Does Religion Buffer the Effects of Discrimination on Mental Health? Differing Effects by Race

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Much research has shown that experiences of discrimination are negatively related to mental health. In this study, a national probability survey of whites and African Americans at midlife is used to examine whether attendance at religious services and religious comfort seeking protect people from the effects of discrimination on mental health, and if the protective power of religion varies by race. Results show that reports of discrimination are related to greater negative affect and less positive affect, but only attendance at religious services moderates this relationship, and then only for African Americans' negative affect. The historical involvement of African-American religious bodies in combating discrimination may help to explain the specificity of these moderating effects.

Introduction

Discrimination is one of the most pervasive problems in contemporary American life. Despite 40 years of civil rights legislation, discriminatory acts continue to saturate American society. This is indicated by a wealth of studies showing discrimination based on a number of characteristics, including race, age, gender, and sexual orientation (Coleman 2003; Horvath and Ryan 2003; Mueller, Mutran, and Boyle 1989; Page 1998; Solberg 1999; Squires, Friedman, and Saidat 2002; Yinger 1998). For its victims, the persistent nature of discrimination can be quite stressful, and the cumulative toll of this stress is reflected in a number of studies showing that increased exposure to discrimination is associated with increased risk for mental health problems (for a review, see Williams, Neighbors, and Jackson (2003)).

There have been and continue to be efforts to stem discrimination, and one major source of these efforts can be found in religious institutions. Especially within the African-American community, religious bodies have a history of aiding efforts to battle discriminatory laws and practices (Baer and Singer 1992; Lincoln and Mamiya 1990; Morris 1984). However, while the history of the effects of efforts by religious bodies and institutions from a *macro-level* context is well researched, there is surprisingly little research examining whether religion helps people in their *individual* efforts to resist the negative effects of discrimination. Given the research showing the deleterious effects of discrimination on mental health, this is an important question to ask. Therefore, in this article, I examine whether religious involvement helps prevent the negative effects of discrimination on mental health.

Discrimination as a Chronic Stressor

Broadly speaking, researchers in the sociology of mental health divide stress-causing factors into two categories. The first are *negative life events,* which, although traumatic, are discrete in nature, such as the death of a spouse or loss of a job; the second category of stressors are considered

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chronic because they are more longstanding or frequent (Wheaton 1999). One example of chronic stress is a lack of financial resources, and, as Pearlin points out, a stressor such as this can have powerful effects on mental health because it is "a condition that can condemn people to a grinding life of uncertainty and fear" (1999:399). The effects of chronic stressors are often quite pernicious because their consistency has a wearing effect on mental health and well-being.

Another stressor that may also affect mental health through its cumulative, wearying process is discrimination. The stress caused by specific discriminatory events, such as being denied housing or a promotion, should not be underestimated, but what may be far more frequent and persistent are slights that occur at an interpersonal level during daily interactions. However subtle they may be, the cumulative effect of derisive or discourteous experiences due to discrimination may cast a heavy strain over an individual's everyday life, leading to an increased risk for mental health problems. This is well demonstrated in research showing not only that measures of experiences of chronic discrimination are significantly and negatively related to mental health, but that these measures often are more powerful predictors of mental health than aggregates of specific discriminatory events (Kessler, Mickelson, and Williams 1999; Mossakowski 2003; Williams et al. 1997). It is for this reason that chronic or everyday discrimination is examined in this research.

Religion as a Buffer for Chronic Stressors

In the past several years, a wealth of research has shown a *direct* effect of religion on mental health (Hackney and Sanders 2003; Koenig and Larson 2001). Less well studied, though, is the role of religion in protecting against the negative effects of stressors on mental health (Wink, Dillon, and Larsen 2005), a process called a "buffering" effect (Wheaton 1985). Furthermore, research on religious buffering has studied a variety of dimensions of religiosity and a number of chronic stressors with surprisingly inconsistent results. For instance, some have found that a composite measure of religiosity buffers the effects of chronic health problems on depression (Wink et al. 2005), while others have shown that neither prayer nor religious attendance buffers the effects of health problems on mental health, but belief in eternal life does provide a buffering effect (Ellison et al. 2001), and still others have found that attendance at religious services buffers the effects of health problems on psychological distress (Williams et al. 1991). Similarly, belief in eternal life has also been shown to buffer the effects of financial strain on mental health (Ellison et al. 2001), while others have found that praying and seeking comfort through religion buffers financial strain, but only for women (Wang and Patten 2002). Strawbridge et al. (1998) found a more distinctive pattern to these effects, as both public and private forms of religiosity were shown to protect against stressors that were not associated with one's family, but *exacerbated* the effects of *family* stressors on depression.

Since chronic discrimination is likely to originate from outside the family, this suggests that religion may indeed buffer the effects of this stressor. However, the degree to which specific aspects of religious involvement buffer the effects of chronic stressors appears to vary between studies and stressors. What is therefore needed is a more clear rationale for why religious buffering may occur specifically in the case of discrimination, including an identification of and explication for the particular aspects of religious involvement most likely to provide these buffering effects. I describe this rationale below in two parts—first, the causes and specific aspects of religiosity that may most likely facilitate these buffering effects for both African Americans and whites and, second, additional factors that may lead the buffering effects of religion to be stronger for African Americans than whites.

Religion as a Social and Psychological Resource in the Face of Discrimination

Researchers have identified a variety of psychological and social resources that may help explain the beneficial relationship between religious involvement and psychological well-being (for reviews, see George, Ellison, and Larson (2002) and Oman and Thoresen (2002)). Several

of these resources may contribute to religion's ability to buffer the effects of discrimination on mental health, as well as point to the aspects of religious involvement most likely to provide these buffering effects.

One of the most important of these is the social support resources that may accrue to individuals who are more involved in religious communities. Research has shown that increased involvement in religious services is associated with an increased level of both perceived social support and more objective measures, such as frequency of in-person and telephone contacts, and the size of the respondent's social network (Bradley 1995; Ellison and George 1994; Krause 2002a; Taylor and Chatters 1988). This may be important for buffering the effects of discrimination, because greater access to social support may both help people cope with the stress of discrimination and facilitate behavior addressed at stopping or lessening discriminatory actions themselves.

In addition to social resources, research also indicates that increased involvement in religion bolsters individuals' willingness to forgive. While forgiveness does not mean that one must tolerate mistreatment, an increased willingness to forgive could help individuals to let go of the anger and resentment that may arise from experiences of discrimination and lead to mental health problems. Both attendance at religious services and a factor analytically derived "personal religiousness" component have been related to measures of willingness to forgive (Gorsuch and Hao 1993; Krause and Ellison 2003). This suggests that not only being involved in a religious community, but also privately turning to religion as a means of comfort when faced with discrimination, may lead people to be more likely to forgive their tormentors, with possible consequent mental health benefits.

Religious involvement may also be important because it offers religious-specific coping resources, although research differentiates between the types of religious coping that individuals may use. Research has shown that *positive* religious coping, such as looking to a higher power for strength, can be beneficially related to mental health, but *negative* religious coping, such as expressing anger at a higher power, is detrimentally related to mental health (Koenig, Pargament, and Nielsen 1998; Pargament et al. 2001; Pargament, Koenig, and Perez 2000). Hence, religious comfort seeking may help buffer the effects of discrimination on mental health through religious coping, but this depends on the way in which an individual seeks comfort in religion. However, Krause et al. (2001) found that attendance at religious services is associated with use of positive religious coping, providing an additional reason why increased attendance at religious services may help buffer the effects of chronic discrimination on mental health.[1]

Differences in the Buffering Effects of Religion by Race

Religious involvement may buffer the effects of discrimination on mental health more strongly for African Americans than whites. This may be due in part to the role religion has played in African Americans' struggle against discrimination. Historically, black churches and members have been heavily involved in civil rights and other social justice movements (Dressler 1991; Lincoln and Mamiya 1990). This emphasis continues today, as Baer and Singer (1992:236) conclude in their study of African-American religion in the 20th century: "African-American religion has retained and developed a firm emphasis on resisting, at both the individual and collective levels, the ugliest expressions of racist ideology and behavior." Similarly, McRoberts (2003:100) states in his recent ethnographic study of a predominantly African-American religious district that "[n]early all of the clergy felt that their churches had to leave an indelibly positive imprint on the world and could therefore be called 'activist'." This legacy means that, even well past the 1960s, there is a stronger emphasis on social justice in African-American than to predominantly white congregations, as African-American congregations are more involved in civil rights activities and serving disprivileged segments of their respective surrounding communities (Chaves and Higgins 1992).

From an individual-level perspective, research suggests that the greater focus of African-American churches on combating discrimination may provide parishioners with coping resources in the face of discrimination that are not available in predominantly white religious bodies. Some African-American churches include specific mention of historical instances of suffering during worship services, as well as opportunities for "members of the church to recount sources of suffering," in which calls of "amen" or "tell Jesus" by other parishioners serve as "a communication to fellow members that they understand their troubles" (Gilkes 1980:33–34). Importantly, in some cases, these opportunities may take a specific form of "locating the persecutor," in which "not only are prayers offered up against the offender, plans of action may be formulated to change the offending behavior" (Gilkes 1980:35).[2] The power of African-American religious services to provide support and foment individual change is also shown in reports by parishioners who "ascribe to the service both a sense of group closeness and a conviction that they could help other worshipers while there" (Griffith, Young, and Smith 1984:466; see also Griffith, English, and Mayfield 1980). That these social support resources may be more specific to African-American churches is also suggested by research among older parishioners indicating that church-based social support tends to be greater for African Americans as compared to whites (Krause 2002b). Thus, African Americans may have more religious resources to help them gain social support in the face of discriminatory behavior, and also enact behavior to change the stressor. Moreover, while these resources may have originally come about in part due to the effort against racial discrimination, their utility is less restrained, and may be used for a variety of experiences of discrimination. As Gilkes points out, "the right to 'tell God about our troubles' means just that—ALL of our troubles" (1980:35; emphasis in original).[3]

A second reason the buffering effects of religious involvement on discrimination may differ by race is because religious leaders may play a very different role in the mental health care of African Americans and whites. This is indicated by research showing that African-American pastors are more heavily involved in counseling their congregants than some white pastors (Mollica et al. 1986), and that when clergy are African Americans' first professional contact for dealing with emotional problems, they are less likely to seek help from other professionals (Neighbors, Musick, and Williams 1998).[4] Research has also shown that emotional support provided by ministers is positively related to the self-esteem of older African-American parishioners, but not aged white parishioners (Krause 2003). This suggests that, when they provide support to their congregants, African-American religious leaders may also be more effective at attending to the mental well-being of their parishioners than white religious leaders, possibly because white parishioners are more likely to be receiving professional help from nonreligious sources than African-American parishioners.

In sum, results of these studies clearly suggest that religious involvement may better aid African Americans not only because African-American religious bodies are more likely to be oriented to issues of discrimination, but also because these bodies are more likely to offer social support in the face of discrimination.[5] This support may be provided by other members during a religious service, or by religious leaders who are more likely to provide counseling to African Americans. This suggests not only that attendance at religious services may be a more efficacious buffer for African Americans than whites, but also that the stronger emphasis on discrimination and social justice in the black community, along with the greater role of black religious leaders in mental health counseling, will mean that African Americans who seek comfort in religion will find greater resources than whites to buffer the effects of discrimination on mental health.

Methods

Data

Data for this analysis come from the National Survey of Midlife Development in the United States (MIDUS) (Brim et al. 1996). The MIDUS is a large ($N = 3{,}032$) probability survey that

was conducted in 1995 of noninstitutionalized, English-speaking adults aged 25–74 living in the coterminous United States. Data for the MIDUS were gathered at two separate times. Respondents were initially contacted by telephone through random-digit dialing and were asked a short series of questions in an interview that lasted an average of 30 minutes. Within a week of the telephone stage of the survey, subjects were mailed a longer and more detailed questionnaire that took an average of two hours to complete. All respondents were given $20 with the mailed questionnaire, as well as a boxed pen. Furthermore, one-fourth of the households was randomly designated during the telephone stage of sampling for an additional financial incentive ($100) if they refused the telephone or mail survey. It is estimated that the response rate for the MIDUS was 70 percent for the telephone interview, 86.8 percent for the completion of the main questionnaire among the telephone respondents, and 60.8 percent for the overall response rate. Because race is a focal point of this article, and there were a small number of minorities who were not African American in the sample, this analysis is limited to whites and African Americans (unweighted $N = 2{,}581$ whites, 201 blacks). Weights included in the MIDUS correct for biases in the sample, including race, so all analyses use weighted data.[6]

Measures

Dependent Variables

Negative and Positive Affect: Scales of positive and negative affect were used to measure mental health. The negative affect scale included measures of anxiety, depression, and appraisals, and can be thought of as an indicator of "nonspecific psychological distress" (Kessler, Andrews, and Colpe 2002; Mroczek and Ameida 2004). In part, the usefulness of this measure is derived from the fact that, even though mental illness is conceptualized to include a broad array of disorders, mental dysfunction is usually reflected in a core number of symptoms, which this scale was designed to reflect (Kessler, Andrews, and Colpe. 2002). This measure is therefore useful for gauging overall levels of mental dysfunction. The negative affect scale contained six indicators of distress—"so sad nothing could cheer you up," "nervous," "restless or fidgety," "hopeless," "that everything was an effort," and "worthless"—and respondents indicated how often in the past 30 days they had experienced each of these on a scale of 1 (all the time) to 5 (none of the time).

Positive affect was measured using the same 30-day format and response range, but the items included "cheerful," "extremely happy," "calm and peaceful," "satisfied," "full of life," and "in good spirits." This can be seen as a measure of "positive emotional experience" or "emotional well-being" (Consedine, Magai, and King 2004:49; Keyes 2002:211). Hence, positive affect indicates the degree to which an individual is imbued with vigor and contentment, providing a useful gauge of an individual's optimal functioning, as opposed to the dysfunction measured by negative affect. While these types of affect may be related, one is quite clearly different from another, and research consistently demonstrates that positive and negative affect are distinct aspects of psychological health (Watson, Clark, and Tellegen 1988; Watson and Tellegen 1985). This was confirmed using the MIDUS data, as items for each scale loaded on a separate component in a varimax-rotated principal components analysis.

For both scales, all responses were reverse coded, so that higher values indicated greater negative or positive affect. Responses were summed separately for each scale, with nonrespondents dropped before the responses were combined. The scales had alpha coefficients of 0.87 for negative affect and 0.91 for positive affect.

Independent Variables

Religious Involvement: Attendance at religious services was measured using one question: "How often do you usually attend religious or spiritual services?" Responses ranged from 1 (more than once a week) to 5 (never) with all responses reverse coded. Religious comfort seeking was

measured with one question that measured the frequency with which individuals turned to religion during times of trouble. This question asked: "When you have problems or difficulties in your family, work, or personal life, how often do you seek comfort through religious or spiritual means, such as praying, meditating, attending a religious or spiritual service, or talking to a religious or spiritual advisor?"[7] Responses ranged from 1 (often) to 4 (never) and all responses were reverse coded.

Discrimination: Chronic discrimination was measured using a list of nine daily experiences. Respondents were asked: "How often on a day-to-day basis do you experience each of the following types of discrimination?" The items included, "You are treated with less courtesy than other people," "You are treated with less respect than other people," "You receive poorer service than other people at restaurants or stores," "People act as if they think you are not smart," "People act as if they are afraid of you," "People act as if they think you are dishonest," "People act as if they think you are not as good as they are," "You are called names or insulted," "You are threatened or harassed." Respondents indicated the frequency they experienced each treatment from a scale of 1 (often) to 4 (never) with all responses reverse coded so that higher scores indicated a greater frequency of experiencing discrimination. Responses were summed to form a scale of chronic discrimination, with nonrespondents to any of the items dropped before the responses were combined. Following previous practice using this scale on the MIDUS (Ryff, Keyes, and Hughes 2003), because there were few summed responses above 24, summed responses above 24 were recoded as 24. Alpha coefficient for the scale was 0.93.[8]

Race: Race was measured by asking respondents to state their self-identified race, and coded as a dichotomous variable so that African Americans were the higher value.

Control Variables

Physical Limitations: Previous research has shown that religious attendance and involvement in religious activities are linked with individuals' health-related physical limitations (Ainlay, Singleton, and Swigert 1992), suggesting that part of the relationship between religion and mental health may be due to a situation where individuals with poorer health are less able to be involved in religion. To account for this possibility, a nine-item scale was used to control for physical limitations due to health. Respondents were asked: "How much does your health limit you in doing each of the following?" Items included "Lifting or carrying groceries," "Bathing or dressing yourself," "Climbing several flights of stairs," Bending, kneeling, or stooping," "Walking more than a mile," "Walking several blocks," "Walking one block," "Vigorous activity (e.g., running, lifting heavy objects)," and "Moderate activity (e.g., bowling, vacuuming)." Responses ranged from 1 (a lot) to 4 (not at all), with all responses reverse coded. Responses were summed to form a scale of physical limitations, with nonrespondents to any of the items dropped before the responses were combined. Alpha coefficient for the scale was 0.92.

Denominational Affiliation: Respondents to the MIDUS could indicate denominational affiliation using a 46-item list of denominations, and this list included both Christian and non-Christian denominations. To reduce this list to a usable number of categories, Smith's (1990) classification system of fundamentalist/mainline/liberal was used to classify Protestant denominations.[9] The result was a series of dummy variables—liberal Protestant, fundamentalist Protestant, Catholic, Jewish, other, and atheist/agnostic/none—with mainline Protestant as the comparison group.

Geographic Location: Since some research indicates that the effect of religion on mental well-being may vary by geographic location (Ellison and Gay 1990), controls were also included for area of the country in which the respondent lived. Using a four-category variable included in the MIDUS data set, a series of dummy variables was included in the analyses: midwest, west, and south, with northeast as the reference group.

Demographic Variables: Several standard background variables in health research were also controlled. These included income and education, as well as gender and martial status. Marital status and gender were both coded as dichotomous variables. Education was measured on a scale of 1 (no school/some grade school (1–6)) to 12 (PhD, Ed.D, MD, DDS, LLB, LLD, JD, or other professional degree). Respondents were asked to indicate their income using a scale of 39 categories of income, from less than $0 (loss) to $1,000,000 or more. Respondents were asked about six different types of income: personal earnings, spouse's or partner's personal earnings, other family members' earnings, Social Security retirement benefits, government assistance, and other family income. Responses for each question were assigned the midpoint for the income category, and the responses for the six items were summed. Several people did not respond to one or more of the six income questions, though, and, for these cases, on five of the six questions I imputed income by using the mean income for the respondent's level of education. The only exception to this was for the item on Social Security income, for which mean income for age rather than level of education was used. Furthermore, to avoid outliers unduly influencing data analyses, all respondents whose combined income was at or above the 95th percentile (greater than $185,000) were reclassified to have $185,000 in income. Means and standard deviations for all variables are listed in Table 1, both for the sample overall and separately by race.

Results

Bivariate Analyses

Zero-order correlations for the main variables of interest are presented in Table 2. The virulent effects of discrimination are quite clear, as discrimination is significantly ($p < 0.001$) and harmfully related to both measures of mental health. Chronic discrimination is also related to religious comfort seeking; possibly, this may be due to race, as these analyses show that African Americans report a higher degree of discrimination and African Americans are also more likely to seek religious comfort during times of trouble. African Americans also attend religious services more regularly than whites. In addition, as has been shown in previous studies, religiosity is beneficially related to both measures of mental health, although these benefits appear to extend from religious attendance. This does not, however, discount the possibility that religious comfort seeking may moderate the relationship between discrimination and mental health, and I examine this possibility below.

Multivariate Analyses

Table 3 presents the results of OLS regression analyses. For each outcome, three models are presented. The first, the main effects model, examines the effects of discrimination, religious attendance, religious comfort seeking, and race, independent of the control variables. The second model includes an interaction between religious attendance and discrimination, and the third model includes an interaction between religious comfort seeking and discrimination. A significant interaction indicates that the religion variable moderates the effects of discrimination on the mental health outcome under consideration in the model.[10] These interactions are tested separately to avoid multicolinearity biasing results. In addition, to further guard against multicolinearity, perceived discrimination and all continuous religion variables were centered over their respective means prior to the creation of interaction terms (Aiken and West 1991).

In both of the main effects models, discrimination continues to significantly ($p < 0.001$) affect mental health. In addition, attendance remains significantly and beneficially related to both aspects of mental health, although the significance of the relationship with negative affect is reduced somewhat from the bivariate analyses, and ancillary analyses showed that this reduction

TABLE 1
MEANS AND STANDARD DEVIATIONS FOR ALL MEASURES USED IN ANALYSES

	Range	Whites	African Americans	Overall
Negative affect	6–30	9.478	9.285	9.456
		(3.822)	(3.907)	(3.831)
Positive affect	6–30	20.082	20.899	20.178**
		(4.451)	(4.439)	(4.456)
Chronic discrimination	9–24	12.503	18.381	13.183***
		(4.224)	(5.117)	(4.726)
Attendance at religious services	1–5	2.723	3.306	2.793***
		(1.345)	(1.253)	(1.348)
Religious comfort seeking	1–4	2.808	3.268	2.862***
		(1.160)	(0.971)	(1.148)
Physical limitations	9–36	13.549	15.001	13.718**
		(6.372)	(7.631)	(6.546)
Age	25–74	45.783	43.905	45.558*
		(13.581)	(12.950)	(13.518)
Education	1–12	6.258	5.735	6.195***
		(2.396)	(2.355)	(2.397)
Income (units of 10,000)	0–18.5	6.488	4.804	6.287***
		(4.785)	(4.462)	(4.778)
Midwest	0/1	0.272	0.155	0.258***
		(0.445)	(0.363)	(0.438)
South	0/1	0.350	0.629	0.384***
		(0.477)	(0.484)	(0.486)
West	0/1	0.191	0.055	0.175***
		(0.393)	(0.227)	(0.380)
Northeast	0/1	0.187	0.161	0.184
		(0.390)	(0.368)	(0.387)
Gender (male = 1)	0/1	0.437	0.368	0.429*
		(0.496)	(0.483)	(0.495)
Marital status (married = 1)	0/1	0.711	0.520	0.688***
		(0.453)	(0.500)	(0.463)
Mainline Protestant	0/1	0.257	0.121	0.240***
		(0.437)	(0.327)	(0.427)
Liberal Protestant	0/1	0.080	0.031	0.074***
		(0.271)	(0.172)	(0.261)
Conservative Protestant	0/1	0.272	0.716	0.325***
		(0.445)	(0.452)	(0.469)
Catholic	0/1	0.260	0.072	0.238***
		(0.439)	(0.258)	(0.426)
Jewish	0/1	0.023	0.000	0.020***
		(0.150)	(0.000)	(0.141)
Other religion	0/1	0.007	0.031	0.009*
		(0.081)	(0.172)	(0.097)
No religion	0/1	0.102	0.030	0.093***
		(0.302)	(0.172)	(0.291)

Unweighted $N = 2{,}581$ whites, 201 African Americans. Specific sample size for each variable varies depending on item response rates. Standard deviations are listed in parentheses. Significance tests indicate significant mean differences between whites and African-Americans. $^{*}p < 0.05$; $^{**}p < 0.01$; $^{***}p < 0.001$.

TABLE 2
ZERO-ORDER CORRELATIONS FOR MAIN INDEPENDENT AND DEPENDENT VARIABLES

	1.	2.	3.	4.	5.	6.
1. Negative affect	1.000					
2. Positive affect	−0.641***	1.000				
3. Discrimination	0.177***	−0.133***	1.000			
4. Attendance	−0.077***	0.115***	0.002	1.000		
5. Comfort	0.012	0.026	0.057**	0.555***	1.000	
6. Race (African American = 1)	−0.016	0.059**	0.398***	0.141***	0.129***	1.000

*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$.
Unweighted $N = 2{,}782$. Specific sample size for each correlation varies depending on item response rates.

in significance is not due to loss of sample size between the bivariate and multivariate analyses. Religious comfort seeking remains unrelated to either measure of mental health.

As can be seen in Models 2 and 3, religious attendance, but not religious comfort seeking, significantly interacts with the effects of discrimination on mental health. Furthermore, the interaction between attendance and discrimination is significant for negative affect, but not positive affect. Nevertheless, the direction of this coefficient is negative, indicating that the effects of discrimination on negative affect decrease as attendance at religious services increases.

However, further analyses indicated that these buffering effects are conditioned on race. In analyses not shown here, in a model with negative affect as the dependent variable, a three-term interaction between attendance, discrimination, and race was significant ($p < 0.01$). When tested for positive affect, as well as for religious comfort seeking instead of religious attendance, no other three-term interaction was significant.

The meaning of the significant three-term interaction is made clear in Table 4. When the sample is split by race, the interaction between attendance and discrimination is significant only for African Americans.[11] Thus, attendance does buffer the effects of discrimination on psychological distress, but it does so only for African Americans. In addition, the interaction between attendance and discrimination for African Americans actually has a *greater* level of significance than the interaction between attendance and discrimination shown in Table 3 for the entire sample, despite this interaction being tested with a much smaller sample size and therefore much less statistical power, which speaks to the robustness of this buffering effect for African Americans.[12]

Discussion

This study examined the capability of religion to protect people from the effects of chronic discrimination on two different aspects of mental health. While discrimination both increased individuals' psychological dysfunction and reduced the positive aspects of psychological functioning, religious involvement was able to buffer the effects of discrimination only for negative affect. This buffering effect should not be discounted, though, because religion helped protect individuals from what is arguably one of the more pernicious effects of discrimination on mental health, the ability of discrimination to make people feel sad and hopeless.

It is also intriguing to note the conditions under which these buffering effects occur. First, they appear to be due to the public involvement of individuals in religious bodies—as indicated by attendance at religious services—rather than the tendency to seek comfort in religion during times of stress, and then for African Americans, but not whites. As was touched upon in the introduction, a host of research suggests a variety of mechanisms that may explain the ability of attendance to

TABLE 3
BUFFERING EFFECTS OF RELIGION ON THE RELATIONSHIP BETWEEN CHRONIC DISCRIMINATION AND MENTAL HEALTH

	Model 1	Model 2	Model 3
Negative affect			
Discrimination	0.147***	0.144***	0.146***
	(0.017)	(0.017)	(0.017)
Attendance	−0.155*	−0.161*	−0.159*
	(0.068)	(0.068)	(0.068)
Comfort	0.043	0.033	0.037
	(0.078)	(0.078)	(0.079)
Race (African American = 1)	−1.530***	−1.454***	−1.486***
	(0.261)	(0.264)	(0.264)
Attendance × Discrimination		−0.024*	
		(0.012)	
Comfort × Discrimination			−0.016
			(0.014)
Constant	10.290	10.249	10.279
Adjusted R^2	0.139	0.140	0.139
Positive affect			
Discrimination	−0.142***	−0.143***	−0.142***
	(0.020)	(0.020)	(0.020)
Attendance	0.334***	0.332***	0.335***
	(0.080)	(0.080)	(0.080)
Comfort	−0.073	−0.077	−0.071
	(0.092)	(0.092)	(0.092)
Race (African American = 1)	1.878***	1.918***	1.865***
	(0.306)	(0.310)	(0.310)
Attendance × Discrimination		−0.012	
		(0.014)	
Comfort × Discrimination			0.004
			(0.016)
Constant	19.866	19.847	19.868
Adjusted R^2	0.093	0.093	0.093

*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$.
Unweighted sample size fluctuated slightly depending on the response rate for the dependent variable, and is 2,561 for negative affect and is 2,572 for positive affect. All analyses control for age, gender, marital status, income, education, functional status, region, and denominational affiliation. Unstandardized OLS regression coefficients are presented, with standard errors for coefficients in parentheses.

buffer discrimination. Some of these are more general, such as forgiveness and religious coping, while others tend to be race specific, such as the practice of "identifying the persecutor" (Gilkes 1980). However, that the buffering effect of attendance was limited to African Americans clearly supports the idea that, because of their historical involvement in the fight against discrimination, African-American religious communities have more specialized resources to help individuals cope with the effects of discrimination.

The next step is to identify the particular specialized resources that lead to the race-specific buffering effect of attendance for discrimination. In part, this buffering effect may be due to fac-

TABLE 4
BUFFERING EFFECTS OF RELIGION ON THE RELATIONSHIP BETWEEN CHRONIC DISCRIMINATION AND NEGATIVE AFFECT, SEPARATED BY RACE

	African Americans	Whites
Discrimination	0.169**	0.155***
	(0.064)	(0.018)
Attendance	0.307	−0.150*
	(0.356)	(0.072)
Comfort	0.199	0.019
	(0.352)	(0.081)
Attendance x Discrimination	−0.130**	−0.013
	(0.048)	(0.013)
Constant	12.833	9.826
Adjusted R^2	0.136	0.154

*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$.
Unweighted sample size is 168 for African Americans and 2,393 for whites. All analyses control for age, gender, marital status, income, education, functional status, region, and denominational affiliation. Unstandardized OLS regression coefficients are presented, with standard errors for coefficients in parentheses.

tors associated with the service itself, such as the aforementioned "identifying the persecutor," or an increased attention in liturgy and sermons to overcoming persecution and discrimination. It is also possible, however, that these resources may be more related to the community itself, rather than the service specifically, as African-American religious communities may more readily offer emotional and instrumental social support when individuals experience psychological distress as a result of discrimination. Such social support resources are likely to be increasingly available as individuals become more involved in the religious community, and the measure of attendance used here may in part reflect individuals' varying level of religious community involvement.

This does not mean, however, that more general religious resources do not have the capability to buffer the effects of discrimination on mental health. The ability to forgive our persecutors may especially be a quite powerful ameliorator because the ability to let go of anger at our persecutors in part reduces the power that they have over us. A more general mechanism, such as a religiously inspired willingness to forgive, may consequentially provide a buffering effect that extends beyond African Americans. It is also possible that these resources underlie the buffering effect of attendance observed here. However, if this is the case, then the race-specific nature of this buffering effect suggests that there is also racial differentiation in the use or efficacy of these resources in the case of discrimination, and it is likely that this differentiation is tied to the historical involvement of African-American churches in the struggle against discrimination.

It should also be asked why, even if religion is a buffer for the relationship between discrimination and mental health, people who tend to turn to religion during times of stress do not find a benefit in this case from their comfort seeking. In part, the answer to this question may be that, while individuals sometimes turn to religion during times of stress, they may not necessarily turn to religion due to the stress caused specifically by discrimination. Therefore, even if they provide resources that help individuals cope with the effects of discrimination, religious leaders and religious bodies may need to be more active in encouraging their parishioners to use these resources during times of stress caused by discrimination.

A similar explanation may also explicate why religion was a protective factor only for the effects of discrimination on negative affect. The other outcome examined in this research dealt with

more positive aspects of mental health, and being made less happy or satisfied by discrimination may appear to be less serious or be more subtle than increases in distress. Therefore, it may be that religious resources are available to help people cope with the effects of discrimination, but these resources are used or are more likely to be made available when the discrimination has expressly negative effects.

One important drawback to this study is the cross-sectional nature of the sample. While this research assumes that the observed interaction was evidence of a buffering effect, an alternate interpretation is that the more individuals were negatively affected by discrimination, the less they attended religious services. It is possible that this could occur, as depressed people may become more disenchanted and therefore less likely to attend religious services, but for a number of reasons this is unlikely. First, if people who were more distressed due to discrimination did become less religious, it is difficult to explain why this would make them less likely to attend religious services, but not less likely to turn to religion for comfort during times of stress. Second, it is also difficult to explain why these effects would occur for African Americans, but not whites. Especially given the historical involvement of African-American churches in the civil rights movement, it is far more likely that African Americans would turn to, rather than away from, religion when discrimination caused them distress.

Conclusion

A wealth of research has shown that religious bodies have played a central role in combating discriminatory laws and practices. Less well established is whether these religious bodies aid people on an *individual* level by helping people to resist the negative effects of discrimination on mental health. Religion does appear to help people, but only under a limited set of conditions. Given the continued pervasive nature of discrimination in current society, it is undoubtedly a worthy task for researchers to identify more clearly how and why religion has these effects. By identifying these resources and helping religious bodies across the racial spectrum to bolster them, religious bodies may be better able to help their members lead happier and more productive lives. Therefore, from both a social scientific and a social advocacy perspective, this area of research is clearly worthy of further attention.

Notes

1. One important caution regarding the religious coping literature is that it is often based on questionnaires where respondents indicate their methods of coping with major problems. Given the more common or ordinary nature of the stressors examined here, it is quite possible that individuals would not identify these as major problems, and their coping responses may differ substantially from reactions to more momentous event-based problems.
2. While chronic discrimination may be more diffuse or subtle than other types of stressors, it is conceivable that experiences of "locating the persecutor" may nevertheless help parishioners to gain behavioral skills to help them avoid or defend themselves when the discrimination occurs, as well as cognitive skills to better cope with this stressor.
3. It should also be noted that some have pointed out that African-American religious services sometimes have an ecstatic quality (e.g., Nelson 1996), and others have suggested that ecstatic experiences may provide a means of emotional release (Gritzmacher, Bolton, and Dana 1988), thus indicating another way in which religious services may better help African Americans cope with discrimination.
4. In Mollica et al.'s (1986) study, African-American ministers spent more time on counseling than "traditional" Protestant ministers, but not evangelical Protestant ministers. No comparisons to Catholic priests were made.
5. One caution that should be taken in interpreting this research is that not all African Americans will necessarily belong to a predominantly black or other religious body, nor will whites necessarily belong to a predominantly white religious body. Nevertheless, it continues to remain axiomatic that the most segregated place in America on Sunday mornings is the church.
6. For more information on the MIDUS, including the weights used in this analysis, see the homepage for the Research Network on Successful Midlife Development at http://midmac.med.harvard.edu/.
7. One possible problem with these measures is that both ask about attendance at religious services; in theory, then, by including the two in the same regression model, the attendance aspect of religious comfort seeking is partialled out of

the comfort seeking measure. However, when each measure was used separately in additional analyses, the buffering effects were no different than those presented here. Therefore, including a measure of attendance in the same model as the measure of comfort seeking does not distort the buffering effects of religious comfort seeking.

8. One question that arises when using self-reports of discrimination is causality, as depressed mood may lead individuals to perceive or recall more experiences of discrimination. However, longitudinal analyses have shown that, while experiences of discrimination lead to increased rates of psychological distress, psychological distress is unrelated to later reports of discrimination (Brown et al. 1999; Pavalko, Mossakowski, and Hamilton 2003).
9. For people who indicated that their affiliation was not listed, two additional questions were used. If individuals indicated that they were not Christian, they were classified as "other." If they indicated that they were Christian, an additional item regarding biblical literalism was used to make a determination into liberal, mainline, or fundamentalist Protestant. This was done in part because the number of Catholic denominations listed in the MIDUS suggested that, if a Christian's denomination was not listed, it was highly likely that he or she was Protestant. A similar process was used for people who indicated that they were Protestant but went to more than one church, were "born-again Christian," or "Protestant, other," as well as for individuals who skipped the denominational affiliation question, but did indicate that they were Christian.
10. Since the effects of most of the control variables on mental health have been extensively examined in previous research (see Aneshensel and Phelan 1999, for several reviews), in the interests of presenting a concise and clear description of results, the effects of the control variables are not shown. They are, however, included in all models, and a full description of results is available from the author upon request.
11. Prior to performing split-sample regressions, the weighting variable was standardized for each subsample.
12. One alternative possibility that should also be considered is that racial differences in the buffering effects of religion are due to differences in the frequency with which blacks and whites experience discrimination. However, while whites did report a lower mean level of chronic discrimination than African Americans, preliminary analyses showed that the mean level of discrimination reported by whites was significantly greater than reports of no experiences of discrimination ($p < 0.001$). In addition, an ancillary interaction analysis showed no difference between blacks and whites in the relationship between discrimination and negative affect. Therefore, it does not appear that racial differences in the buffering effects of religion observed here are due to differences in the frequency that whites and African American experience chronic discrimination, or racial differences in distress due to chronic discrimination.

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