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An investigation of the relationship between religion and marriage on self-reported health

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AN INVESTIGATION OF THE RELATIONSHIP BETWEEN RELIGION AND MARRIAGE ON SELF-REPORTED HEALTH

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Abstract

A significant body of literature has focused on the effects of religion on health and marriage on health, as well as on religion and marriage. However, there is limited research on the effects of religion and marriage on self-reported health. Using the first and only wave of the Panel Study of American Religion and Ethnicity, ordinary least square regression models are compared to investigate the causal effects of religion and marriage on self-reported health. In the analysis, it is found that religion and marriage, as forms of social support, individually have significant affects on self-reported health as the literature indicates it should. Yet religion and marriage have no significant effect on one another; there is no causal effect found between religion and marriage. From this analysis, it is suggested that religion and marriage should be discussed in the context of social support that has a positive relationship on health.

Introduction

Health is an important factor in our everyday lives. Consequently, we are constantly reminded of the importance of being healthy. The professional opinions on how to get healthy vary. They can range from exercising and eating healthy to nurturing ourselves physically as well as mentally, emotionally, and spiritually. Research points to a number of factors that explain why some individuals are healthier than others, such as: age, occupation, martial status, income, community involvement, and religious/spiritual involvement (Manning et al. 2010; Crimmins and Saito 2001; Waldron, Weiss and Hughes 1997; Ellison 1991; Berkman 1984).

This paper examines the effects of marriage and religiousness on self-reported health ass well as a test of independence between marriage and religion. Because of the cross-connections, I seek to investigate more deeply, the relationship between religion and marriage as forms of social support on health outcome. The questions asked for this investigation are: does religion have an effect on health through marriage or; is religion the direct effect with marriage as an indirect effect on health outcomes?

In the sections that follow, I will first discuss relevant previous works that examine the association of marriage and health as well as religion and health. I will also examine the relationship between marriage and religion. This is the literature that framed the questions and informed the analysis of this paper. This section is followed by an analysis of the effects of religion and marriage on health, in which I estimate OLS regression models. A comparison of models will indicate if these variables are independent of one another, or if there is a causal effect that exists between religion and marriage when trying to explain self-reported health. Finally, I discuss the implications of these findings and what future work can be done to further understand the dynamic and interactive association of religion, marriage and health.

Previous Literature

The literature that informs this analysis has often looked at marriage and religion separately in their association with health. However, I seek to understand what the relationship is when both marriage and religion are included in the analysis. In this section, I will discuss some of the relevant literature, starting with a discussion of health. I will then discuss the literature that pertains to marriage and religion as well as other factors that have been found to be important for health

Health

Health is reported in different manners. One method of reporting is based on respondent diagnoses, whether a mental or physical ailment (Comstock and Partridge 1972; Berkman 1984; Crimmins and Saito 2001). However, it is common for researchers to use self-reported health as a measurement of health (Ellison 1991; Waldron, Hughes and Brooks 1996, Waldron, Weiss and Hughes1997; Hughes and Waite 2009). There are many factors that affect individuals' responses to health questions. When a person is asked if s/he is healthy, there are several types of health that may be evaluated in giving one broad, encompassing answer. Respondents are likely to always evaluate their physical health, although they may also evaluate their mental health and perhaps even their spiritual health. Self-reported health has been used by many researchers as a proxy for overall, general health, and has been deemed reliable in research on health (Ellison 1991; Waldron et al. 1996, 1997; Hughes and Waite 2009).

Just as there are factors that affect how a respondent answers a general health question, there are other, larger social factors that affect individual health (Manning et al. 2010; Hughes and Waite 2009; Waldron et al. 1996, 1997; Waite and Lehrer 2003; Crimmins and Saito 2001). Two of the factors that have been shown in previous research to have a significant effect on

health are religion and marriage. Other variables known to affect health and used frequently as controls are race, education, age, sex and income.

Marriage and Health

Studies have shown that while controlling for other factors, such as work status, education and sex, marriage has a positive effect on health (Waldron, Hughes, and Brooks 2009; Hughes and Waite 2009). Waldron, Hughes, and Brooks (1996) found that married women who were unemployed had better health than their unmarried and unemployed peers. They attribute this difference to the lack of not only financial but also social support that comes from both being married and interacting with others in the work place. Furthermore, Waldron, Hughes and Brooks (1996) conclude from their analysis that for women, having better health is in part due to being married and having higher family income.

Similarly, Hughes and Waite (2009) carried out an analysis using four different health measures, including self-reported health. They found that never married respondents reported significantly worse self-rated health than their married peers. Waldron, Hughes, and Brooks (2009) also found that married women had better health than not married women. Previously, they had found inconsistent results when controlling for family income; this suggests that, "income may account for part of the marriage protection effect" (Waldron, Hughes and Brooks 1996:120). They suggest that husbands providing increased income and social support contribute to the positive marriage effect. "It appears that either marriage or employment may provide important health promoting benefits, including increased income and social support" (Waldron, Hughes and Brooks 1996:120). Conversely, from this discussion, it could be expected that the group most vulnerable and likely to report bad health are single unemployed women.

Religion and Marriage

Previous work has shown that not only does a relationship exist between marriage and health, but also between marriage and religion. I begin the discussion of religion with the relationships that have been found between marriage and religion, since the purpose of the paper is to explore the effects of religion and marriage on self-reported health.

Several studies found that there is a positive correlation between being religious and being married (Uecker, Regeneus, and Vaeler 2007; Ploch and Hastings 1998; Sandomirsky and Wilson 1990). Wilcox and Wolfinger (2006) found that single urban mothers who attended church frequently were more likely to get married than those who attended church less regularly or not at all. Specifically, attending church regularly increased the chance of getting married by 63 percent (males by 95 percent and females by 40 percent). Married respondents are also least likely to report a decline in religious attendance/participation or apostasy (a total desertion of one's religion) (Sandomirsky and Wilson 1990; Uecker, Regeneus, and Vaeler 2007). Uecker et al. (2007:1684) suggest that "Marriage and religion are both commitments; [one] who is prone to make one commitment is also more likely to make the other." There is no need for concern of a bidirectional relationship[1] because "marriage continues to be associated with heightened religious commitment in early adulthood" (Uecker et al. 2007:1684). Religion, much like marriage, provides a sense of social stability for individuals (Comstock and Partridge 1972). Both marriage and religion are places where there are commonly shared beliefs, motives, influences, goals, and resources. These commonalities are shared and supported through religious involvement. Religious involvement is arguably the best empirical measure of

[1] Those who are religious may choose to marry at higher rates. This is also explored by Waldron, Weiss and Hughes (1997).

religious behavior which, as discussed in the next section, has been shown to lead to positive health.

Religion and Health

Religious participation, most frequently measured by attending religious services, has been shown to positively affect an individuals' health. "Attendance at worship services provides one place in which the interpersonal ties that are necessary for the exchange of spiritual support are forged" (Krause 2010:26). This effect has been explained by arguing that religious participation provides social support and promotes fundamental norms regarding health behaviors (Ellison 1991; Comstock and Partridge 1972; Waite and Lehrer 2003). Religious participants are part of a larger belief system. Many religions have beliefs, i.e., norms and practices that take a part in shaping the way members live their lives. Those who participate in religion are likely to be indoctrinated into the belief system. "Individuals may internalize strong religio-ethical norms; the prospect of violating these internalized religious norms may evoke feelings of guilt and shame or even fear of divine punishment" (Ellison and Levin 1998:704).

These beliefs and norms may also lead people to live healthier lives by dietary restrictions and discouraging such bodily abuses as smoking and drinking (Ellison and Levin 1998). Comstock and Partridge (1972) find that the relationship between religion, specifically religious attendance, and health is unclear and they do not interpret their results as causal because of other explanatory observations of church attendance and health. They note that some of the associations they find may be due to health affecting church attendance. However, Waite and Lehrer (2003) argue that both marriage and religion lead to positive outcomes by providing social support and integration that encourage healthy behavior and lifestyles.

Through religious attendance, whether this involves participation in social groups or functions, services, or prayer groups, norms and beliefs are reaffirmed for the individual. Through this continual interaction and support, religious participation makes religious beliefs, practices, and goals more commonplace in peoples' lives. "Religious persons may alter their lifestyles to make them consistent with those of reference group members, persons they consider worthy of emulation" (Ellison and Levin 1998:704). Conversely, there are religious participants that do so for the purpose of avoiding the fear and threat of embarrassment and possible social sanctions for not attending (Ellison and Levin 1998).

Social Support

As the literature thus far has indicated, religion and marriage are both seen as forms of social support in the discussion of health outcomes. In the theory of social support there are two types of support that are discussed: perceived and received. Others have referred to these support types as: socio-emotional support and instrumental support, respectively (Ellison and George 1994). Perceived support is the support that an individual identifies as having available to him/her through the interactions and/or networks s/he shares with people or groups (Lakey and Cohen 2000). Perceived support is not tangible support, it is potential tangible support that people are confident exists, and if a moment were to arise the support would be activated. On the other hand, received support is the support that is tangibly received by an individual from a person or a group (Lakey and Cohen 2000).

In the context of social support, being married has been shown to provide individuals a support system of coping in times of mental and physical illness (Waite and Lehrer 2003). For unemployed women, the support of their husband's income is often hypothesized under the theoretical view of the 'marriage protection effect' (Waldron, Hughes and Brooks 1996).

Similarly, religious institutions provide an opportunity and place to initiate friendships that can be expanded to more secular social contexts (Ellison and George 1994). Ellison and George (1994) find that those who attend church services more frequently have larger nonkin networks than their non-attending peers. Because of their larger social support network, "Frequent churchgoers benefit from a wider array of supportive transactions than do their less religious counterparts, including instrumental support and socio-emotional support. (Ellison and George 1994:57). Church members may provide informal socio-emotional support to their fellow church goers, boosting morale through confiding and companionship; they may also provide instrumental support through visitations to shut-ins, comfort for the bereaved, and in other ways (Ellison and Levin 1998).

Control Variables

Although religion and marriage are expected to both have strong effects on health outcomes, they are not the only factors that have been shown to affect health. In this section, I briefly discuss additional variables that have been shown to affect health. These variables will be included in the models in order to assess the net effects of marriage and religion—the two variables of interest in this paper—on health outcomes.

Education. Education has often been used in the previous literature as the measure for SES instead of income (Hughes and Waite 2009). Although education is a strong predictor of income, when it comes to health, the actual knowledge attained by education is as strong a predictor on health outcomes as SES. Crimmins and Saito (2001) found in their work that persons with more years of education live more of their life healthier than their less educated peers. Men ages 30-34 and with a grade school education are three times more likely to have a

disability than those with some college. Similarly, black women of similar age and education are four times as likely to have a disability than are those with more education.

In addition, Crimmins and Saito (2001) also found that highly educated black men and women can expect approximately 16 more years of healthy life than less educated black men and women. Similarly, Walseman, Geronimus, and Gee (2008), using the theoretical arguments of such people as Bourdieu, Passeron, and Dannefer, found "that (1) greater educational advantage in youth is associated with lower probabilities of health-induced work limitations in adulthood and later onset of health-induced work limitations, (2) the health gap between those with greater versus fewer educational advantages widen with age, and (3) the magnitude of the racial health disparities over the life course is modified by educational advantage" (192).

Income. Waldron, Hughes and Brooks (1996) found that income plays a role in the marriage protection effect; they see income as a health promoting benefit that is attributed to being married, especially for unemployed women. Yet, unlike the other controls, income has not been observed to explain the differences of sex, race or education in self-reported health outcomes. Waldron, Hughes and Brooks (1996) observed inconsistent results when they added income to the model. Although not discussed in this literature, income may also better explain health because of the affordability or ease of access to health insurance and health care services.

Sex. In addition to the effects of education and income on health, there are some health differences by sex. Regarding hypertension, Geronimus et al. (2007) found that estimated male-female relative odds of being hypertensive favored women at younger ages. However, as women age this begins to revert itself; for whites this relationship crossed at age 65 and for blacks at age 55. In the literature, there are very few significant health differences found between men and women. Studies that report health outcomes separate for men and women frequently do so for

the purposes to explain age and racial health differences. (i.e., Geronimus et al. 2007; Crimmins and Saito 2001; Waite and Lehrer 2003)

Race. Race is another factor that has been shown to explain health differentials. Blacks have been found to have higher hypertension rates than whites (Geronimus et al. 2007). The black-white differences in hypertension increase with age. For instance, Geronimus et al. (2007) find that whites and blacks reach the same probability of hypertension at ages 64 and 50 respectively. Similarly, Fuller-Thomson et al. (2009) find in their analysis that blacks had significantly higher odds of functional and activities of daily living (ADL)[2] limitations than whites.

All four of these control variables are important factors when studying health differences. All four have been shown to have an affect, with education being the most important (Crimmins and Saito 2001; Waite and Lehrer 2003). Education is the factor that helps to shrink racial health differences, with highly educated individuals health being better than those who are less educated. Thus, it is important to control for these variables in order to identify the net effects of marriage and religion on health.

From this discussion, it is hypothesized that religion and marriage both have positive associations with health outcomes. However, I also hypothesize that these two variables are independent of one another, i.e., that neither has an interactive or causal effect on the other when they are introduced into the model. The literature discussed above leads to no potential theoretical argument that religion and marriage have an interactive or causal effect on one another.

[2] Functional limitations are conditions that compromise physical functioning that may be interpreted as more organic in nature, whereas activity of daily living (ADLs) are any physical, mental, or emotional condition that impairs daily functioning.

Data and Methods

Data

Demographic, religious, and health data used in this analysis come from the first, and currently only, wave of the Panel Study of American Religion and Ethnicity (PS-ARE)[3] (Emerson and Sikkink 2006). The study interviewed 2610 participants between April and October 2006, oversampling Asians (177), Hispanics (520) and African Americans (528) (see Table 1)[4]. I chose this dataset for my analysis because of its strength in helping to "understand the impact of religion in everyday life, and ultimately the connections between religious change and other forms of change in individuals and families over the course of their lives and across generations" (Emerson and Sikkink 2006). The variables for my analysis have been chosen on the basis of the literature discussed above.

Dependent Variable. The dependent variable in this analysis is self-reported health. Self-reported health has been determined the best variable for evaluating the effects of religion and marriage on health. As discussed above, several works find that marriage and religion both have effects on mental and physical health. Interviewees were asked, "Would you say your health in general is excellent, very good, good, fair, or poor?" It is coded from five (excellent) to one (poor).

Independent Variables. The independent variables of interest for this analysis are indicators of religiousness and marital status. The religiousness variable used is: attendance, coded one (never) to eight (three or more time a week). Marriage was broken into four dummy variables, 'married' (used as the reference category), 'partner', 'widowed/divorced/separated', and 'never married.' I combined the three categories, widowed, divorced, and separated,

[3] This study is also known as the Portraits of American Life Study (PALS).
[4] There are an additional 190 participants that are categorized as 'other' race/ethnicity.

Table 1: Descriptive Statistics

Variables	Mean	SD	Min	Max	*n*
Dependent Variable					
Self-reported Health	3.43	1.14	1	5	2602
Independent/Control Variables					
Religion					
Frequency of attendance	3.66	2.22	1	8	2603
Would you like to attend services more or less often	3.53	1	1	5	2532
Marriage					
Married◆	0.46	0.50	0	1	2610
Partnered	0.07	0.26	0	1	2610
Widowed/divorced/separated	0.22	0.41	0	1	2610
Never married	0.25	0.43	0	1	2610
Race					
White◆	0.48	0.50	0	1	2610
Black	0.20	0.40	0	1	2610
Hispanic	0.20	0.40	0	1	2610
Other	0.12	0.32	0	1	2610
Education					
Highest completed degree	13.46	2.65	10	22	2542
Income	8.35	4.46	1	16	2330
Age	43.60	16.39	18	80	2610
Female	0.59	0.49	0	1	2610

Notes: ◆ Reference category.
SD = standard deviation. Max = maximum value. Min = minimum value.
n = valid number of cases.

because each of these categories is an immediate indicator that they have been married at least once before and each carries similar stresses when a marriage ends.

Control Variables. The control variables used for this analysis are standard demographic variables: age, gender, race, years of education and income. Age is measured in years. Gender was coded as female (1) and male (0). Race was expressed in four dummy variables: black, Hispanic, and other, with white as the reference category. Years of education was recoded: less than high school diploma = 10; high school diploma/GED = 12; vo-tech/associates/2 year religious = 14; bachelor = 16; masters/master of divinity/professional degree = 18; doctorate = 20; and other as system missing. This variable was chosen as a proxy for socioeconomic status (SES) because it represents the best indicator of SES across age and over time (Crimmins and Saito 2001). Similarly, Hughes and Waite (2009) used education as the measure for SES instead of income or other variables. However, I also chose to include income in the model because of its identified role in marriage protection, as previously described. The last of the control variables is if the respondent would like to attend religious services more often, coded 'more often' (5) to 'less often' (1).

Analytic Strategy

The statistical method used for this analysis is OLS regression. Three models will be employed to estimate the effects of religion and marriage on self-reported health. The first model will estimate the effect of marriage on self-reported health, followed by a test of the effect of religion on self-reported health. The final model will include both marriage and religion in the estimation. By comparing the marriage coefficients from Models 1 and 3, as well as the religion coefficients from Models 2 and 3, it will become apparent whether religion or marital status is the more important factor explaining variations in health. If the coefficients for

marriage and religion remain relatively unchanged in the respective models, then there is an independent relationship between each of the independent variables and the dependent variable, self-reported health.

However, before the models can be tested, the data must be weighted. "Weighting is used to offset known biases, such as non-response, which can vary for different sub-groups of the population" (Emerson and Sikkink 2006). A weight (PAWT2) is provided in the data set and was derived from an analysis of the Census Bureau's American Community Survey, 2006. For this analysis, the weight is executed to correct for oversampling of regarding race, gender and household size.

Results

Regarding race across models, 'Hispanic' and 'other' have negative and significant (at the P<.05 and P<.001 levels respectively across all models) associations with self-reported health. Blacks show no significant differences to their white peers. As expected, income and education both have positive and significant effects , and age has a negative significant effect on self-reported health at the P<.001 level across all models. Also, female is insignificant across all models. In sum, the results for the control variables suggest that those who are young, highly educated, and more affluent report having the best health.

Model 1 presents the ordinary least square (OLS) regression of the independent variable marriage, controlling for race, income, education, age, and sex. This model explains 19 percent of the variation of the dependent variable, self-reported health. It is observed that only those who are cohabitating report having worse health (see Model 1, Table 2) than their married counterparts. From the literature, it was expected that all marital-status variables in the model would show a significant negative relationship on self-reported health when compared to being married. Yet those who are 'widowed, divorced, separated' or 'never married' have no significant health difference from those who are 'married'.

In Model 2, I replace the marriage variables with religion. This model explains slightly more variation (19.1 percent) in the dependent variable than does Model 1 that includes marriage. As predicted, religion is both positive and significant at the P<.001 level. This result tells us that individuals who are religious, white or black, educated, with a good income, and young are the healthier subgroup of the population.

When both independent variables are entered into the model (see Model 3) there are a few minor observed differences. Nonetheless, all variables maintain their direction and

Table 2: Regression of Self-reported Health as Influenced by Education, Income and Religion

	Model 1		Model 2		Model 3	
	b	B	b	B	b	B
Frequency of attendance to worship services			.034***	.069	.033***	.066
			(.010)		(.010)	
Partner	-.204*	-.047			-.181*	-.042
	(.086)				(.086)	
Widowed/divorced/seperated	.049	.016			.056	.019
	(.065)				(.064)	
Never married	.117	.041			.120	.043
	(.064)				(.064)	
Black	.039	.011	.028	.008	.014	.004
	(.071)		(.071)		(.071)	
Hispanic	-.137*	-.040	-.165*	-.048	-.157*	-.046
	(.068)		(.068)		(.068)	
Other	-.292***	-.071	-.303***	-.074	-.307***	-.075
	(.080)		(.080)		(.080)	
Income	.058***	.229	.054***	.215	.058***	.228
	(.006)		(.006)		(.006)	
Education	.099***	.216	.099***	.214	.097***	.210
	(.010)		(.010)		(.010)	
Age	-.016***	-.232	-.017***	-.251	-.017***	-.242
	(.002)		(.001)		(.002)	
Female	.028	.012	.012	.005	.009	.004
	(.043)		(.043)		(.043)	
Would like to attend services more	-.014	-.012	-.027	-.023	-.024	-.020
	(.023)		(.023)		(.023)	
Intercept	2.351		2.397		2.344	
Adjusted R square	.190		.191		.194	
N	2219		2219		2219	

* P<.05 ** p<.01 *** p<.001

significance from Models 1 and 2. Cohabitating remains significant at the P<.005 level and the coefficient slightly decreases (-.204 in Model 1 and -.181 in Model 3). Similarly, religion maintains its significance with a slight drop in the coefficient (.034 in Model 2 and .033 in Model 3).

The variable, 'Would like to attend services more' was added to test the concern of there being a group of respondents who may be unable to attend religious services because of health. If this were the case, this variable would have been significant. By including this variable, its results dismiss any concern that people do not attend religious services because of their health.

Discussion and Conclusions

This paper investigates how religion and marriage jointly have an effect on self-reported health. Just as previous research had found, this analysis shows that those who are married, as well as those who are religious, report better health than do those who are cohabitating or not religious. Individuals who are young, white, educated, make a good salary, and are married and/or religious have much greater health than those who fall into the other demographic categories. However, there are a few points in the findings that do not fit the expectations informed by the literature.

The most surprising findings were that 'widowed/divorced/separated' and 'never married' categories were not significant. Only those who are cohabitating have significantly worse health than those who are married. I speculate that the majority of never married respondents are young adults who are physically healthy and do not carry the particular stresses of being married or married with children. The most surprising result was 'widowed/divorced/separated' being insignificant. These are the categories that according to the literature and social support theory would be most vulnerable to having negative health results. The only explanation I can give is the majority of respondents who are categorized in this group are either male or they are mostly older individuals who have good paying jobs or accumulated wealth and either have no children or adult children.

Based on the literature, it is expected that those who are religious are more likely to get married, and this marriage may intercede on the relationship between religion and health. However, in this analysis neither religion nor marriage has much of an overlapping or joint effect on one another. This analysis does not indicate that religion or marriage intercedes the effect of the other variable, respectively, on self-reported health. The changes in the coefficients from

Models 1 and 2 to Model 3 are minimal (see Table 2). This implies that marriage and religion have independent effects on self-reported health. There is no evidence of a cause-and-effect relationship between religion and marriage in the context of their respective effects on self-reported health.

According to the literature on the theory of social support that is commonly used to explain the effects of religion and marriage on health, never married and widowed, divorced or separated should have a significant, negative effect on self-reported health. Those who are 'never married' do not have the social support that those who are married experience. Similarly, it would not be expected that those who are widowed, divorced or separated had lost the social support that marriage provides, and may have otherwise been positively impacting their health.

Because of the unexpected findings of marital status I further investigated this issue by creating two additional variables: a per-capita-income variable (by dividing income by the number of persons living in the household), and I dummied education as college degree or higher and less than college. These variables replaced education, previously used as a continuous variable by years of education, and spread income out across household. The variable "number of persons living in the household" is added to the model as a control as well.

As a result of this further investigation, I found that education has more of an effect on health than does income. This model does not change the initial findings that marriage and religion are independent of one another. What does change, and what might lead to further investigating, is that the marriage variables 'partner', 'widowed/divorced/separated', and 'never married' in the full model are negative. Most importantly, they are statistically significant except for 'never married'. It is possible that those who have never married are more likely to have a

Table 3: Regression of Self-reported Health as Influenced by Education, Income and Religion

	Model 1		Model 2		Model 3	
	b	B	b	B	b	B
Frequency of attendance to			.044***	.089	.041***	.082
			(.010)		(.010)	
Partner	-.285***	-.067			-.256**	-.060
	(.087)				(.087)	
Widowed/divorced/seperated	-.180**	-.060			-.170**	-.056
	(.064)				(.064)	
Never married	-.040	-.014			-.036	-.013
	(.065)				(.065)	
Black	-.003	-.001	-.050	-.014	-.031	-.009
	(.072)		(.071)		(.072)	
Hispanic	-.203**	-.059	-.243***	-.071	-.224***	-.066
	(.070)		(.070)		(.070)	
Other	-.252**	-.061	-.271***	-.066	-.272***	-.066
	(.081)		(.081)		(.081)	
Per-capita-income	.097***	.230	.100***	.237	.098***	.233
	(.011)		(.011)		(.011)	
Education: college or more	.465***	.210	.462***	.209	.453***	.233
	(.047)		(.047)		(.047)	
Age	-.018***	-.256	-.019***	-.268	-.019***	-.269
	(.002)		(.001)		(.002)	
Female	.019	.009	-.020	-.009	-.003	-.001
	(.044)		(.044)		(.044)	
Number living in household	.064***	.088	.076***	.104	.064***	.082
	(.018)		(.018)		(.010)	
Would like to attend services	-.013	-.011	-.026	-.022	-.025	-.021
	(.023)		(.023)		(.023)	
Intercept	3.603		2.397		3.555	
Adjusted R square	.173		.191		.179	
N	2219		2219		2219	

* P<.05 ** p<.01 *** p<.001

college degree or higher and have larger incomes. Similarly, they are more likely to be living alone.

The present analysis fills a void in the literature regarding the effects of religion and marriage on health. The answer for the questions asked in this paper confirm what others have found on how religion and marriage individually have an effect on health. However, this present study answers a question not yet investigated: do religion and marriage intercede on one another in their effects on self-reported health? Again, the observed change between the significant marriage and religion variables from Models 1 to 3 and Models 2 to 3, respectively, is not large enough to indicate that either intercedes on the other regarding their effects on self-reported health. This indicates that marriage and religion have an independent effect on self-reported health.

This paper does not address concerns of specific health outcomes such as physical health. The use of specific physical health factors, such as specific illness or disease diagnoses, may provide an explanation of how being religious or married via dietary or risk evasion behaviors may effect health. A pre-test was run early on for this research to create a health index from a series of physical health diagnosis. However, the diagnoses of variables available in the data set whowed that the sample was skewed, with more respondents not having been diagnosed. Similarly, this study also does not look at specific religious or denominational differences.

Another limitation of the data used is the lack of a more detailed marital breakdown. The marital status break down is limited to those who are married, living with a partner, widowed/divorced/ separated and never married. This does not allow for separating those who have been married more than once from those who have been married only once. This is a sub-group that may potentially have differing self-reported health from other martial status groups.

Other directions this research can take besides those mentioned above are to investigate geographic regional differences of health. This would also add to the discussion of the effects of religion and marriage on self-reported health. Intuitively, it could be expected that regions that have a strong religious culture would have higher rates of marriage and potentially have better health scores.

Finally, the present analysis suggests and supports previous literature that marriage and religion are forms of social support. It is through social support systems that marriage and religion are found to have positive effects on self-reported health outcomes. Because of the independence found in religion and marriage on self-reported health, including them in social support indices, or in models such as these, is imperative to the theoretical understanding of social support systems.

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Vita

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