Aging in the Church

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How Social Relationships Affect Health

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Templeton Foundation Press
West Conshohocken, Pennsylvania

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West Conshohocken, PA 19428
www.templetonpress.org

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Typeset and designed by Glen Burris Book Design

Library of Congress Cataloging-in-Publication Data

Krause, Neal M. (Neal Miller)
Aging in the church : how social relationships affect health / Neal M. Krause.
p. ; cm.
Includes bibliographical references and index.
ISBN-13: 978-1-59947-144-0 (pbk. : alk. paper)
ISBN-10: 1-59947-144-2 (pbk. : alk. paper) 1. Older people—Religious life. 2. Aging—Religious aspects—Christianity. 3. Aging—Social aspects. 4. Interpersonal relations—Religious aspects—Christianity. 5. Health—Religious aspects—Christianity. I. Title.
[DNLM: 1. Aging—psychology. 2. Aged. 3. Empirical Research. 4. Interpersonal Relations. 5. Religion and Psychology. 6. Social Environment. WT 145 K91a 2008]
BV4580.K73 2008
261.8'32—dc22 2008008875

Printed in the United States of America

08 09 10 11 12 13 10 9 8 7 6 5 4 3 2 1

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Acknowledgments

This work is truly a social product, and as a result, there are so many people to thank. It would be impossible to acknowledge them all here, but I wish to make five brief acknowledgments to recognize the individuals who were especially influential. First, I would like to thank all the older men and women who participated in the studies that form the backbone of this volume. What I have learned from them is beyond measure. Second, I would like to thank the National Institute on Aging for funding my research program on religion, aging, and health (RO1 AG014749; RO1 AG026259). I could never have brought my ideas to fruition without their generous support. Third, I am especially grateful to a number of colleagues whose work has had a substantial impact on my own thinking. Among them are Christopher G. Ellison, Harold Koenig, Kenneth Pargament, and Jeffrey S. Levin. Fourth, I would like to express my appreciation to the people at Templeton Foundation Press. I am indebted to them for giving me a free hand in writing this book. Their commitment to fostering creativity and their support of free inquiry made it possible for me to color outside the lines a bit. Finally, but by no means lastly, I wish to thank my wife, Maria, for the love and support she has consistently provided throughout my career. This book would never have been written without her support and encouragement.

Aging in the Church

Chapter 1

Social Relationships in the Church and Health

Problems and Prospects

The purpose of this book is to examine how social relationships that arise in church affect the physical and mental health of older men and women. A number of books have been written about other dimensions of religion and health, such as religious coping (Pargament 1997) and forgiveness (McCullough, Pargament, & Thoresen 2000), but this appears to be the first book that focuses specifically on the health-related consequences of different types of social relationships that are formed by older people in the church. But rather than merely reviewing and critiquing existing studies, the intent of this book is to strike out in a different direction by making a concerted effort to provide researchers with a concrete blueprint for moving forward work on church-based social ties and health. This is accomplished by developing a range of specific and testable hypotheses that link various types of church-based social ties with health and by providing well-developed survey measures that can be used to evaluate them. In the process, a number of methodological and conceptual problems are identified that must be overcome if further progress is to be made. The insights provided in this book arise from the author's extensive experience conducting the first nationwide survey that was devoted exclusively to the study of religion and health in late life. The seven years that it has taken to conduct this research and report the findings that have emerged from it have provided the opportunity for invaluable hands-on experience. When viewed at the broadest level, the intent of this book is to share the insights that were gleaned from this experience with other investigators.

The discussion that follows is divided into four main sections. First, a brief overview of the state of research on religion and health is pro-

vided. Problems in this literature are traced to three fundamental shortcomings that involve both conceptual and methodological issues. The field of religion and health is vast, and as a result, it would be impossible to cover adequately in a single volume all the work that has been done. Consequently, the second section is devoted to placing boundaries on the scope of this book, which is accomplished by arguing why it is best to focus on religion instead of spirituality and why it makes sense initially to study older Christians only. Section three contains a detailed rationale for why it is important to study religion, why older people are an especially important group to investigate in this context, and why researchers should focus specifically on social relationships that arise in religious settings. Finally, an overview of the chapters that follow is provided in section four.

Religion and Health: What We Know and What We Need to Do Next

An impressive body of research suggests that people who are involved in religion tend to enjoy better physical and mental health than individuals who are not involved in religion (see Koenig, McCullough, & Larson 2001; Lee & Newberg 2005; and Oman & Thoresen 2005 for reviews of this research). Especially convincing evidence is found in studies on the relationship between religion and mortality. This research reveals that people who go to worship services on a regular basis tend to live longer than individuals who do not attend church as often (e.g., Hummer, Rogers, Nam, & Ellison 1999).

Unfortunately, research on religion and health suffers from a number of problems, and as a result, work in this area is not without its critics (e.g., Sloan & Bagiella 2002). Although a number of shortcomings have been identified in the literature, three are especially troubling: the first has to do with the measurement of religion, the second involves the theoretical and conceptual models that have been developed to explain the relationship between religion and health, and the third arises from overlooking the critically important interface between measurement and theory.

Issues in the Measurement of Religion

With respect to measurement, many investigators often rely on single indicators of involvement in religion, especially the frequency of church attendance. However, religion is a vast conceptual domain that cannot be measured adequately with a single item. Evidence of what is

missed by relying on limited strategies to measure religion may be found in three sources. First, a panel of experts who were convened by the National Institute on Aging and the Fetzer Institute identified twelve key dimensions of religion that they maintain are important for research on religion and health (Fetzer Institute/National Institute on Aging Working Group 1999). Included among the potentially important dimensions of religion that were identified by the members of this group are religious meaning, forgiveness, and religious beliefs. Second, based on a detailed series of qualitative studies, Krause (2002a) expanded the field of inquiry by identifying fourteen major dimensions of religion. Among the potentially important facets of religion identified by Krause (2002a) are God-mediated feelings of control, religious doubt, and having a close personal relationship with God. Third, Hill and Hood (1999) compiled a comprehensive catalogue of religion measures. This volume comprises seventeen chapters that contain measures of many different facets of religion that may be associated with health and well-being, including scales of religious development (i.e., developing a mature religious faith) and measures of beliefs about death and the afterlife.

Although researchers have made significant progress in measuring religion during the past few years, there are at least two reasons why many investigators have failed to take advantage of these advances. First, a good deal of the work on the conceptualization and measurement of religion is tucked away in specialty journals and books that are outside the mainstream social and behavioral science literature. For example, the Journal of Psychology and Theology contains a number of papers on how to measure various facets of religion, but this journal is not carried by many libraries. As a result, many health-oriented researchers are unaware of the progress that has been made simply because they do not have ready access to the measures that have been developed. The second reason why there are problems with the measures of religion has to do with the wider context in which research on religion and health is often conducted. A good deal of the work in this field is done by investigators who are primary interested in health and who have not received formal training in religion. As a result, these researchers often design questionnaires that devote considerable space to assessing health-related outcomes while leaving much less room for measures of religion. In the process of developing their interview schedules, they often turn to experts on religion and ask them to provide "three or four good questions to measure religion." It is time to stop this practice. If researchers hope to better understand the relationship between religion and health, then

more attention must be given to the complex ways in which religion should be measured.

Developing Conceptual Models of Religion and Health

Delving more deeply into the complex multidimensional aspects of religion presents researchers with a significant challenge. Many of the multidimensional batteries of religion were not developed specifically for research on religion and health, and even those that are used in studies of religion and health are often based on underdeveloped theoretical perspectives. This situation led McFadden (2005) to conclude, "Considerable gerontological research has been designed and conducted with little explicit reference to metatheoretical perspectives and frameworks that guided the development of hypotheses, selection of participants, measures and research design, and interpretation of findings" (166).

However, the call for greater conceptual and theoretical development creates yet another challenge. More specifically, researchers must decide whether they want to devise comprehensive models of religion that encompass all the ways religion may influence health in a single conceptual framework (Koenig et al. 2001), or whether they want to develop more focused models that examine the complex ways in which a single dimension of religion may affect health-related outcomes. For example, Pargament (1997) has done outstanding work with conceptual models that show how religious coping responses affect health. Simply put, the dilemma facing researchers is whether to devise grand theories or mid-range theories to study the relationship between religion and health (Merton 1949).

A central premise in the current volume is that it is not advisable at the present time to devise one grand theoretical model of religion and health. Instead, it makes more sense to begin modestly by developing a series of mid-range theories that aim to capture a number of different ways in which specific components of religion may affect health. There are three reasons for recommending that researchers begin by developing more circumscribed theoretical models. The first may be found in the classic work of William James (1902/1997), who argued, "The divine can mean no single quality, it must mean a group of qualities, by being champions of which in alternation, different men may all find a worthy mission.…So a 'god of battles' must be allowed to be the god for one kind of person, a god of peace and home, the god of another. We must frankly recognize the fact that we live in partial systems, and that parts are not interchangeable in spiritual life" (509).