Introduction and Background

Religious practice and belief are an important part of life for many Americans. Although ignored in the research literature over much of the twentieth century, recently social scientists and others have come to respect the importance of religion in people's lives and better understand the role that it plays. Much of this recent work revolves around the role of religion in the production of physical and mental health. In general, the published research in this area shows that people who attend services more often tend to live longer (Hummer, et al. 2004; Musick, House and Williams 2004) and are in better physical (Idler and Kasl 1997) and mental (Ellison et al. 2001) health. In a relatively recent review of the literature in the field, Koenig and his colleagues (2001) catalogued hundreds of such studies.

Given this bevy of research, some might conclude that we have a firm understanding of how and why religion often has beneficial health outcomes. Rather, due to a lack of data or a narrow theoretical orientation, researchers still do not understand the religion-health relationship. Over time, Idler (1987) and others have proposed pathways that lie between religion and health. These pathways have been tested and have received some support in the literature, but they have not been able to fully explain the relationship. Also unknown is whether and how religion affects people in differing ways. Some analysts (e.g., Strawbridge et al. 1997) have sought to determine whether the beneficial effects of religion are consistent across subgroups in the population, but many tend to treat the population as a whole without tests for subgroup variation.

The goal of this paper is to extend our understanding of the religion and health relationship in ways that attempt to overcome some of the limitations noted above. First, the paper examines standard measures of religion (e.g., religious service attendance and prayer) that might explain the possible beneficial effects on mental health. To date researchers have mostly considered health behaviors and certain personality traits to understand these connections. This paper uses a variety of different measures, including forgiveness and finding meaning in life, to understand these connections. These mediators are almost completely untested in the existing literature and could provide important new insights into the religion and health relationship.

Second, the paper focuses on the ways religion affects mental health within different racial groups. We know that religion is heavily patterned by race in the United States. For example, Blacks are much more likely to regularly engage in religious practice than Whites (Levin, Taylor and Chatters 1994). Some research has attempted to address these racial differences in health, but few are able to make comparisons between more than two races. Given the growing multiracial composition of the United States, these biracial studies tend to cover much of the variation that actually exists in the population. Our paper overcomes this limitation by making comparisons between the three biggest racial groups in the United States: Blacks, Hispanics, and Whites.

Third, our paper focuses on mental health like many previous papers (see Koenig et al. 2001 for a review), but unlike almost all of those papers we incorporate multiple measures of mental health. In so doing we are not limited by the deficiencies of a single measure of mental health and can uncover patterns that tend to be consistent regardless of the measure of mental health employed. In short, this paper is not simply an extension of previous research on religion and physical health; rather, the use of new data allows us to take a step forward in advancing the field in new ways.

Data and Measurement

The data for the study come from the Chicago Community Adult Health Study (CCAHS), a probability sample of 3105 adults aged 18 and over, living in the city of Chicago, IL and stratified into 343 neighborhood clusters (NCs) previously defined by the Project on Human Development in Chicago Neighborhoods (PHDCN) (Sampson, Raudenbush and Earls 1997). Between May, 2001 and March, 2003, one individual was interviewed per household, with a response rate of 71.82%, which is quite high for surveys in large urban areas.

As noted above, we employ three measures of mental health. The first is the 11-item form of the Center for Epidemiologic Studies Depression scale (Radloff 1977). This is a standard measure used in many studies of religion and mental health. However, we also employ a measure of depression relatively unused in religion studies: diagnosed depression as assessed by the Composite International Diagnostic Interview Short Form (CIDI-SF) (Kessler et al. 1998). The third mental health measure used is a five-item index of anxiety based on the Hopkins Symptom Checklist (Derogatis et al. 1974).

One of the major goals of the CCAHS project was to better understand the relationship between religion and multiple forms of health. Consequently, measurement of religion and related factors is especially strong in the data set. For this study we include two measures of religious practice: attendance at religious services and prayer. We also include measures overlapping with religious experience, such as self-ratings of spirituality and methods of coping with stressful events that involve religious belief. Unlike many previous studies, we also incorporate measures that are often thought of in religious terms, and often find their roots in religion, but are not explicitly religious. These measures include an inclination to find meaning in life and a willingness to forgive oneself and others.

Analyses

To test the effects of religion on mental health, we regress each of the mental health variables noted above on the religious activities, mediators and other controls (e.g., gender, age, SES). To test for differences in the effects of religion by racial group, we include cross-product terms between the religious variable in question and two racial groups, Blacks and Hispanics, with Whites serving as the reference. Effects on CESD and anxiety are estimated using Ordinary Least Squares regression, whereas effects on CIDI-SF are estimated using logistic regression.

Results

Our preliminary results reinforce several of the themes noted above. First, our findings indicate that the effects of service attendance on mental health outcomes do vary a great deal by race. In most cases, the effect of religious service attendance is more beneficial for Whites regardless of the mental health outcome. In some cases there are no racial differences, but where they do exist, Whites tend to receive the greatest benefit. Finding meaning in life, something other research has not tested in this context, is one of the single biggest predictors of mental health. However, unlike the case for religious attendance, it does not appear that the effects of meaning vary across racial groups. Other religiously-oriented variables, such as forgiveness of self and others, also affect mental health outcomes, but their effects are relatively stable across racial groups.

Conclusion

Using data from a community-dwelling sample of adults in Chicago, our paper shows that religious service attendance and other related factors have beneficial consequences for

several mental health outcomes. Our work further shows that measures not commonly used in this literature can be very powerful predictors of mental health outcomes when used in this context. Finally we show that the effects of religion can vary across racial groups, as is the case for service attendance, but that other measures of religiously oriented factors have very stable effects across racial groups.

Somewhat surprisingly we found that the beneficial effects of religious service attendance were not as powerful for Hispanics and Blacks as they were for whites. A religious compensation model would suggest otherwise. That is, because Blacks and Hispanics are more likely to have lower levels of socioeconomic status and are more likely to face barriers in status attainment due to discrimination and other factors, they would benefit more from religious practice in terms of mental health outcomes. Yet, we found the opposite to be true. One possible explanation, and one that will be fully explored in the larger paper, is the beneficence of certain activities within contexts in which those activities are expected versus contexts in which the activity tends to be more optional. In other words, the case could be made that because religious activity is normal and expected within Black communities, engaging in that form of behavior does not yield results because it may take on the characteristics of obligatory behavior. In contrast, in communities where religious practice is less common and thus not as obligatory, the activity becomes more self-initiated and thus gains more inherent worth to the person engaging in the activity. Similar arguments about the semi-involuntary nature of religious practice in Black communities have been made elsewhere (e.g., Ellison and Sherkat 1995) and would seem to inform our own work.

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