of those closest to them. If that is the case, then the questionnaire would have failed to address this possibility.

A second reason for the lack of confirmation of the second hypothesis may be the degree to which religion is important to the individuals in this sample. As this sample was taken at a public, state university where there are typically more diverse attitudes toward religion, these individuals may not have felt that their religious beliefs were of such importance to them that not living up to their own or others’ expectations would lead to a propensity for depressive symptoms and lower self-esteem, or that having moved away from close proximity to those significant others, high self-monitors may feel less pressure to live up to those others’ expectations. It is possible that taking a sample from a private, religiously affiliated institution or from church groups, where the level of devotion to and importance of religion to any given individual may be higher, might yield different results than those reported here.
A third possibility for the lack of relationship between high self-monitors' religious self-discrepancies and negative affect may be the relative age of the participants. Perhaps the older and more mature a person grows, the more important religious beliefs become. If this is the case then perhaps not having lived up to the expectations one has set in religious beliefs may become more salient and therefore more likely to result in depressive symptoms and lowered self-esteem.

Fourth, it may simply be that there is no relationship for high self-monitors between their level of negative affect and the presence of a religious self-discrepancy.

As implied earlier, one of the limitations of this study is the nature of the sample. A clinical sample may yield a different set of results and may give us a better understanding of what is needed of the clinician who is approached for treatment from a clinically depressed individual. Additionally, though Christianity is demographically the largest religious faith in Western culture, other faiths such as Judaism and Islam constitute large numbers of individuals, and the particular nature of the Orthodoxy Scale in specific, as well as the survey in general, did not account for individuals of other faiths. Future research as to the applicability of these hypotheses to individuals with other religious beliefs besides Christianity would be prudent. Development of an orthodoxy scale for these other faiths would be necessary for continuation in this line of research.

As stated at the beginning of this study, there are countless individuals in the world who suffer from depression and low self-esteem. Until the last few years, many clinical psychologists have sought to minimize the effects of religion on a person's mental health, if not outrightly implicate religion as part of the cause of mental illness.
Much recent research has indicated that religion can indeed be beneficial to one’s mental health, as well as detrimental. The findings presented in this study lend support to the notion that religion does indeed play a role in the mental health of individuals, and they provide clinicians with another point at which to probe the causes of depression in their religious clients.
References


Appendix A

Self-Monitoring Scale

T – True  F – False

1. I find it hard to imitate the behavior of other people.

2. At parties and social gatherings, I do not attempt to do or say things that others will like.

3. I can only argue for ideas which I already believe.

4. I can make impromptu speeches even on topics about which I have almost no information.

5. I guess I put on a show to impress or entertain others.

6. I would probably make a good actor.

7. In a group of people I am rarely the center of attention.

8. In different situations and with different people, I often act like very different persons.

9. I am not particularly good at making other people like me.

10. I’m not always the person I appear to be.

11. I would not change my opinions (or the way I do things) in order to please someone or win their favor.

12. I have considered being an entertainer.

13. I have never been good at games like charades or improvisational acting.

14. I have trouble changing my behavior to suit different people and different situations.

15. At a party I let others keep the jokes and stories going.
16. I feel a bit awkward in public and do not show up quite as well as I should.

17. I can look anyone in the eye and tell a lie with a straight face (if for a right end).

18. I may deceive people by being friendly when I really dislike them.
Appendix B

Rosenberg Self-Esteem Scale

1 – Strongly Agree  2 – Agree  3 – Disagree  4 – Strongly Disagree

1. I feel that I’m a person of worth, at least on an equal plane with others.

2. I feel that I have a number of good qualities.

3. All in all, I am inclined to feel that I am a failure.

4. I am able to do things as well as most other people.

5. I feel I do not have much to be proud of.

6. I take a positive attitude toward myself.

7. On the whole, I am satisfied with myself.

8. I wish I could have more respect for myself.

9. I certainly feel useless at times.

10. At times I think I am no good at all.
Appendix C

Extrinsic Scale of Religious Orientation

1 – Strongly disagree  2 – Disagree  3 – Neutral  4 – Agree  5 – Strongly agree

1. Although I believe in my religion, I feel there are many more important things in my life.

2. It doesn’t matter so much what I believe so longs as I lead a moral life.

3. Although I am a religious person I refuse to let my religious considerations influence my everyday affairs.

4. A primary reason for my interest in religion is that my church is a congenial social activity.

5. Occasionally I find it necessary to compromise my religious beliefs in order to protect my social and economical well-being.

6. One reason for my being a church member is that such membership helps to establish a person in the community.
Appendix D

Intrinsic Scale of Religious Orientation

1 – Strongly disagree  2 – Disagree  3 – Neutral  4 – Agree  5 – Strongly agree

1. It is important for me to spend periods of time in private religious thoughts and meditation.

2. If not prevented by unavoidable circumstances, I attend church.

3. I try hard to carry my religion over into all my other dealings in life.

4. I read literature about my faith (or church).

5. If I were to join a church group I would prefer to join a Bible study group rather than a social fellowship.

6. My religious beliefs are what really lie behind my whole approach to life.
Appendix E

Quest Scale of the Religious Life Inventory

1 – Strongly disagree  2 – Disagree  3 – Neutral  4 – Agree  5 – Strongly agree

1. As I grow and change, I expect my religion also to grow and change.

2. I am constantly questioning my religious beliefs.

3. It might be said that I value my religious doubts and uncertainties.

4. For me, doubting is an important part of what it means to be religious.

5. My life experiences have led me to rethink my religious convictions.

6. There are many religious issues on which my views are still changing.
Appendix F

Doctrinal Orthodoxy Scale

1 – Strongly disagree  2 – Disagree  3 – Neutral  4 – Agree  5 – Strongly agree

1. I believe God created the universe.

2. I believe Jesus Christ is the Divine Son of God.

3. I believe one must accept Jesus Christ as Lord and Savior to be saved from sin.

4. I believe in life after death.

5. I believe there is a transcendent realm (an “other” world, not just this world in which we live).

6. I believe the Bible is the unique authority for God’s will.
Appendix G

Frequency of Religious Behavior

34. I am a religious person.
   a. Strongly disagree
   b. Disagree
   c. Neutral
   d. Agree
   e. Strongly Agree

35. I attend church
   a. Never
   b. 2-3 times a year
   c. 1 time a month
   d. 3-4 times a month
   e. whenever the doors are open

36. I read the Bible
   a. Never
   b. 2-3 times a year
   c. 2-3 times a month
   d. 2-3 times a week
   e. daily

37. I pray
   a. Never
   b. 2-3 times a year
c. 2-3 times a month

d. 2-3 times a week

e. daily
Appendix H

Anxiety Subscale, HSCL

“How have you felt during the past seven days including today?”

1 – Not at all  2 – Some  3 – A lot  4 – Extreme

1. Nervousness or shakiness inside

2. Trembling

3. Suddenly scared for no reason

4. Feeling fearful

5. Heart pounding or racing

6. Having to avoid certain places or activities because they frighten you

7. Feeling tense or keyed up
Appendix I

Depression Subscale, HSCL

“How have you felt during the past seven days including today?”

1 – Not at all  2 – Some  3 – A lot  4 – Extreme

1. Loss of sexual interest or pleasure

2. Thoughts of ending your life

3. Poor appetite

4. Crying easily

5. A feeling of being trapped or caught

6. Blaming yourself for things

7. Feeling lonely

8. Feeling blue

9. Worrying or stewing about things

10. Feeling no interest in things

11. Feeling hopeless about the future