

## **Religious Practices and Mental Health Among Older Adults in the US**

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An expansive body of theory and research has linked various aspects of religious involvement with a range of mental health outcomes. Although recent work has broadened the array of religious constructs and measures in this area, the vast majority of studies have focused on behavioral indicators of religiousness, both organizational and non-organizational. Despite strong correlational findings, surprisingly few studies in this area have employed longitudinal data, which is a necessary condition for establishing causal relationships between religion and mental health. Further, investigators remain far from a consensus over (a) the consistency of these links across major subgroups of the population, and (b) the pathways linking religious practices with psychological outcomes.

This paper uses data from a recent longitudinal survey of older adults in the United States. The baseline probability sample drawn in 2001 is designed to include roughly 50% African American and 50% non-Hispanic white respondents; given the strong focus on elders' religious engagement, the sample was restricted to persons who are (or were raised) within the Christian tradition. Participants were reinterviewed in 2004. This study considers six mental health outcomes: distress; life satisfaction; self-esteem; personal mastery; death anxiety; and optimism. As in many previous studies, the key indicator of organizational religious involvement is the self-reported frequency of attendance at services. However, a number of other organizational practices are also considered, including participation in Bible study groups and prayer groups, congregational service activities, leadership roles and official positions within the congregation, among others. The key indicator of non-organizational religious practice is the frequency of private prayer, although other indicators were also explored, including the frequency of reading the Bible or other religious materials and the consumption of religious media products (music, radio and TV). In addition to religious measures, all models control for age, gender, race, marital status, education, financial conditions, and health problems; longitudinal models also adjust for the baseline measure of mental health.

Cross-sectional findings based on the baseline (2001) data reveal strong associations involving religious attendance and prayer and each of the mental health variables. Although most of these patterns are found for both whites and blacks, several patterns are notably stronger for African Americans. However, the effects of religious practice on changes in mental health between the two data points are weaker and less consistent. Nearly all of the significant patterns highlight the salutary effects of religious attendance on African Americans' positive mental health, particularly optimism, self-esteem, and feelings of mastery. No effects of religious practice on psychological distress were observed. Other indicators of organizational religious involvement were unrelated to these outcomes. A number of potential explanations for the desirable effects of religious attendance among African Americans were explored, including: (a) multiple aspects of

church-based social support; (b) the sense of divine control; (c) feelings of closeness to God. None of these factors accounted for the observed effects of religious attendance on changes in mental health outcomes.

These results confirm the strong cross-sectional associations between religious practices and mental health among older adults. However, our findings underscore the need to: (a) distinguish between cross-sectional and longitudinal patterns; and (b) provide more careful interpretation of the many cross-sectional findings in the research literature. The findings here highlight the distinctive role of religious practices, and especially organizational religious life, among older African Americans. Within this population, elders who attend services more enjoy better mental health than others at the start of the project, and they continue to enjoy enhanced optimism, mastery, and other important psychosocial resources over time. Thus, it is important to continue to compare the role of religiousness in shaping mental health across various subgroups within the diverse US population. Closer attention to contextual variations (cultural and structural) can further illuminate the rich complexity of religion-health relationships.