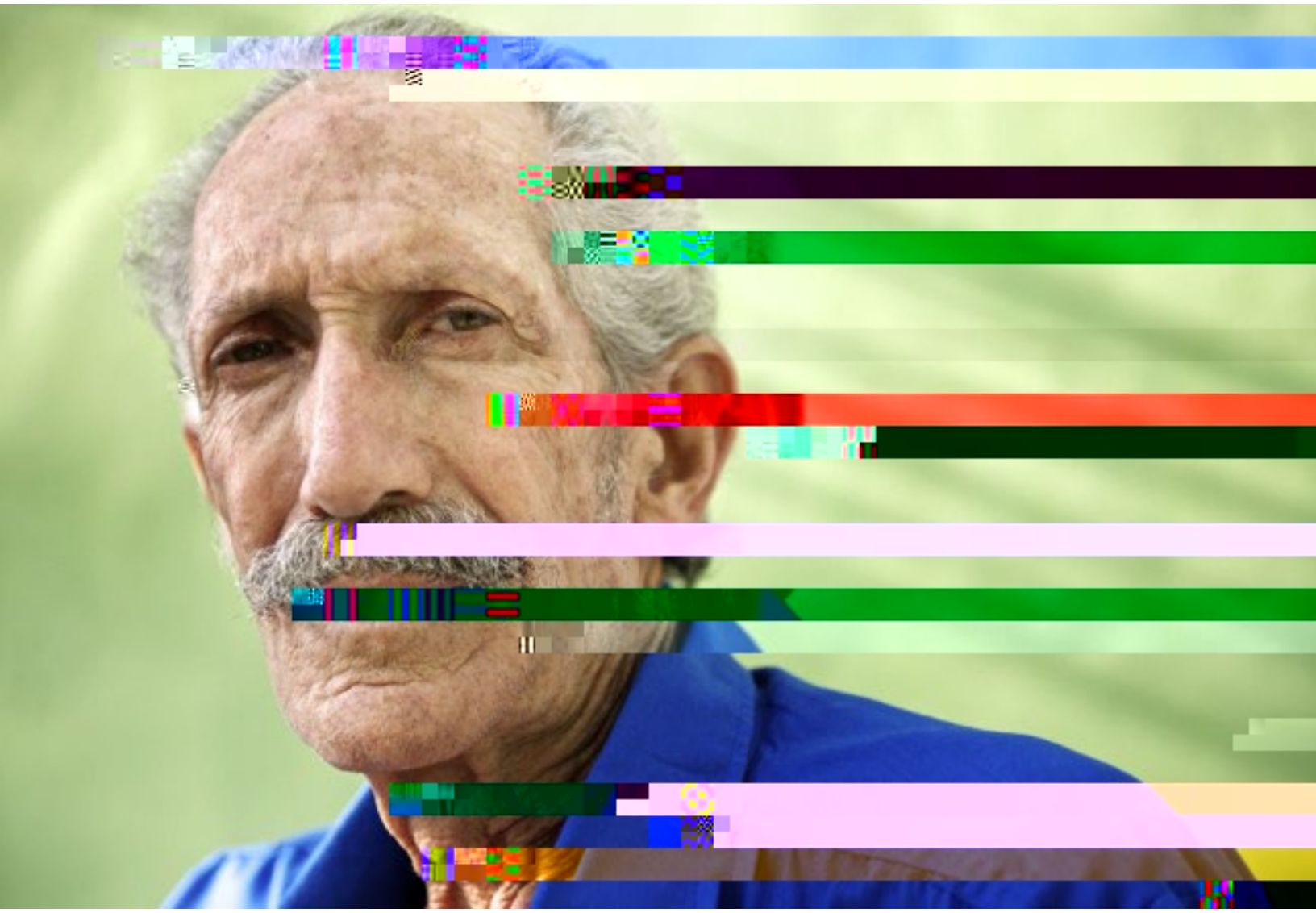
Aging, Health, and Religious Attendance among Mexican Americans

A Research Report

by Samuel Stroope



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This report relied on data from the Hispanic Established Population for the Epidemiological Study of the Elderly (Hispanic EPESE). The Hispanic EPESE was administered by researchers from the University of Texas Medical Branch-Galveston, the University of Texas-Austin, and the University of Texas-San Antonio. Hispanic EPESE data are available The Hispanic EPESE was funded by the United States Department of Health and Human Services, National Institutes of Health, and National Institute on Aging. Hispanic EPESE fieldwork was conducted by Louis Harris and Associates, Inc.

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Additional copies of this report and further information about its contents are available from the author (https://www.lsu.edu/hss/sociology/people/faculty/profiles/stroope_samuel.php).

Executive Summary
Many people believe older adults are more religious than younger people. But this belief overlooks certain basic facts. Populations of older Hispanic adults are growing faster than almost every other group of older adults in the United States. Mexican Americans are the largest subgroup among Hispanic Americans. For older Mexican Americans, churchgoing increases at age 66, but then declines from the mid-70s onward. Two aspects of health are most strongly related to this decline in churchgoing: (1) problems with instrumental activities (e.g., traveling alone, cooking alone, etc.); and (2) a history of smoking. Other health factors, including mobility performance (e.g., walking speed), depressive symptoms, and cognitive impairment (e.g., memory problems) also contribute. This study establishes these findings with community health data from 1993 to 2013 on over 2,000 older Mexican American adults in the southwestern U.S. Practical implications drawn from the findings include the following. Religious leaders and individuals can make churchgoing more accessible, help people preserve their functional abilities, discourage smoking, and create inclusive environments in religious communities. These efforts can help the well-being of older churchgoers and the vitality of religious communities.

Introduction
One of the most pervasive beliefs about older adults is that they are more religious than younger people. Older adulthood is thought to be a time of returning to one's core beliefs, often looking to an afterlife rather than the minutia of day-to-day life. There is some truth to these assumptions about older adulthood. While there is truth to the assumption that religiosity increases with age, researchers specializing in older adulthood find a more complex picture. According to research, older adults in the United States are the most religious age group in terms of attending services, devotional activities (e.g., private prayer), financial giving, volunteering, and having a sense of belonging in religious congregations.[1] But grouping together all older adults glosses over important trends. Studies find that after a substantial increase in churchgoing from ages 65 to 66, older adults maintain a high level of attendance up to their mid-70s, and then attendance tends to decline from the mid-70s onward.[2,3] This decline in churchgoing is likely caused by several factors related to the declining health status of older adults. While important, this fails to recognize the health details that explain this decline in participation. Researchers voice the need for identifying the most important factors in older adults' declining churchgoing.[2,3]

Understanding religious behavior in old age has practical significance beyond building scientific knowledge. It also has practical significance. Identifying how health conditions lead to declines in church attendance can help religious leaders and physicians better serve older churchgoers dealing with health issues. Understanding these declines can also lead to the development of supports that can help people maintain their churchgoing as they age.[4] This is important because participation in religious congregations can benefit older adults themselves and their religious communities. Research shows that congregational participation can lead to older adults living longer and healthier lives.[5–10] Helping

older adults extend their years of church participation is beneficial for congregations because attendance declines in old age correspond with reduced financial and volunteering contributions to congregations.[11]

Why Older Mexican American Adults?

Most research on the link between aging and churchgoing among older adults focuses on samples largely made up of non-Hispanic white and black participants. As a result, the conclusions drawn from that research is mostly applicable to white and black populations. This limitation in previous research makes it hard to develop more general applications that are valid for other groups such as Hispanic Americans. Hispanic Americans currently have one of the highest

attendance. Participants were asked how often they go to mass or services and could give a range of responses:

1. never (or almost never)
2. several times a year
3. once or twice a month
4. almost every week
5. more than once a week

For the 3,050 participants at the beginning of the survey, 20% answered that they never (or almost never) attend services, 19% that they attend several times a year, 12% attend once or twice a month, 40% almost every week, and 10% more than once a week.

This study investigated how declines in religious attendance could be linked to a variety of aspects of health. Aspects of health were included that spanned areas of physical functioning, cognitive functioning, mental health, illness diagnoses, injury, weight, and smoking behavior. The specific variables used were the following:

basic functional limitations (e.g., eating, bathing, dressing, etc.)
instrumental functional limitations (e.g., cooking, shopping, using stairs, etc.)
mobility performance (e.g., standing, walking, balancing)
cognitive impairment (memory, understanding, thinking, and communication)
depressive symptoms
physical illness diagnoses (e.g., arthritis, cancer, heart attack, etc.)
urinary incontinence
hip or bone fracture
hearing impairment
vision impairment
body mass index (BMI)
smoking history
self-rated health

Research Findings

Simple Descriptive Results

Before combining the above aspects of health and church attendance into a single analysis, we look at relationships between pairs of variables. In the following graphs, regular church attendance is defined as attending once a month or more. Figure 1 shows the percent of study participants who regularly attend church within each age group. As can be seen, about 60% of 65-year-olds attend church regularly. Regular attendance then jumps to 72% among 66-year-olds. The level of reguly. Rehp65

Figure 2 shows the relationship between study participants' number of instrumental functional limitations and the percentage of participants who regularly attend church. As with age, there is a clear relationship between instrumental functional limitations and regular church attendance. About 70% of those with no or one limitation attend church regularly. This number drops to 26% among participants with eight limitations.

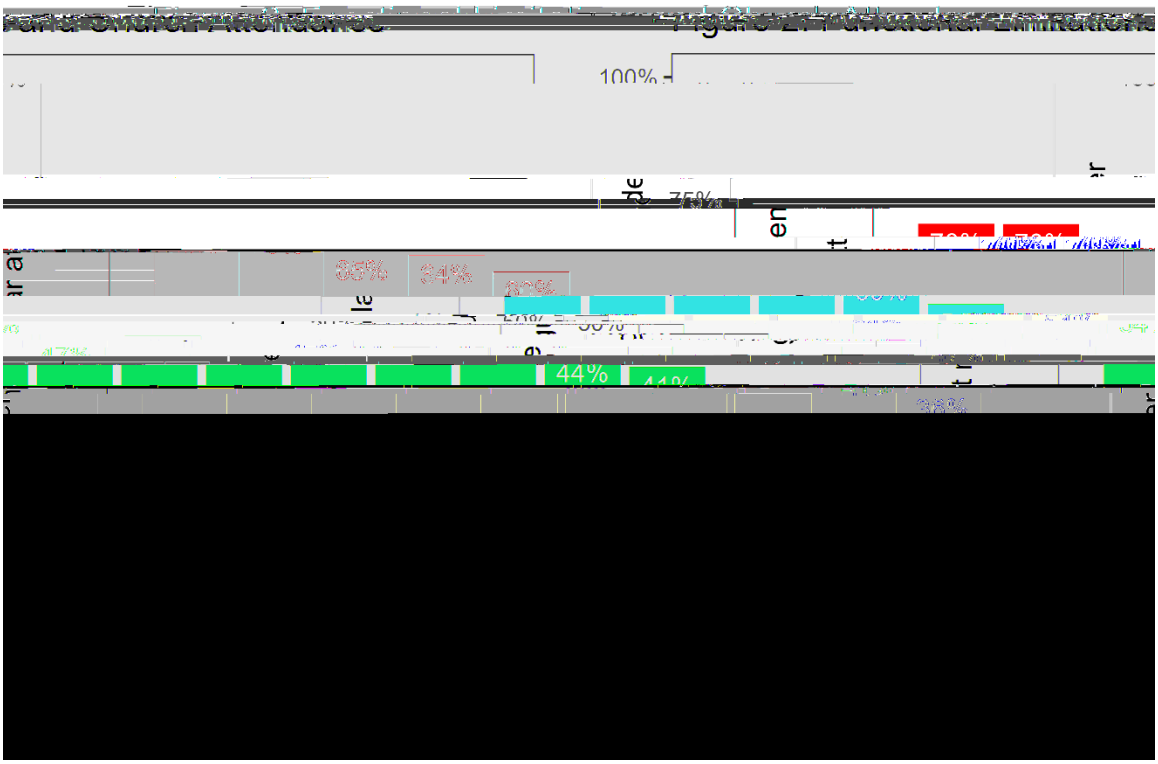
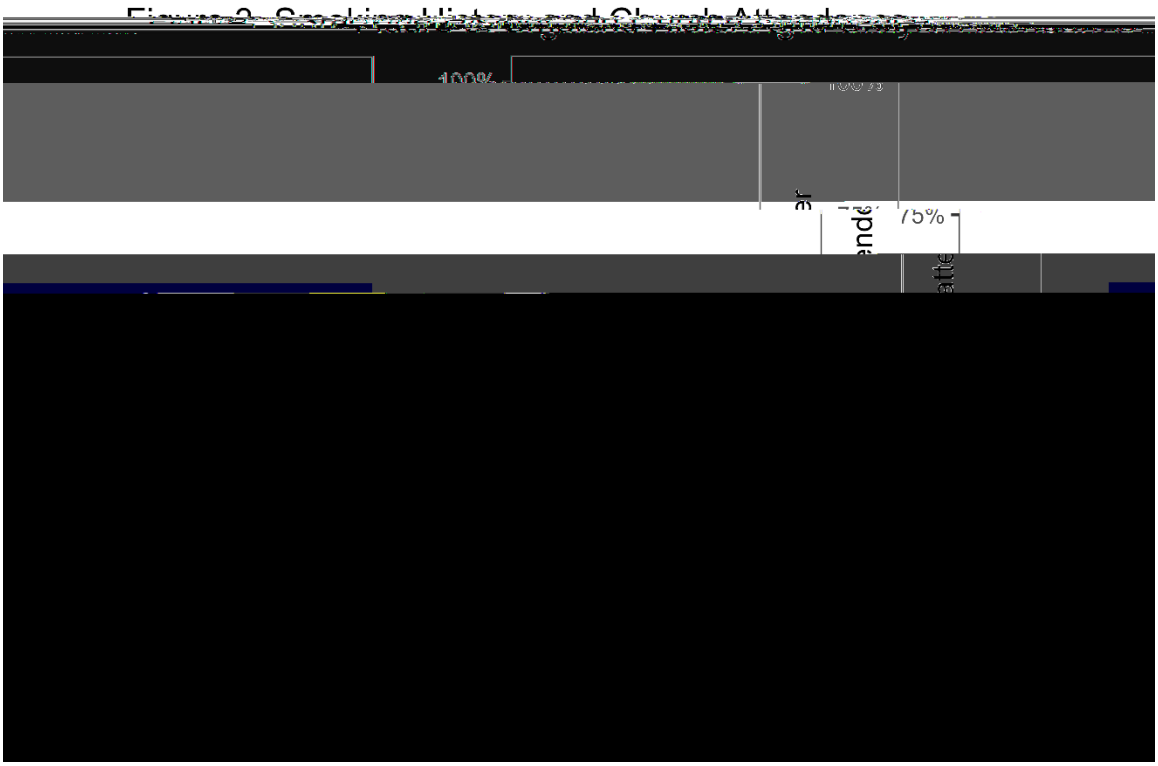


Figure 3 shows how the percentage of participants with a history of smoking is related to the percentage of participants who regularly attend church. Participants were grouped into smokers and non-smokers based on whether they had smoked 100 cigarettes in their life. As with both previous graphs, there is clear relationship between being a smoker and regular church attendance. About 62% of non-smokers in the study attended church regularly. The percentage of regular attenders declines by more than 10% among smokers to a level of 51%, a substantial decrease.



three categories: Catholic (87%), Protestant (10%), or other/no religious affiliation (3%).

The following are the results[iv] from the multiple regression analysis. The effect strength of health variables are ranked from greatest to least:

1. instrumental functional limitations (e.g.,

church attendance in older adults.[18] Solutions such as a shuttle ministry or help with ridesharing can make attendance more accessible. Additionally, installing ramps, elevators, and other building modifications could increase accessibility for congregants. While online worship services can be a cheap and easy solution for leaders, religious leaders should be aware that new research suggests that online services do not provide the same benefits as in-person worship in terms of well-being.[19]

In addition to helping overcome challenges to churchgoing impeded by instrumental functional limitations, it is also worth considering approaches that can counteract or postpone instrumental functional limitations. Research conducted among older adults has revealed that walking speed, along with other movements like turning, sitting down, and standing, were the most influential short-term predictor of instrumental functional limitations.[20] Maintaining regular physical activity (e.g., aerobic exercises and muscle strengthening) and avoiding a sedentary lifestyle play a critical role in preserving physical mobility.[21] Furthermore, cognitive impairment significantly contributes to the decline in instrumental functional abilities.[22] Implementing preventive measures to reduce the risk of cognitive impairment could involve installing home carbon monoxide detectors and taking steps to prevent brain injury, such as eating a healthy diet and keeping a healthy weight. These aspects of a healthy life help prevent stroke, an important cause of brain injury. There are also a range of behaviors that lower the likelihood of cognitive impairment: exercise, eating healthfully, not smoking, getting sufficient sleep, coping with stress, and spending time in positive face-to-face interaction with people.[23] Some religious leaders already promote many of these behaviors and collaborate with other organizations around exercise, diet, smoking, stress management, and combatting social isolation.[24] These existing efforts could be applied more widely and new efforts could be added.

Religious leaders promote older adults' physical activity by supporting local programs and infrastructure for walking and exercising. They can also encourage neighborhood walking groups, exercise programs, and improvements

relationship with attendance is noteworthy. The direct relationship between smoking and church attendance suggests that religious leaders have good reason to discourage smoking. In addition to the moral obligation to protect life, churches also benefit when people don't smoke because people are then more likely to continue participating in the congregation as they age. Since smoking often starts during the teenage years, religious leaders may find it effective to include a strong focus on young people in their smoking prevention efforts.

Congregations can also aim to create an inclusive environment for all attendees. They can accommodate people with physical disabilities and provide support for those facing mental health challenges and cognitive impairment. Church leaders can regularly emphasize the importance of welcoming individuals with different abilities through announcements, teachings, and even physical modifications to their facilities il0o4 (el (a)2 ()Tji(y e)4(f)3 (e)4 -2 (p /MCID 1 BDC -20.52 ’s)-1001)4 o

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[i] Funded by the United States Department of Health and Human Services, National Institutes of Health, National Institute on Aging, the Hispanic EPESE was administered by researchers from the University of Texas Medical Branch-Galveston, the University of Texas-Austin, and the University of Texas-San Antonio.

[ii] These examples are adapted from Putnam and Campbell.[16]

[iii] We use the term 'effects' because of its use in social science methods and for readability. We do not use this term to assert definitive proof of causation.

[iv] This section focuses on statistically significant results.