

IMPACT OF PARENTING STYLE AND RELIGIOUS ATTACHMENT ON ADOLESCENTS' MENTAL HEALTH: A CASE STUDY FOCUSING ON NORTH MACEDONIAN YOUTH

ARTA XHELILI¹, NITA BELULI LUMA¹, URIME DEMIRI SHAIPI¹, MERJEM GASHI,
ELISABETA BAJRAMI OLLOGU¹, KALTRINA ZEKOLLI SHAQIRI¹

¹Mother Teresa University Skopje, r. 1669, no: 11A, 1000 Skopje, North Macedonia, contact: arta.xhelili@unt.edu.mk

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Abstract: Religion can play a significant role in determining family traditions, roles, and human behaviours. Many studies have shown the indisputable relationships between these factors and the impact that they can have on one another. Purpose: This study investigates the relationship between parenting styles and religious attachment, and their impact on adolescents' mental health in a traditional cultural context. It examines how religious devotion interacts with adolescents' perceptions of parenting styles in relation to their mental well-being. Methodology: The study involves a non-randomly selected sample of 629 adolescents who participated in surveys, which were available in both Albanian and Macedonian to ensure broader representation. Standardised instruments and parametric statistical tests were used for data analysis. Results: The results show that the authoritative parenting style, characterised by responsiveness and involvement, is associated with stronger religious attachment and more positive mental health outcomes, compared to the permissive or authoritarian styles. The findings imply that, in the North Macedonian community, religion influences both parenting practices and adolescent mental health, highlighting the importance of considering cultural and spiritual factors in youth development.

Keywords: parenting style, adolescents, religion, mental health, North Macedonia

INTRODUCTION

Adolescence is considered a critical developmental period due to radical changes that occur in biological, psychological, and social areas (Kessler et al., 2007; Steinberg, 2014; Erikson, 1968). According to Estrada et al. (2019), during this period, a person develops the ability to comprehend and incorporate religion, its beliefs, values, and practices, which can lead to changes in patterns of religious involvement and practice. It is a period of intense physical, psychological, and intellectual growth that can cause disorders in many adolescents. As noted by Kessler et al. (2007), this stage of development is linked to a heightened threat of emerging mental health concerns.

Mental health in adolescents encompass multiple domains and is influenced by a combination of personal factors (such as biological and psychological aspects) and environmental factors (including family, school, and peer relationships)

(Carr, 2015). These domains can be broadly conceptualised as emotional, cognitive, behavioural, and social functioning domains. The General Health Questionnaire – 28 (GHQ-28) assesses mental health by measuring specific domains, including somatic symptoms (physical manifestations of distress), anxiety and insomnia (emotional and physiological responses), social dysfunction (interpersonal and social functioning), and severe depression (affective and cognitive symptoms) (Goldberg & Williams, 1991). Empirical studies in North Macedonia indicate that the most prevalent mental health issues among adolescents include depression, stress, anxiety, suicide, and unmet mental health care needs (Национален младински совет на Македонија, 2021). The COVID-19 pandemic further aggravated the situation by increasing isolation and psychological distress among adolescents, with 30% reporting moderate to severe depression and 42.1% reporting moderate to severe anxiety (Bajraktarov et al.,

2023). These findings emphasise the urgency of addressing adolescent mental health comprehensively, considering both individual and environmental influences alongside societal and cultural factors.

The influence of parenting approaches and religious attachment on adolescents' psychological well-being is a multifaceted area of study, with various factors playing significant roles. While many elements affect adolescents' psychological and emotional outcomes, the family factor, in particular, the parenting style, is the crucial determinant of adolescents' development and mental health (Baumrind, 1991; Skrove et al., 2013; Simpson et al., 2018). A supportive and nurturing parenting approach, coupled with a healthy religious environment, generally promotes better mental health outcomes in adolescents.

On the other hand, other studies show that, in traditional societies, religious attachment can have an influential role on young peoples' mental health. The religious attitudes of the adolescents are determined by his/her own family, friends, and the social institutions to which he/she belongs and is affected by (İmamoğlu & Ferşadoğlu, 2013; Behere et al., 2013; Culver et al., 2017; McGuire, 2007). In addition, religion determines the adolescent's belief, offers a philosophy of life for the present and the future in his/her practical life, and thus becomes a reference in solving one's identity problem.

Religious Attachment and Adolescents Mental Health

From a sociological perspective, religion constitutes one of the most powerful forces, which is deeply felt and has a great impact on human society. In addition to being a social phenomenon, religion is also an individual phenomenon (McGuire, 2007). McGuire treats the definitions of religion more as a strategy than as "truths". The two main strategies used by sociologists of religion are *substantive* and *functional* strategies. While the first strategy aims to show what religion actually is, the second one focuses on the impact of religion on the individual and the social group.

Literature on religion has described the aspects of an applied theology that may foster positive psychological well-being. Behere et al. (2013) identified several aspects, including awareness of God, acceptance of God's grace and love, regret and social accountability, faith and trust, participation in organised religion, fellowship, ethical conduct, tolerance, and openness to others' experiences. Religious experience may also include the awareness of belonging to a group of believers. The shared religious experiences and the rituals of the group constantly reproduce and transmit to future generations the collective feeling of "who we are" and "what it means to be one of us". Rituals remind the individual of affiliation with the group and foster a strong feeling of belonging. As McGuire (2007) notes, the capacity of religion to give meaning to human life has been a central theme in the sociology of religion since Max Weber's foundational study, *The Protestant Ethics and the Spirit of Capitalism* (1905).

The sociology of religion has been ignored until the end of the 1940s and 1950s. Only after the 1980s has the sociology of religion seriously begun to create meaningful connections with other subfields, such as gender studies, the sociology of health, and the media. Therefore, the sociology of religion has greatly broadened its conceptual focus and research interests (McGuire, 2007). Regarding the psychological aspect of studies on how religious engagement relates to mental well-being, earlier studies, influenced by the prevailing paradigms of the 19th and 20th centuries, highlighted religion as a significant factor in mental health. For many years, mental health professionals have regarded religious involvement as beneficial for psychological well-being. Although recent epidemiological studies have presented varying findings on religiosity, positive associations between religiosity and psychological well-being generally prevail (Gürsu, 2015). In the domain of clinical psychology, there is an ongoing debate regarding the degree to which religion should be incorporated into both training and practice. Historically, religion has been omitted or overlooked in the psychotherapy. Bergin (1980, 1991) is the most influential author who has recognised the thera-

pist's own values in the therapeutic process and has encouraged practitioners to gain a deeper understanding of the religious beliefs and values that their clients may hold (Ventis, 1995).

Attachment theory examines the formation and dynamics of interpersonal emotional bonds and offers a framework for understanding individuals' relationship with God, a core aspect of religion (Cherniak et al., 2020). Researchers in the fields of psychology and sociology of religion have drawn on attachment theory to explore the relationship with the divine as a form of attachment that can influence the life outcomes of religious individuals (Culver et al., 2017). In their study, Culver et al. (2017) explored how attachment to God related to a sense of life purpose among emerging adults. This period of emerging adulthood is crucial for exploring personal identity and establishing trajectories of adult life. When young individuals experience a connection with the divine, they tend to perceive their life path and their life meaning more positively. Supporting this, Cherniak et al. (2020) found that emerging adults who have secure attachments to parents and peers convey themes of stability, such as optimism, confidence, and feelings of security, more often during interviews about religious exploration. In a survey conducted by İmamoğlu and Ferşadoğlu (2013), the Turkish pupils who participated expressed that they were minimally influenced by their friends in terms of religious beliefs. Taking into consideration the fact that adolescents interact mostly with their friends during this period, the influence of peers remains weak, compared to education and mentality provided by the family, which were shown to be more dominant factors (İmamoğlu & Ferşadoğlu, 2013).

The significance of the association between religion and psychological well-being has already been acknowledged. According to Ventis (1995), mental health can be characterised by several criteria, including self-acceptance and self-actualisation, appropriate social behaviour, freedom from worry and guilt, personal capability and control, open-mindedness and flexibility, the unification and organisation of personality, as well as the absence of mental illness. Many studies have re-

ported a significant positive relationship between religiosity, spiritual well-being, and psychological well-being (Behere et al., 2013; Culver et al., 2017; Bamford et al., 2023; Estrada et al., 2019; Ventis, 1995). As stated by Culver et al. (2017), religion is capable of positively influencing an individual's well-being by fostering a deeper sense of moral order, strengthening psychological resources, and providing social support and integration.

Various research studies have been carried out on the role of religious education in shaping adolescents' psychological well-being (Estrada et al., 2019; İmamoğlu & Ferşadoğlu, 2013; Bamford et al., 2023; Behere et al., 2013; Culver et al., 2017). Estrada et al. (2019), for example, examined how engagement in religious learning can influence mental health outcomes during adolescence. Social experiences and interpersonal interactions throughout this critical developmental stage are crucial in fostering religiosity. Furthermore, the structure of the family and patterns of attachment significantly affect the transmission of religious practices, beliefs, and attitudes from parents to children. Adolescents raised by both parents within close-knit families are more inclined to embrace their parents' religious perspectives and behaviours.

Another case study conducted in Northern Ireland examined how adolescent mental well-being is related to religion and family activities within a school setting. The findings indicate that adolescents who identify themselves as non-religious tend to report lower level of mental well-being compared to their more religious peers, regardless of religious denomination. Moreover, adolescents experiencing low family cohesion appear to be more susceptible to a decline in psychological well-being (Bamford et al., 2023). Evidence suggests that greater religiosity is linked to greater overall well-being among adults. For adolescents, both religiosity and spirituality are associated with healthier attitudes and behaviours, as well as positive psychological outcomes, including lower levels of risky behaviours, reduction in depressive symptoms, as well as enhanced self-esteem and overall well-being. Participation in religious

services may further support mental health by reducing feelings of loneliness, providing social support, and fostering community involvement (Bamford et al., 2023). To sum up, Bamford et al. (2023) found that adolescents identifying as atheist or agnostic scored lower in terms of mental well-being compared to peers in Catholic, Protestant, or other religious groups.

Both public and private religious activities can contribute to sustaining mental well-being and preventing psychological disorders. Such practices assist individuals in managing anxiety, fear, frustration, anger, feelings of anomie, inferiority, hopelessness, and social isolation. Cognitive processes and personal beliefs shape how individuals respond to stress, grief, and life challenges. Religious beliefs can offer support by promoting acceptance, persistence, and resilience. Additionally, they foster inner peace, self-confidence, a sense of purpose, the capacity to forgive one's failures, altruism, and a positive self-image (Behere et al., 2013). Religious beliefs can influence the way individuals cope with stressful experiences, adversity, and life challenges by fostering acceptance and enhancing one's capacity to function effectively under pressure. Research indicates that participation in religious practices can have beneficial outcomes for adolescents, including increased self-esteem and lower likelihood of engaging in substance use; involvement in religious activities also promotes a sense of belonging (Es-trada et al., 2019).

In a comprehensive review and meta-analysis of 74 studies, Aggarwal et. al (2023) examined the impact of religious and spiritual engagement on the prevention and management of depression and anxiety in youth aged 10-24 years. Their study aimed to systematically assess the available evidence regarding the role of both formal and informal religious and spiritual activities in supporting mental health and mitigating symptoms of depression and anxiety among young people. The authors concluded that spiritual well-being can serve as a protective factor against depressive symptoms, while negative forms of religious coping may aggravate stress and elevate the threat of depression. Engagement in religious and spiritual

practices during adolescence and early adulthood has been found to provide short- to medium-term protective effects against depression and, to a lesser degree, anxiety.

Another study examining the role of religiosity as a moderator between interpersonal distrust and self-reported depressive symptoms among adolescents in the UK revealed that those identifying as Muslim reported the lowest levels of depressive symptoms, yet exhibited relatively higher values of distrust toward others, compared to their own religious peers. This finding may reflect the increased rates of victimisation faced by this particular group of adolescents (Tsomokos & Dunbar, 2023).

Furthermore, according to the literature referred to in the present study, attitudes towards religion in general and the correlation between religiousness and mental health in particular have changed during the last decades. Most of the studies that have been conducted during the last two decades show that religion remains an important factor in an individual's social life.

Parental style and mental health

Parents and parenting style play a vital role in adolescents' development. Parenting styles are a set of practices employed by parents to monitor and interact with their children, and they include discipline, supervision, maturity expectation, and preparedness to handle a troublesome youngster. Previous studies have shown that these practices can significantly influence the mental health, as well as the academic and socio-emotional development of youngsters and adolescents (Baumrind, 1991; Skrove et al., 2013; Inchley & Currie, 2013; Simpson et al., 2018; Wang et al., 2021; Bajrami Ollogu et al., 2024)). According to Baumrind (1991), there are four primary parenting styles that shape child development: authoritarian, authoritative, permissive, and neglectful (uninvolved or avoidant). Each style has different patterns of parental control, responsiveness, and involvement, which can have an impact on children's and adolescent's psychological well-being.

Studies have shown that the authoritative parenting style, marked by both high responsiveness and elevated expectations, is associated with beneficial mental health outcomes. Adolescents raised under this parenting style exhibit greater self-esteem, better social skills, and reduced levels of anxiety and depression. This style fosters open communication and encourages independence, while providing support.

Conversely, the authoritarian parenting style, defined by low responsiveness combined with high expectations, may contribute to elevated levels of anxiety and depression. Adolescents may struggle with self-esteem and have difficulties in social situations due to the lack of warmth and support from the parents. It is a super-dependent relationship in which the parent uses the power of authority to subdue the child, thereby limiting freedom of expression and the right to choose, discouraging individuality, and impeding independence (Baumrind, 1991).

In regard to permissive parenting, which is marked by high responsiveness and low expectations, adolescents may experience greater freedom and creativity. However, they often struggle with self-regulation and discipline, potentially leading to issues such as anxiety or behaviour problems. This has been highlighted in relevant studies. For instance, Bajrami Ollogu et al. (2024) found that the permissive parenting style exerts a more detrimental effect on mental health compared to both authoritative and authoritarian styles. In particular, paternal permissiveness increased symptomatic problems related to anxiety.

Baumrind (1991) described the fourth parental style as the neglectful parenting style, which is characterised by low responsiveness and low demands. This style is typically associated with the most adverse mental well-being outcomes, including elevated rates of depression, anxiety, and behavioural difficulties. The lack of emotional support and guidance can leave adolescents feeling isolated and undervalued. Optimal parenting itself includes the element of control, but also that of warmth towards children (Bajrami Ollogu et al., 2024).

METHOD

From a methodological aspect, the present study is based on quantitative methods. Our survey consists of a non-randomly selected sample of 629 adolescents belonging to different ethnic communities in North Macedonia, with an evident prevalence of the Albanian and Macedonian communities.

Research objective: *To examine the interaction between adolescents' perceptions of parenting style and religiosity in relation to their mental health.*

Hypothesis 1: There is a statistically significant association between religiosity and different parenting styles.

Hypothesis 2: There is a significant difference in mental health outcomes between religiously devoted adolescents and their non-religious peers.

Hypothesis 3: Parenting styles, adolescents' religious devotion, and mental health are significantly correlated.

Participants

The study employed a non-probability sampling method, utilising the snowball technique to gather data. Acquaintances in secondary schools were used to distribute the questionnaire to their students. Participation was voluntary and anonymous. The survey achieved a 100% response rate, yielding a total of 629 participants, among which 24.1% (n = 151) were male and 75.7% (n = 476) were female, with an age range of 14-22 years (M = 16.3). The majority of respondents resided in urban areas (62.5%), while 37.2% lived in rural locations. Most respondents identified as belonging to the Albanian community (91.1 %), followed by those belonging to Macedonian (7.2 %), Turkish (1.0%), and Roma (0.5%) ethnicities. In terms of religious affiliation, 92.5 % reported being Muslim, while 6.7% reported being Orthodox and 0.5% Catholic. Regarding family income, 28.3% reported that their family earned between 450-650 Euros per month, 24.3% reported family earnings of up to 1000 Euros per month, 23.2% reported family earnings between 200-400 Euros per month, 13.5% reported family earnings between 700-900 Euros per month, and 10.3% reported family earnings below 200 Euros per month.

Table 1. Sociodemographic characteristics of participants

| | Adolescents | |
|--------------------------------|-------------|------|
| | N | % |
| Family type | | |
| Nuclear family | 388 | 61.7 |
| Extended family | 218 | 34.7 |
| Single parent family | 12 | 1.9 |
| Other | 9 | 1.4 |
| Birth order | | |
| Oldest child | 249 | 39.6 |
| Middle child | 194 | 30.8 |
| Youngest child | 160 | 25.4 |
| Only child | 10 | 1.6 |
| Mothers' age (years) | | |
| < 35 | 20 | 3.2 |
| 36-40 | 163 | 25.9 |
| 41-45 | 246 | 39.1 |
| 46-50 | 136 | 21.6 |
| > 51 | 62 | 9.9 |
| Mothers' level of education | | |
| Uneducated | 17 | 2.7 |
| Primary education | 303 | 48.2 |
| Secondary education | 196 | 31.2 |
| Bachelor's | 76 | 12.1 |
| Master's | 15 | 2.4 |
| Doctoral | 10 | 1.6 |
| Other | 10 | 1.6 |
| Mother's work status | | |
| Full time employed | 163 | 25.9 |
| Part time employed | 37 | 5.9 |
| Unemployed and not seeking job | 323 | 51.4 |
| Unemployed in search of a job | 45 | 7.2 |
| Self-employed | 61 | 9.7 |
| Fathers' age (years) | | |
| < 35 | 1 | 0.2 |
| 36-40 | 54 | 8.6 |
| 41-45 | 253 | 40.2 |
| 46-50 | 190 | 30.2 |
| + 51 | 129 | 20.5 |
| Fathers' level of education | | |
| Uneducated | 2 | 0.3 |
| Primary education | 157 | 25.0 |
| Secondary education | 290 | 46.1 |
| Bachelor's | 123 | 19.6 |
| Master's | 28 | 4.5 |
| Doctoral | 12 | 1.9 |
| Other | 15 | 2.4 |

| | | |
|--------------------------------|-----|------|
| Father's work status | | |
| Full time employed | 446 | 70.9 |
| Part time employed | 60 | 9.5 |
| Unemployed and not seeking job | 23 | 3.7 |
| Unemployed in search of a job | 40 | 6.4 |
| Self-employed | 57 | 9.1 |
| Retired | 1 | 0.2 |
| Family income in Euros | | |
| < 200 | 65 | 10.3 |
| 200-400 | 146 | 23.2 |
| 450-650 | 178 | 28.3 |
| 700-900 | 85 | 13.5 |
| >1000 | 153 | 24.3 |
| Religious attachment | | |
| Weak | 10 | 1.6 |
| Moderate | 58 | 9.2 |
| Rather strong | 254 | 40.4 |
| Very strong | 304 | 48.3 |
| Not at all | 3 | 0.5 |

Survey instruments

The study employed a close-ended questionnaire consisting of three sections: a demographic section, including items on religiosity attachments; the Perceived Parenting Style Scale (PPSS); and the General Health Questionnaire Scale (GHQ-28). Perceptions on parenting style were operationalised by a 30-item scale established by Divya and Manikandan (2013), in which respondents rate their relationship with their parents on a 5-point Likert-type scale, ranging from 1 (Strongly disagree) to 5 (Strongly agree). The PPSS measures perceived parenting styles across three dimensions: authoritative, authoritarian, and permissive. The Cronbach's alpha coefficients of the subscales of authoritative, authoritarian, and permissive were 0.901, 0.806, and 0.872 respectively, indicating strong internal consistency. Mental health was operationalised using the GHQ-28, a 28-item scale developed by Goldberg and Williams (1991). The GHQ-28 is used to assess adolescents' mental health and is divided into four subscales: somatic symptoms (items 1-7); anxiety/insomnia (items 8-14); social dysfunction (items 15-21), and severe depression (items 22-28). Each item has four possible responses, scored on a scale from 0 to 3: "not at all", "no

more than usual", "rather more than usual", and "much more than usual". A higher score on the GHQ-28 indicates higher levels of distress. The scale demonstrated excellent internal consistency with a Cronbach's alpha of 0.909. Three variables were computed by averaging items from the PPSS and grouping them into the following subscales: authoritative, authoritarian, and permissive. Religious attachment in this study was assessed using survey questions measuring the strength of the participants' connection to their religion. Respondents were asked to rate their level of religious attachment on a 5-point Likert scale, with responses ranging from "not at all" to "very strong", with intermediate options of "weak", "moderate", and "rather strong". A religious devotion variable was recoded into a different variable by merging groups within religious attachments, and creating two unique groups - weak and strong. Similarly, five GHQ-28 subscales were computed based on the mean of relevant items, yielding the following: mental health, somatic, anxiety, social dysfunction, and depression. To reach a broader audience and ensure more accurate responses, the surveys were provided in two languages: Albanian and Macedonian.

DATA ANALYSIS

The data collected were coded and entered into SPSS 20.00 software, with the significance level set at $p < 0.05$. Several tests were conducted to determine reliability, as well as to examine descriptive and inferential statistics, including means and standard deviations, Pearson correlations, independent sample t-tests with Levene's test, one-way ANOVA, a multivariate analysis of covariance (MANCOVA), and moderation analysis.

Table 2. Descriptive Statistics for Parenting Scales: Means and Standard Deviations

| | N | Minimum | Maximum | Mean | Std. deviation |
|--------------------|-----|---------|---------|------|----------------|
| Authoritative | 627 | 1.00 | 5.00 | 4.07 | 0.85 |
| Authoritarian | 627 | 1.00 | 4.80 | 2.29 | 0.76 |
| Permissive | 627 | 1.00 | 4.80 | 1.90 | 0.81 |
| Valid N (listwise) | 627 | | | | |

The descriptive statistics on the mental health subscale displayed a mean response of 45.06, which indicates poor mental health (> 24). The separated mean scores showed that these scores

RESULTS

Descriptive statistics

Descriptive statistics were calculated based on the newly developed scales. The results show that, on average, adolescents rated their parents' parental style highest on the authoritative scale, yielding a mean value of 4.07 (SD = 0.85), followed by the authoritarian scale (Mean = 2.29, SD = 0.76), and the permissive scale (Mean = 1.9, SD = 0.81; Table 2).

were higher for social dysfunction (Mean = 2.20), followed by somatic symptoms (Mean = 1.65), anxiety (Mean = 1.37), and depression (Mean = 1.22; Table 3).

Table 3. Descriptive Statistics for Mental Health Subscales: Means and Standard Deviations

| | N | Minimum | Maximum | Mean | Std. deviation |
|-----------------------------|-----|---------|---------|-------|----------------|
| Somatic symptoms | 629 | 0.00 | 3.00 | 1.65 | 0.78 |
| Anxiety symptoms | 629 | 0.00 | 3.00 | 1.37 | 1.04 |
| Social dysfunction symptoms | 629 | 0.00 | 3.00 | 2.20 | 0.64 |
| Depression symptoms | 629 | 0.00 | 3.00 | 1.22 | 1.02 |
| SUM - Mental health | 629 | 0.00 | 84.00 | 45.06 | 18.34 |

Inferential statistics

As presented in Table 4, correlational analysis between religious attachment and parenting styles scales revealed statistically significant relationships ($p < 0.001$). The relationship between the authoritative parenting style and religious devotion was positive and stronger ($r = 0.158$) than the relationships observed for the authoritarian ($r = - 0.153$) and permissive parenting styles ($r = - 0.139$), which were both inversely related to religious devotion. This suggests that adolescents who perceived their parents' parenting styles as being authoritative also scored higher in religious devotion. In contrast, adolescents who perceived

their parents' parenting style as being authoritarian or permissive scored lower on measures of religiosity, indicating a significant negative relationship between the two variables. Therefore, hypothesis 1 is accepted.

Table 4. Pearson Correlation Coefficients Between Parenting Styles and Religious Attachment

| Variable | | 1 | 2 | 3 | 4 |
|-------------------------|---------------------|-----------|-----------|---------|---|
| 1. Religious attachment | Pearson Correlation | - | | | |
| | Sig. (2-tailed) | | | | |
| 2. Authoritative | Pearson Correlation | 0.158** | - | | |
| | Sig. (2-tailed) | 0.000 | | | |
| 3. Authoritarian | Pearson Correlation | - 0.153** | - 0.350** | - | |
| | Sig. (2-tailed) | 0.000 | 0.000 | | |
| 4. Permissive | Pearson Correlation | - 0.139** | - 0.484** | 0.735** | - |
| | Sig. (2-tailed) | 0.001 | 0.000 | 0.000 | |

Note: ** indicates that the correlation is significant at the 0.01 level (2-tailed); Total $N = 627$.

Based on the results presented in Table 5, adolescents who perceived their parents as being authoritative scored higher in religious devotion

(Mean = 4.1), as opposed to those adolescents who considered their parents as authoritarian (Mean = 2.2) and permissive (Mean = 1.9).

Table 5. Comparison of Means in relation to Parenting Styles and Religious Attachment

| Religious devotion | | Authoritative | Authoritarian | Permissive |
|--------------------|----|---------------|---------------|------------|
| Weak | M | 3.78 | 2.60 | 2.16 |
| | N | 68 | 68 | 68 |
| | SD | 0.89 | 0.92 | 0.86 |
| Strong | M | 4.10 | 2.25 | 1.87 |
| | N | 558 | 558 | 558 |
| | SD | 0.84 | 0.73 | 0.80 |

Note: M, mean; N, number; SD, standard deviation

Levene's test was employed to evaluate whether groups with differing levels of religious devotion show variation in mental health. When comparing the means of the two groups (weak

and strong religious devotion) of the independent variable, we can see that there is no noteworthy difference in the means with regard to mental health (Table 6).

Table 6. Inferential Statistics for Religious Attachment in Relation to Adolescents' Mental Health

| Group | N | Mean | Std. deviation | Std. Error Mean |
|---------------------------|-----|------|----------------|-----------------|
| Weak religious devotion | 68 | 1.47 | 0.63 | 0.08 |
| Strong religious devotion | 558 | 1.62 | 0.66 | 0.03 |

| Independent Samples Test | | | | | | | |
|---|-------|-------|---------|------------------------------|-----------------|-----------------|-----------------------|
| Levene's Test for Equality of Variances | | | | t-test for Equality of Means | | | |
| | F | Sig. | t | Df | Sig. (2-tailed) | Mean Difference | Std. Error Difference |
| Mental health | 0.221 | 0.638 | - 1.794 | 624 | 0.073 | - 0.15056 | 0.08394 |

The second part of the table shows the data for the Levene’s test. The p-values of the t-test for all variables are above 0.05, indicating no statistically significant differences between the two groups. This suggests that levels of religious devotion do not differ in relation to adolescents’ mental health. The comparison of the averages shows that adolescents with weak religious devotion and adolescents with strong religious devotion have reported similar mental health scores (an average score of 1.5 for the weak religious devotion group and 1.6 for the strong religious devotion group). Therefore, we can conclude that the differences between religious devotion and mental health are not statistically significant.

Based on these findings, we were triggered to investigate further and broaden these findings, since we found that a considerable percentage of

respondents had shown disturbing signs of suicidal thoughts. Therefore, we analysed the statistical relationship between three specific depression symptoms and religion, and came to the following conclusions:

As seen in the table below (Table 7), a one-way analysis of variance (ANOVA) revealed statistically significant differences between groups across all three items. Specifically, significant variations were found for: “*Been thinking of yourself as a worthless person*” ($F(2,624) = 5.771, p = 0.003$); “*Been feeling that life is entirely hopeless*” ($F(2,624) = 5.911, p = 0.003$); and “*Been feeling that life is now worth living*” ($F(2,624) = 7.072, p = 0.001$). These findings indicate significant differences in the means across religious groups, therefore, we reject the null hypothesis and accept hypothesis 2.

Table 7. ANOVA testing the relationship between depressive symptoms and levels of religious attachment

| Measure | | Sum of Squares | df | Mean Square | F | Sig. |
|---|----------------|----------------|-----|-------------|-------|-------|
| Been thinking of yourself as a worthless person | Between groups | 19.399 | 2 | 9.699 | 5.771 | 0.003 |
| | Within groups | 1048.777 | 624 | 1.681 | | |
| | Total | 1068.175 | 626 | | | |
| Been feeling that life is entirely hopeless | Between groups | 20.770 | 2 | 10.385 | 5.911 | 0.003 |
| | Within groups | 1096.296 | 624 | 1.757 | | |
| | Total | 1117.065 | 626 | | | |
| Been feeling that life is not worth living | Between groups | 24.340 | 2 | 12.170 | 7.072 | 0.001 |
| | Within groups | 1073.816 | 624 | 1.721 | | |
| | Total | 1098.156 | 626 | | | |

When we consider *Hypothesis 3* stating that ‘parenting styles, adolescents’ religious devotion, and mental health are significantly correlated’, our findings based on the multivariate analysis of covariance (MANCOVA) test indicated statistically significant differences in adolescents’ mental health when parenting styles and religious attachment were considered jointly. The covariate variable in this test was religious attachment, based on the assumption that it would be correlated with the dependent variables.

Here are the results based on the MANCOVA test: religious devotion - Wilks $\Lambda = 0.972, F(3,621) = 5.975, p < 0.001, \eta^2 = 0.028$, and adolescents’ overall mental health - Wilks $\Lambda = 0.975, F(3,621) = 5.406, p < 0.001, \text{partial } \eta^2 = 0.028$; Table 8).

When taking into consideration the data from the descriptive statistics (Table 9), the above-mentioned conclusion from the MANCOVA analysis offers a new point of view when closely examining the means of these two variables jointly.

Table 8. MANCOVA Analysis of Parenting Styles and Religious Devotion on Adolescents' Mental Health

| | Effect | Value | F | Hypothesis df | Error df | Sig. | Partial Eta Squared |
|--------------------|--------------------|-------|-----------------------|---------------|----------|-------|---------------------|
| Intercept | Pillai's Trace | 0.862 | 1291.507 ^b | 3.000 | 621.000 | 0.000 | 0.862 |
| | Wilks' Lambda | 0.138 | 1291.507 ^b | 3.000 | 621.000 | 0.000 | 0.862 |
| | Hotelling's Trace | 6.239 | 1291.507 ^b | 3.000 | 621.000 | 0.000 | 0.862 |
| | Roy's Largest Root | 6.239 | 1291.507 ^b | 3.000 | 621.000 | 0.000 | 0.862 |
| Mental Health | Pillai's Trace | 0.025 | 5.406 ^b | 3.000 | 621.000 | 0.001 | 0.025 |
| | Wilks' Lambda | 0.975 | 5.406 ^b | 3.000 | 621.000 | 0.001 | 0.025 |
| | Hotelling's Trace | 0.026 | 5.406 ^b | 3.000 | 621.000 | 0.001 | 0.025 |
| | Roy's Largest Root | 0.026 | 5.406 ^b | 3.000 | 621.000 | 0.001 | 0.025 |
| Religious Devotion | Pillai's Trace | 0.028 | 5.975 ^b | 3.000 | 621.000 | 0.001 | 0.028 |
| | Wilks' Lambda | 0.972 | 5.975 ^b | 3.000 | 621.000 | 0.001 | 0.028 |
| | Hotelling's Trace | 0.029 | 5.975 ^b | 3.000 | 621.000 | 0.001 | 0.028 |
| | Roy's Largest Root | 0.029 | 5.975 ^b | 3.000 | 621.000 | 0.001 | 0.028 |

As shown in Table 9, the mean values among respondents who identify as devotedly religious are higher than the values detected for those who perceived their parents as using authoritative par-

enting styles ($M = 4.10$), followed by those who perceived an authoritarian parenting style ($M = 2.25$), and lastly the permissive parenting style ($M = 1.87$).

Table 9. Descriptive Statistics for Parenting Styles and Levels of Religious Devotion

| | Religious devotion | M | SD | N |
|---------------|---------------------------|------|------|-----|
| Authoritative | Weak religious devotion | 3.78 | 0.89 | 68 |
| | strong religious devotion | 4.10 | 0.84 | 558 |
| | Total | 4.07 | 0.85 | 626 |
| Authoritarian | Weak religious devotion | 2.60 | 0.92 | 68 |
| | strong religious devotion | 2.25 | 0.73 | 558 |
| | Total | 2.29 | 0.76 | 626 |
| Permissive | Weak religious devotion | 2.16 | 0.86 | 68 |
| | strong religious devotion | 1.87 | 0.80 | 558 |
| | Total | 1.90 | 0.81 | 626 |

Note: M, mean; N, number; SD, standard deviation

In addition, moderation analyses revealed that religiosity significantly moderates the relationship between permissive parenting and mental health ($B = 0.052$, $p = 0.039$), indicating that the negative impact of permissive parenting on ado-

lescents' GHQ-28 scores is buffered or amplified depending on the adolescent's level of religious devotion. No significant moderation effects were found for authoritative or authoritarian parenting (Table 10).

Table 10. Interaction Effects of Parenting Styles and Religiosity on Mental Health Scores

| Model | Unstandardised Coefficients | | Standardised Coefficients | t | Sig. |
|---------------------------|-----------------------------|------------|---------------------------|-------|-------|
| | B | Std. Error | Beta | | |
| (Constant) | 1.199 | 0.123 | | 9.737 | 0.000 |
| Interaction_authoritative | 0.020 | 0.013 | 0.064 | 1.582 | 0.114 |
| Interaction_authoritarian | 0.016 | 0.026 | 0.037 | 0.607 | 0.544 |
| Interaction_permissive | 0.052 | 0.025 | 0.129 | 2.067 | 0.039 |

Note: Dependent variable: Mental health

Taken together, the MANCOVA and moderation findings provide sufficient evidence to support Hypothesis 3, confirming that parenting styles, adolescents' religious devotion, and mental health are meaningfully interrelated. Moreover, the moderation effect highlights the nuanced role of religiosity in shaping the impact of parenting styles on adolescent mental health.

DISCUSSION

This study aimed to analyse how parenting and religiosity could impact adolescents' mental health. A highly significant relationship was observed between parenting styles and religiosity, suggesting that perceived authoritative parents were associated with higher religiosity devotion in adolescents. There were no statistically significant relationships between weak religious devotion and strong religious devotion and mental health. However, it was found that authoritative parenting had a positive correlation with mental health. Thus, since authoritative parenting is associated with high religious devotion, as well as with better mental health, it can be inferred that religious devotion affects adolescents' psychological well-being. These results are consistent with previous research on the positive association between authoritative parenting, religiosity, and adolescent mental health (Behere et al., 2013; Culver et al., 2017; Bamford et al., 2023; Estrada et al., 2019; Ventis, 1995), but they also provide new insights specific to the North Macedonian context. These results extend existing literature by demonstrating that the combination of authoritative parenting and positive religiosity can serve as a protective factor against mental health challenges in adolescents. From a practical perspective, this implies that interventions aimed at improving parental practices and enhancing positive religious involvement could be beneficial for adolescents' mental health, highlighting the importance of integrating family and religiosity in preventive mental health strategies. It is important that authoritative parenting practices are promoted and adolescents' engagement in constructive religious activities is encouraged. Workshops and programmes should be aimed at providing guidance on effective par-

enting styles and ways to integrate religiosity in supporting adolescents' mental health.

Limitations

The first limitation of this study relates threats to external validity. Due to the use of a non-random sample, the findings cannot be generalised to the entire population. Additionally, the sample did not capture the ethnic and religious heterogeneity of the Republic of North Macedonia. Although the survey was shared among respondents from diverse cultural backgrounds, the number of respondents of Macedonian nationality was insufficient, which limits the generalisability of the results. A larger and more diverse population should be included in order to examine the social and cultural aspects of all nationalities in North Macedonia.

In future research, we recommend that cluster sampling be employed, as it would better represent the target population and provide more reliable and statistically significant results.

Despite the aforementioned limitations, the present study contributes to the existing literature by examining the relationship between parenting styles, religious devotion, and mental health in North Macedonia. Furthermore, it adds to the growing body of evidence emphasising that both parenting style and religiosity should be carefully considered in research and practice when investigating adolescents' mental health. Educative programmes should be implemented to teach parents about the most effective parenting styles, while keeping religiosity in mind, since these aspects can both have an effect on creating an environment that supports better mental health. Such parenting programmes could help improve parenting skills, foster healthy relationships with their adolescents, and thus prevent the rise of mental health challenges.

CONCLUSION

The relationship between parenting styles, religious attachment, and mental health is complex and varies significantly. In case of a mismatch between the values taught by parents and those en-

couraged by a religious community, adolescents may experience internal conflict, leading to stress or anxiety.

Overall, a supportive and nurturing parenting approach, along with a healthy religious environment, tends to enhance adolescents' mental health. Specifically, an authoritative parenting style, combined with positive religious attachment, can cre-

ate a nurturing environment that fosters resilience and promotes mental well-being. Conversely, authoritarian or neglectful parenting, especially when paired with rigid or conflicting religious expectations, can have detrimental effects. Gaining insight into these dynamics can assist parents, educators, and mental health practitioners to provide effective support to adolescents.

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