The Relation of Religious Preference and Practice to Depressive Symptoms Among 1,855 Older Adults

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Religious devotion is a complex phenomenon but a potentially important source of support and meaning in the lives of older adults. Nonetheless, attendance at religious services and religious preference (affiliation) have received relatively little prominence in epidemiological studies of late life mental illness despite their relative ease of measurement. We examined differences in the prevalence and course of depressive symptoms and associated characteristics among 1,855 older community residents who expressed a Jewish, Catholic, or other religious preference. At baseline, Jewish religious preference was associated with a twofold elevation in the prevalence of depressive symptoms compared to Catholics. Lack of attendance at religious services was associated with greater prevalence of depression among all groups, significantly so among Catholics. The relationship of depression with Jewish religious preference and with failure to attend services could not be accounted for by measures of age, gender, health, disability, or social support. Twenty-four months following baseline, Jewish religious preference was associated with the emergence of depressive symptoms and remained significant when the effects of age, gender, health, disability, and social support were controlled. Failure to attend services was associated with both the emergence and persistence of depression but did not remain significant once the effects of other characteristics were controlled. For both religious and health care institutions, these findings have implications for the prevention, recognition, and treatment of late life mental illness.

METHODS

Sample

Approximately 2,580 households from a Medicare Master Beneficiary file of recipients in the Norwood area of the North Bronx were sampled. A response rate of 73% yielded 1,855 randomly selected individuals who agreed to respond to a baseline interview. Because only one elderly respondent per household was recruited, the sample size was weighted for the probability of entry in the study by the number of

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elderly per household. The Norwood area differs from most studies of the elderly, including the Established Populations for the Epidemiologic Study of the Elderly (Cornoni-Huntley & Lafferty, 1986), in that 39.6% express a Jewish religious preference compared to less than 0.7% in the Iowa and Washington state populations, 0.7% in the East Boston population, and 13.9% in New Haven, Connecticut. Nearly 48% of Norwood respondents express a Catholic religious preference as compared to approximately 14% in Iowa and Washington state, 90% in East Boston, and 54% in New Haven. Norwood respondents, in contrast to the national elderly population, are older, more often female, more often live alone, and have lower median incomes (Kelman, Thomas, Kennedy, & Chen, 1994). They may be more representative of vulnerable seniors, those potentially in need of services and support.

Measures

During baseline in-person interviews, respondents provided information on health, chronic illness, physical and cognitive functioning, utilization of and attitudes toward health care, interactions with family, friends, and social service agencies, and financial resources. Self-assessed health was rated on a 4-point scale ranging from excellent to poor. The number of problems with instrumental and other activities of daily living was calculated from a 9-item scale adapted from work by Katz et al. (1963) and Lawton and Brody (1969). Items included getting in or out of the house, getting around inside, using kitchen and bathroom facilities, dressing, and getting in and out of bed. The measure was designed to incorporate activities required for elderly people to reside independently in the community, and to apply to the non-disabled as well as those with more extensive difficulties. Although the scale permits distinguishing difficulties that are present all of the time, most of the time, occasionally, or not at all, a yes/no response was used to facilitate scoring. Formal social support was defined as use of any of nine services supplied by an agency including meal delivery, special transportation, homemaker services, visiting nurse services, or home health aids. Informal support captured assistance from family or friends outside the household with meals, transportation, cleaning or laundry, shopping, money management, nursing, or personal care.

The number of medical conditions was determined from a checklist of 17 common illnesses including osteoporosis, hypertension, stroke, heart attack, and arthritis. Medical conditions were further divided into two variables (four or more noncardiovascular and two or more cardiovascular conditions) based on their distribution in the sample and the reported elevated rates of depression with heart disease (Oxman, Freeman, & Manheimer, 1995). Respondents were also asked to indicate their religious preference as Catholic, Jewish, Protestant, none, or other and whether they attended religious services weekly, monthly, or less.

The Center for Epidemiological Studies Depression scale (CES-D) was used to measure the level of depressive symptoms experienced during the past week (Radloff, 1977). Scores range from 0–60 with high scores indicating a greater number and frequency of depressive symptoms. From 13% to 19% of older community samples score 16 or above on the CES-D (Kinsie, Lewinsohn, Maricle, & Teri, 1986; Lin & Ensel, 1984; Phifer & Murrel, 1986). Roughly one-third of persons meeting the 16-point criterion for a significant level of depressive symptoms also meet diagnostic criteria for major depression. However, when referring to our respondents as depressed, we are referring to symptoms of depression rather than a major depressive disorder.

Twenty-four months after baseline, 85% of the original sample completed a second administration of the CES-D and responded to questions regarding changes in problems with activities of daily living, formal and informal support, and whether their health had improved, declined, or stayed the same. Persons scoring less than 16 on the CES-D at both baseline and the 24-month assessments were considered free of a significant level of depressive symptoms. Persons scoring 16 or greater at both the baseline and 24-month interviews were designated as persistently depressed. However, for persons who scored between 12 and 20 at baseline, a change of ≥ 4 points (one-half standard deviation) across the criterion score of 16 was necessary to be considered meaningful. We designated respondents whose scores increased by at least 4 points across the criterion to have an emergence of depressive symptoms, and those declining by at least 4 points to have a remission of symptoms. Data from 15 respondents whose change scores fell in this ambiguous range were censored from the longitudinal analysis.

Analyses

First, we used chi-square analyses to compare the prevalence of respondent characteristics categorized by Catholic, Jewish, and a heterogeneous group of "other" religious preferences making up less than 15% of the sample (Protestant, not specified, no preference, or none of the previous). To compare the differences in respondents’ religious preferences and practices in relation to depression, we calculated values for chi-squares and adjusted odds ratios. Second, we performed logistic regression analyses and generated adjusted odds ratios to examine the relative magnitude of characteristics that explained the variance in depression at baseline, and to determine whether or not the greater prevalence of depression among the Jewish group might be explained by characteristics beyond their religious preference.

For the longitudinal examination of depression, stepwise and canonical discriminant analyses were used to distinguish respondents in whom a significant level of depressive symptoms either emerged, remitted, persisted, or was not clinically significant from baseline to the 24-month interview.

RESULTS

Distribution and Response Rate By Religious Preference

Of the 1,855 respondents, 711 (39.6%) reported a Jewish religious preference and 680 (91.4%) of those completed the CES-D. There were 880 (47.7%) respondents reporting Catholic preference with 852 (96.8%) completing the CES-D. Protestants numbered 185 (10%), and 179 (96.7%) completed the CES-D. Persons indicating no religious preference (n = 35), not specified (n = 10), or one other than Jewish, Catholic, or Protestant (n = 34) made up 3.5% of the sample. Respondents not completing the CES-D (n =
160) tended to be confused, disabled, or ill and were more characteristic of persons scoring as depressed (Thomas, 1989) but equally represented across the three religious groups.

**Demographics, Health, and Disability**

Jewish respondents were significantly older and more educated than either the Catholics or Others (Table 1). The distribution of income levels was more favorable for the Jewish than Other respondents but was not significantly different compared to that of the Catholics. The percentage of respondents receiving Medicaid in the Other group was greater overall but significantly so only when compared to Jewish respondents. The proportions of women, number of persons presently married, and persons living alone were equivalent across the groups. A higher percentage of respondents in the Other group, ($n = 34, 13\%$) was separated or divorced than either the Jewish group ($n = 37, 5.2\%$) or Catholics ($n = 42, 4.7\%$). The percentage of those who never married was larger among the Catholics ($n = 119, 13.5\%$) than the Jews ($n = 69, 9.7\%$) or Others ($n = 31, 11.7\%$). More of the Jewish respondents received both formal and informal social support services compared to the Catholics and Others. Although there was no significant difference across the groups for the number of problems with activities of daily living, the percentage of Jewish respondents who experienced four or more noncardiovascular conditions was significantly greater than that of the Catholics.

The Others group reported significantly more cardiovascular conditions than the Catholics. Nonetheless, more than half the Jewish respondents rated their health as no better than fair-to-poor compared to one third of Catholics and 40% of Others.

Of the 41 depressed respondents who had visited a psychiatric social worker, psychologist, or psychiatrist within the previous three months, more than half were Jewish. Cognitive impairment, as determined by a score less than 18 on the Mini-Mental State Exam, and use of a prescribed psychotrophic medication were also more prevalent among the Jewish respondents.

A substantial minority of the sample were foreign born, ranging from almost half the Jewish respondents to more than a third of the Other group. Forty percent of Catholic respondents were born outside the United States. Fifty-eight percent of the foreign-born Catholics were from Ireland, 12% from Italy, and 30% from elsewhere. The majority of foreign-born Jewish respondents were from Eastern Europe (Russia 34.5%, Poland 30.2%) with the remainder from Hungary (8.6%), Austria (9.8%), or areas other than those listed above (14%).

**Religious Preference and Practice**

Table 2 depicts the association of depression with religious preference and practice. Fewer than 10% of the Catholics evidenced a significant level of depressive symptoms, in contrast to 12% of Others and more than 20% of the Jews.

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### Table 1. Comparison of Catholics, Jews, and Others

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Catholics</th>
<th>Jews</th>
<th>Others</th>
<th>Significant differences*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65–74</td>
<td>469 (53.3%)</td>
<td>289 (40.6%)</td>
<td>136 (51.5%)</td>
<td>x, z</td>
</tr>
<tr>
<td>75–84</td>
<td>340 (38.6%)</td>
<td>315 (44.3%)</td>
<td>94 (35.6%)</td>
<td>x, z</td>
</tr>
<tr>
<td>85 or older</td>
<td>71 (8.0%)</td>
<td>107 (15.0%)</td>
<td>34 (12.8%)</td>
<td>x, z</td>
</tr>
<tr>
<td><strong>No. of women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>614 (69.7%)</td>
<td>486 (68.3%)</td>
<td>172 (65.1%)</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>434 (49.7%)</td>
<td>472 (67.9%)</td>
<td>145 (55.5%)</td>
<td>x, z</td>
<td></td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$5,000</td>
<td>153 (20.4%)</td>
<td>104 (15.9%)</td>
<td>59 (24.6%)</td>
<td>z</td>
</tr>
<tr>
<td>$5,000–$15,000</td>
<td>448 (59.8%)</td>
<td>306 (57.5%)</td>
<td>127 (56.9%)</td>
<td>z</td>
</tr>
<tr>
<td>$15,000</td>
<td>147 (19.6%)</td>
<td>122 (22.9%)</td>
<td>37 (16.5%)</td>
<td>z</td>
</tr>
<tr>
<td><strong>Medicaid recipient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>146 (16.9%)</td>
<td>98 (14.0%)</td>
<td>54 (21.0%)</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>Lives alone</td>
<td>465 (52.8%)</td>
<td>402 (56.5%)</td>
<td>150 (58.6%)</td>
<td>n.s.</td>
</tr>
<tr>
<td><strong>Married</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>253 (28.7%)</td>
<td>231 (32.4%)</td>
<td>69 (26.1%)</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>Foreign born</td>
<td>354 (40.2%)</td>
<td>347 (48.8%)</td>
<td>93 (35.2%)</td>
<td>x, z</td>
</tr>
<tr>
<td><strong>Both formal and informal social support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>91 (10.3%)</td>
<td>117 (16.4%)</td>
<td>30 (11.3%)</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td><strong>Attends religious services</strong></td>
<td>648 (73.6%)</td>
<td>139 (19.5%)</td>
<td>103 (39.0%)</td>
<td>x, y, z</td>
</tr>
<tr>
<td><strong>Self-assessed health, fair or poor</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>139 (15.8%)</td>
<td>159 (22.3%)</td>
<td>48 (18.1%)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>$&gt;$ 4 Medical conditions</td>
<td>157 (17.8%)</td>
<td>152 (21.4%)</td>
<td>66 (25.1%)</td>
<td>y</td>
</tr>
<tr>
<td><strong>Self-assessed health, fair or poor</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>291 (33.5%)</td>
<td>355 (51.7%)</td>
<td>105 (40.3%)</td>
<td>x, y, z</td>
<td></td>
</tr>
<tr>
<td>PADL = one or more</td>
<td>234 (26.6%)</td>
<td>217 (30.6%)</td>
<td>78 (29.6%)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Mental health visit†</td>
<td>13 (1.4%)</td>
<td>23 (3.2%)</td>
<td>3 (1.8%)</td>
<td>x</td>
</tr>
<tr>
<td>Use of psychotropic</td>
<td>62 (7.0%)</td>
<td>77 (10.8%)</td>
<td>13 (4.9%)</td>
<td>x, z</td>
</tr>
<tr>
<td>Cognition impaired†</td>
<td>73 (8.5%)</td>
<td>83 (11.8%)</td>
<td>24 (9.2%)</td>
<td>x</td>
</tr>
</tbody>
</table>

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*Includes Protestants, those with no or unspecified religious preference, and others neither Jewish nor Catholic.

*Includes Protestants, those with no or unspecified religious preference, and others neither Jewish nor Catholic.

*PADL = problems with activities of daily living.

*Visits to psychiatric social worker, psychologist, or psychiatrist within three months of baseline.

*Mini-Mental State Exam score < 18.
Indeed, the odds of being depressed for the Catholics were less than half that of the sample as a whole. For the Jewish respondents the odds were more than twofold greater. Overall, 16.9% of the sample were depressed.

Close to three-quarters of the Catholics reported having attended religious services within the last month compared to only 20% of the Jews and 38% of Others. The rate of depression among Catholics who did not attend services compared to those who did, but did not reach statistical significance. Protestants made up the majority of persons labeled as Other. Eleven percent of Protestants were depressed. Of those who had not attended services, 14.2% were depressed compared to 7.9% who attended, but the differences were not significant.

Baseline Characteristics Explaining the Variance in Depression

We performed logistic regression analyses using the respondent characteristics listed in Table 1. As shown in Table 3, seven variables made significant contributions to the explained variance in depression at the \( p < .01 \) or better level of reliability. They included fair-to-poor health, problems with activities of daily living, living alone, Jewish religious preference, nonattendance at religious services, female gender, and education greater than or equal to 9 years. Receipt of both formal and informal social support services and two or more cardiovascular conditions were significant at \( p < .02 \) and \( p < .03 \), respectively. Nonsignificant variables included medical conditions other than cardiovascular, cognitive impairment, foreign birth, age, income, and receipt of Medicaid. Separate regression models incorporating interaction items between Jewish religious preference and age (65–74, 75–84, 85+) did not alter the results. Thus, both Jewish religious preference and failure to attend services contributed significantly to the variance even when measures of sociodemographic status, immigration, health and disability, and social support were taken into account.

Emergence, Persistence, and Remission of Depression 24 Months After Baseline

Table 4 shows the longitudinal course of depressive symptoms in the sample by comparing groups of respondents in whom depressive symptoms emerged, remitted, persisted,
or never reached clinical significance from baseline to 24 months. There were significantly more Jewish respondents than Catholics or Others who experienced an emergence of depression. Jewish respondents also made up a greater percentage of persons in whom depression persisted, but the differences were not significant compared to Catholics and Others. The percentage of persons not attending services was significantly greater in both the depression-emerged and depression-persisted groups.

To determine if Jewish religious preference and attendance at services would remain significant once other variables were taken into account, we used stepwise and canonical discriminant function analyses to identify characteristics which distinguished the never-depressed from those in whom depression emerged. As shown in Table 5, baseline measures of health and disability made up most of the characteristics included in the model and accounted for 15% of the explained variance (average squared canonical correlation = .15). Jewish religious preference was significant but accounted for less than 1% of the variance. Age, gender, social support, and attendance at services were among the characteristics that were not significant.

Stepwise and canonical discriminant function analyses of the respondents who were depressed at baseline indicated that worsening health ($F = 41.61, p = .0001$), increased problems with activities of daily living ($F = 5.00, p = .002$) at 24 months, and advanced age ($F = 9.10, p = .002$) significantly distinguished the persistently depressed from the remission group. These variables accounted for 25% of the explained variance (average squared canonical correlation = .25). Neither religious preference nor attendance at services was significant.

**DISCUSSION**

A number of hypotheses have been advanced to explain why mental symptoms might be more prevalent in one religious group than another (Levin & Schiller, 1987). Immigrant status per se may explain the association between advanced age and depression (Vega, Bohdan, Hough, & Figueroa, 1987) but did not appear to be significant in our sample once other subject characteristics were controlled. However, aspects of social grouping and ethnic density — the extent to which a population is ethnically homogeneous — are important to any understanding of the correlation between depression and immigration. In-migration to a less diverse community may be less distressing than arrival in a dissimilar, mixed group (Rahav et al., 1986). The majority of Catholics in our sample were Irish, whereas the Jewish respondents showed much greater diversity in national origin. Nonetheless, their origins in Yiddish-speaking Eastern Europe suggest a commonality of culture (Yiddishkeit) that may be more significant than differences in nationality. Alternatively, the differences in national origin, first language, and orthodoxy may have diminished as the respondents aged, leaving religious identification as the most salient difference from the dominant culture.

Cross-cultural comparisons suggest that different religious groups develop differing social expectations (Lenski, 1961) which may influence their attitudes toward mental illness (Guttmacher & Ellison, 1971; Srole et al., 1962; Suchman, 1969), expression of negative emotions (Glickman, 1991), and attendance at religious services. Several studies report a tendency among American Irish Catholics to deny feelings (McGoldrick & Pearce, 1981), to be stoic (Zborowski, 1952), and to be less likely to ask for help (Zola, 1966). In contrast, Croog (1961) found that Jews reported more symptoms on the Cornell Medical Index than other ethnic groups of similar educational level. Similarly, Meador et al. (1992) argue that the increased prevalence of major depression among Pentecostals in the Duke Epidemiologic Catchment Area study may be related to greater emotionality as a group trait.

Thus, a culturally related response-bias or underreporting

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**Table 4. Religious Preference and Practice of Respondents Whose Depression Emerged, Persisted, or Remitted After 24 Months**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Never Depressed</th>
<th>Depression Emerged</th>
<th>Depression Persisted</th>
<th>Depression Remitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jewish</td>
<td>397 (32.4%)</td>
<td>72 (50.7%)</td>
<td>60 (64.5%)</td>
<td>59 (50.8%)</td>
</tr>
<tr>
<td>Catholic</td>
<td>643 (52.5%)</td>
<td>53 (37.3%)</td>
<td>26 (27.9%)</td>
<td>41 (35.3%)</td>
</tr>
<tr>
<td>Other</td>
<td>183 (14.9%)</td>
<td>17 (11.9%)</td>
<td>7 (7.5%)</td>
<td>16 (14.0%)</td>
</tr>
<tr>
<td>Attends services monthly</td>
<td>702 (57.4%)</td>
<td>55 (38.7%)</td>
<td>22 (23.7%)</td>
<td>43 (37.1%)</td>
</tr>
</tbody>
</table>

*Significant difference between Jews and Catholics ($\chi^2 = 17.94, df = 1, p < .0001$).
*Significant difference between Jews and Others ($\chi^2 = 5.00, df = 1, p < .01$).
*Significant difference between the Never Depressed and the Emergence groups ($\chi^2 = 17.94, df = 1, p < .0001$).
*Significant difference between the Persistence and Remission groups ($\chi^2 = 4.33, df = 1, p < .03$).

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**Table 5. Characteristics Distinguishing Respondents Who Were Never Depressed From Those in Whom Depression Emerged**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Partial $R^2$</th>
<th>$F$</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in PADL at 24 mo</td>
<td>.085</td>
<td>99.83</td>
<td>.0001</td>
</tr>
<tr>
<td>Health worse at 24 mo</td>
<td>.041</td>
<td>46.01</td>
<td>.0001</td>
</tr>
<tr>
<td>Baseline health, fair/poor</td>
<td>.009</td>
<td>9.70</td>
<td>.001</td>
</tr>
<tr>
<td>Jewish</td>
<td>.006</td>
<td>6.51</td>
<td>.01</td>
</tr>
<tr>
<td>Education &gt; 9 yr</td>
<td>.007</td>
<td>7.76</td>
<td>.005</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>.004</td>
<td>4.47</td>
<td>.03</td>
</tr>
<tr>
<td>Baseline PADL</td>
<td>.004</td>
<td>4.50</td>
<td>.03</td>
</tr>
</tbody>
</table>

*Note: PADL = 1 or more problems with activities of daily living. All missing values were replaced by mean values of the variables.*
of depressive symptoms among Catholic respondents and/or overreporting among Jewish respondents may account for some of the differences in prevalence and course of depressive symptoms in our sample. Jewish respondents did not report excess cardiovascular conditions, which more than any other illnesses outside the central nervous system have been associated with elevated rates of depression (Oxman et al., 1995) or problems with activities of daily living. But the greater prevalence and incidence of depression was accompanied by greater use of mental health services and psychotropic medications and a greater prevalence of cognitive impairment. The Jewish participants were both responding and behaving as though they were genuinely depressed. Finally, familial, heritable factors are thought to contribute to a form of depression, *melancholia Judaica*, among Eastern European Jews (Rahav et al., 1986). Life stressors — notably the European Holocaust and systematic discrimination related to religious preference — might also play a role in depression (Brown & Tirril, 1978; Lin & Enslen, 1984) as well as the development of post-traumatic stress syndrome (Yehuda, Kahana, Southwick, & Giller, 1994).

In summary, our findings are consistent with several hypotheses that have been advanced to explain why religious groups might differ in their expression of depressive symptoms. These include ethnic density, response bias, and Eastern European Jewish ancestry. Lacking a measure to assess the traumatic effects of the European Holocaust on our Jewish respondents, we can only speculate that a significant relationship exists. However, neither the measurement of survivor distress nor the definition of exposed individuals is easily characterized.

Among aged Holocaust survivors, the effects of trauma early in life are compounded by late-life events. Yehuda et al. (1995) found that the severity of post-traumatic stress syndrome among Holocaust survivors was related not only to the original stressor but also to subsequent, accumulated stressful events. However, post-traumatic stress syndrome may not adequately capture the mental morbidity for this population. Krystal and Niederland (1971) described eight sequelae of Holocaust survivorship, first among them being an anxiety syndrome accompanied by chronic insomnia due to nightmares, and second, a chronic depressive reaction characterized by isolation and seclusion. Also, the definition of Holocaust survivorship is not straightforward. Of the 8.8 million Jews living in Europe before the war, approximately 3 million remained afterwards. An estimated 4- to 500,000 survived in labor camps, in the Resistance, or in hiding. No more than 75,000 survived the death camps (Epstein, 1977). Porter (1981) delegates Holocaust survivorship to the 500,000 figure and includes those German and Austrian Jews who fled Europe in the 1930s as well as others from the displaced persons camps who immigrated in the 1940s and 50s. Finally, there may be a ripple effect of Holocaust trauma that flows beyond the camp survivors. Not all Jews are Holocaust survivors, but in some sense all are Holocaust victims.

Regarding religious practice, depression was more frequent among all respondents not attending religious services but was significant only among Catholics. Attendance at religious services is a moral imperative for Catholics, much less so for Jews and Protestants. Also, the major denominations of Judaism — Orthodox, Conservative, and Reform — differ in both practice and beliefs (Glicksman, 1991). Elderly believers whose mobility is compromised by physical limitations or inadequate transportation may choose to forgo attendance if a synagogue from an unacceptable denomination is the only one nearby. However, the regression analysis indicated that receipt of social supports did not displace the contribution of failure to attend services to the variance in depression. Neither did problems with activities of daily living, which might have explained away the relationship because of respondents being too disabled to attend services. It is also important to note that our measures captured tangible rather than emotional support. Neither did we assess the perceived adequacy of support. Finally, differences in sociodemographics, disability and illness, immigrant status, and social supports did not account for the relation of lack of attendance at religious services and Jewish religious preference to symptoms of depression at baseline. Although failure to attend services was associated with the emergence and persistence of depression at 24 months, only Jewish religious preference remained significant once age, disability, and social support were controlled.

**Conclusion**

Levin’s recent book (1994) captures the ambivalence with which epidemiologic studies of mental health and religion have been viewed. Work that focuses on the social, psychological, and biobehavioral import of religion may not be viewed as a viable career path (Sherrill & Larson, 1994) even when questions of “supernatural” causality (Levin, 1994) are assiduously avoided. Added to Freud’s antagonism toward religious belief in general (Williams, 1994) are concerns that science not be used to advance denominational or sectarian conflict or religious bigotry.

For religious practice in late life to be a recognized public health resource, it is necessary to identify those aspects of religiosity that are associated with fewer symptoms of mental illness. Allport (1963) has described religiosity as either extrinsic, related to formal organized practices, or intrinsic, related to personal devotion. Religious practice decreases with age while personal devotion increases (Bergin, 1984; Young & Dowling, 1987). Both aspects are positively related to life satisfaction (Markides, 1983) and morale (Koenig, Kvale, & Ferrel, 1988). Idler (1987) theorizes that religious involvement may enhance health by reducing risky behaviors, increasing social cohesion, and providing coherent, consistent beliefs about coping and shared experience. Koenig (1994) and Kaplan, Munroe-Blum, and Blazer (1994) suggest that faith may have a palliative role in alleviating suffering. Among elderly cardiac surgery patients, Oxman et al. (1995) found that “strength or comfort from religion” was an inverse and independent predictor of 6-month mortality. The survival benefits of religion were not dependent on the social contact involved. Our survey indicates that crude measures of religious preference and practice (Williams, 1994) are related to depressive symptoms among older community residents. These data are relevant to Gallup’s call for religious institutions to take on a more prominent role in combating late-life suicide (Gallup, 1992),
which is so frequently linked to depression. They are equally relevant to the primary health care of older Jewish and Catholic community residents.

Further epidemiologic study is needed to investigate the contribution of personality traits, beliefs, response style, and tangible emotional support not only to the expression of depressive symptoms but to the development of anxiety and depressive disorders. If Jewish elders are genuinely predisposed to depressive disorders, are Catholics somewhat immunized by attendance at religious services and, if so, by what mechanism? Health services studies are needed to identify the mental health burdens and benefits of religious practice and preference. Similarly, the capacity of religious institutions to participate in case finding and therapeutic support while preserving the person's right to privacy and freedom of (from) religion needs to be addressed.

To adequately explore the influence of heritable and traumatic factors among older Jewish persons would require in-depth interviews, biological investigation, and larger samples. Their qualitative portrayal will survive in the art of Barbara Myerhoff's (1978) Number of Our Days. But the confluence of trauma and assumed genetic predisposition deserves further quantitative study before the cohort vanishes. Sadly, the examination of their mental health will be informative for subsequent generations, the forced migration and sectarian violence of 'ethnic cleansing' in the Balkan states being only one example.

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