DOES religious involvement favor healthy cognitive aging? Recent studies published in the *Journals of Gerontology* suggest that it does. In this guest editorial, I review this literature and outline promising avenues for future research.

**Patterns**

Van Ness and Kasl (1) were among the first to emphasize the association between religious involvement and cognitive functioning. They use data from the New Haven Established Populations for the Epidemiologic Studies of the Elderly survey to examine the effects of religious attendance and religious identity on cognitive functioning over 6 years. The study uses Pfeiffer’s Short Portable Mental Status Questionnaire to assess cognitive functioning and includes controls for age, sex, race/ethnicity, education, income, marital status, other secular forms of social engagement, drinking and smoking, depression, chronic disease, physical activity, disability, and baseline cognitive functioning. Their results show that religious attendance, not religious identity, is associated with a reduction in the odds of cognitive dysfunction over time. Compared with those who attend religious services less than once per week, those who attend services once per week or more exhibit a 36% reduction in the odds of cognitive dysfunction over 3 years.

Following the work of Van Ness and Kasl, Hill and colleagues (2) use data from the Hispanic Established Populations for the Epidemiologic Studies of the Elderly (H-EPESE) survey to test whether religious attendance and religious identity on cognitive functioning over 6 years. The study uses the Mini-Mental State Examination (MMSE) to assess cognitive decline over 8 years and includes controls for age, sex, education, English proficiency, secular forms of social engagement, drinking and smoking, depression, chronic disease, sensory impairments, disability, and baseline cognitive functioning. The results of this investigation demonstrate that religious attendance is associated with slower rates of cognitive decline among older Mexican Americans. This study uses the MMSE to assess cognitive decline over 12 years and includes controls for age, sex, marital status, living arrangements, depression, chronic disease, sensory impairments, and disability. Their results corroborate prior research, showing that respondents who attend religious services infrequently (less than weekly) tend to exhibit faster rates of cognitive decline than respondents who attend more frequently (weekly or more). They also find that the rate of cognitive decline associated with chronic depressive symptoms is faster for respondents who attend religious services infrequently.

**Explanations**

Although these studies suggest that religious involvement is associated with favorable cognitive functioning trajectories, explanations for this relationship are not well developed. Nevertheless, prior research (1–4) has identified several theoretically viable mechanisms.

The idea that religious attendance might slow the rate of cognitive decline is generally consistent with prior research on social activities and cognitive functioning in late life. Indeed, numerous studies show that active, stimulating, and socially engaged lifestyles are required for healthy cognitive aging (5–12). Religious attendance in particular may involve a number of activities that are likely to stimulate cognitive faculties, including singing, prayer/meditation, sermons, scriptural study, philosophical discussions, and general socializing. If social ties and activities stimulate cognitive faculties, they may delay the deterioration of cognitive performance in old age, presumably through the maintenance of dense neocortical synapses in the brain.

Religious involvement is also associated with a greater sense of hope, meaning, and purpose. If these factors help elderly people to cope with stress, anxiety, and depression, religious involvement may buffer against hippocampal atrophy and cognitive decline. Religious involvement might also favor healthy cognitive aging by promoting behaviors...
that are known to reduce the risk of cognitive decline in old age. For example, studies show that religious individuals report greater use of preventive healthcare services, lower levels of smoking and drinking, and greater physical activity (13–19).

FUTURE DIRECTIONS

Research on religious involvement and cognitive aging is characterized by several strengths, including large sample sizes, prospective research designs, sophisticated statistical techniques, comprehensive model specification, and consistent patterns across studies. This nascent body of research also has several limitations, including regional samples, restricted measurement of religiosity, and an overemphasis on the main effects of religious involvement.

Because most of what we know about religious involvement and cognitive functioning in late life applies only to non-Hispanic whites in New Haven, Connecticut, and Mexican Americans in the southwestern United States, additional research is needed to test whether this association extends to other regions of the country and other race/ethnic populations (e.g., African American and Asian American populations). Although religiosity is widely recognized as a multidimensional phenomenon, prominent sources of epidemiological data are typically restricted to one or two measures of religious involvement (usually attendance at religious services). Religious attendance is a valid indicator of religious involvement and is clearly relevant to theories of social engagement. Unfortunately, the usual assessment of religious attendance is based on a single item and, as a consequence, is less reliable than would be ideal.

Religious attendance is also subject to a number of health selection processes. Because elderly persons may attend religious services sparingly or not at all as a result of problems associated with psychological and/or physical functioning, the healthiest elderly persons may be selected into religious attendance. This limitation requires that research on religion and health adequately control for baseline mental and physical health.

It is also important for future research to consider other potentially relevant forms of religious involvement, including attendance at religious discussion groups and informal gatherings, frequency of reading religious texts, frequency of prayer, and frequency of listening to or viewing various forms of religious media. Measures like these would offer a more precise account of the cognitive demands and complexities associated with religious involvement. Research along these lines would no doubt lead us to a better understanding of how religious activities might stimulate the mobilization of cognitive faculties and, as a consequence, slow the rate of cognitive decline in late life.

Finally, while studies tend to emphasize the main effects of religious involvement, little is known about potential indirect effects. If religious involvement favors healthy cognitive aging, why does it? If we are going to advance our understanding of the association between religious involvement and cognitive functioning trajectories, future research will be needed to answer this question.

REFERENCES