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RESEARCH

Religious Social Identity as an Explanatory Factor for Associations Between More Frequent Formal Religious Participation and Psychological Well-Being

Emily A. Greenfield
School of Social Work, Institute for Health, Health Care, and Aging Research
Rutgers University

Nadine F. Marks
Human Development and Family Studies
University of Wisconsin-Madison

Guided by social identity theory, this study investigated having a closer identification as a member of one's religious group as an explanatory mechanism for linkages between more frequent formal religious participation and better subjective psychological well-being (more positive affect, less negative affect, and more life satisfaction). Multivariate regression models were estimated based on data from 3,032 respondents, ages 25 to 74, in the 1995 National Survey of Midlife in the U.S. Results provided support for the hypothesis that religious social identity would mediate the associations between more frequent religious service attendance and all three dimensions of subjective psychological well-being examined. These findings contribute to understandings of self, religion, and health while indicating the continued importance of drawing on well-developed social psychological theory in investigations of linkages between religion and mental health.

Corespondence should be sent to Emily Greenfield, School of Social Work, Rutgers University, 536 George Street, New Brunswick, NJ 08901-1167 E-mail: eagreenfield@wisc.edu

Although the centrality of religion in shaping human experiences has been a prominent theme within the behavioral sciences for well over a century (Davie, 1998), only recently have investigators focused significant empirical attention to the implications of religion for personal well-being. Although findings have been somewhat inconsistent, with some studies indicating that religion is detrimental to individuals' well-being and other studies indicating no association at all (Koenig & Larson, 2001; Miller & Kelley, 2005), much previous work suggests that a higher level of religious involvement is associated with better physical health (Levin, 1994) and mental health (Levin & Tobin, 1995). This evidence has been generated by research incorporating clinical and community samples, a range of mental and physical health outcomes, and both cross-sectional and longitudinal designs (George, Ellison, & Larson, 2002). Many factors and processes have been posited as potential mechanisms through which religion can promote individuals' well-being (Oman & Thoresen, 2005), but relatively few explanations have been tested empirically. Therefore, an important task remains for social and behavioral researchers—to understand the mechanisms through which higher levels of religiosity can enhance mental and physical health (Pargament, 2002).

Drawing on social identity theory and previous investigations of religion, self, and well-being, this study aimed to contribute to building a better understanding of the associations between formal religious participation and mental health by examining religious social identity as a possible explanatory factor. More specifically, we used data from adults ages 25 to 74 in the 1995 National Survey of Midlife in the U.S. (MIDUS) to test a mediation model positing that more closely identifying as a member of one's religious group would account for linkages between more frequent formal religious participation and better subjective psychological well-being (more positive affect, less negative affect, and more life satisfaction).

THEORETICAL BACKGROUND

Nearly a century ago, Emile Durkheim (1912/1995) made the classic assertion that religious beliefs and practices are both a group- and individual-level phenomenon. Yet well-developed social psychological theories like social identity theory, which addresses the interface between groups and individuals, have not been widely applied to investigations of religiosity and mental health. Social identity theory begins with the assumption that individuals exist in a society composed of many social categories that stand in relative power and status relationships to each other. Although social categories vary in terms of their scope and duration (e.g., from long-standing geopolitical nations to temporary work groups), all social categories have the potential to shape a person's self-concept.

When individuals define themselves in terms of their belonging to a social category, a social identity is formed. In other words, social identity is "the knowledge that (one) belongs to certain social groups together with some emotional and value significance of ... the group membership" (Tajfel, 1972, p. 292).

Researchers developing and using social identity theory largely have focused on social identity processes in terms of their consequences for intergroup relations, such as stereotyping and prejudice (Hogg, Terry, & White, 1995). Nevertheless, the theory itself constitutes a more general framework on group-mediated social psychological phenomena (Hogg, 1996). It is at this level of theory that social identity theory has relevance for exploring processes through which religious participation might promote individuals' psychological well-being.

First, by focusing on the interface between the psychological and the structural, social identity theory provides a theoretical basis for positing that more frequent formal religious participation would be associated with having a stronger religious social identity. The theory advances the idea that group characteristics—such as structures, roles, and norms—are internalized as part of an individual's sociocognitive system, and that individuals' cognitive and motivational states give rise to structural group characteristics (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987). This substantive focus on the interplay between individuals' subjective experiences of social groups and more external features of social groups points to possible associations between formal religious participation (i.e., an external feature of a social group) and religious social identity (i.e., the psychological experience of that group by an individual). Social identity theory would suggest that formal participation within a given social group would enhance individuals' social identities in terms of that group, and vice versa.

Second, several social identity theorists have posited linkages between social identities and psychological well-being. In its original conceptualization, the theory held that an enhanced positive feeling toward self was a primary motivation for people's formation of social identities (Hogg, 1996). Likewise, theorists have suggested that people are motivated to compare their in-group (i.e., the group to which they perceive belonging) to out-groups in favorable ways, such as by choosing dimensions of comparison on which their group is superior to others or, alternatively, by changing their in-group membership if possible. Moreover, social identities are viewed as functional because they are theorized as providing individuals and society with structure for behavior. The psychological processes involved in forming social identities are posited as serving to simplify social reality and thereby help individuals avoid the distress of being overwhelmed by social complexities (Hogg & Abrams, 1988).

In sum, social identity theory provides a firm theoretical ground for exploring religious social identity as an explanatory mechanism for associations between more frequent formal religious participation and better psychological well-being. Social identity theory suggests that more frequent formal religious participation

would be associated with having a closer identification as a member of one's own religious group, and that this stronger experience of a valued social identity, in turn, would account for individuals' higher levels of psychological well-being.

EMPIRICAL BACKGROUND

Previous research has indicated that religious participation is associated with features of individuals' self-concepts, such as levels of self-esteem and self-efficacy (e.g., Ellison, 1993; Krause, 1995; Schieman, Nguyen, & Elliott, 2003), and that aspects of self contribute to processes related to psychological well-being (e.g., Higgins, 1987; Stryker & Statham, 1985; Taylor & Brown, 1988). Very few studies, however, have empirically investigated social identity as a mediating factor between greater formal religious participation and better psychological well-being. Blaine and Crocker's (1995) study provides one exception. Using data from a regional sample of undergraduate students, this study found that among African American students, individuals' more positive feelings toward their social groups accounted for associations between students' greater religious belief salience and higher levels of psychological well-being.

Previous studies on self-related factors as mediators of the association between religious participation and psychological well-being have focused on other mechanisms besides social identity. For example, two studies (Commerford & Reznikoff, 1996; Krause, 1992) found that self-esteem and mastery partially mediated the effects of religious involvement on psychological well-being; however, another study that investigated self-esteem as a mediator (Braam et al., 1998) failed to find evidence for mediating effects. In their review of research in this area, George et al. (2002) concluded that additional research on self-implicated pathways from religiosity to health is "badly needed" (p. 195).

Krause and Wulff (2005) responded to the call for additional research in this area by investigating how individuals' sense of belonging to their congregations might explain the associations between religious involvement and one measure related to physical health—satisfaction with health. More specifically, the authors found support for their model positing that higher levels of receiving emotional support from other congregational members would lead to a stronger sense of belonging to the congregation and that this stronger sense of belonging, in turn, would lead to individuals' greater satisfaction with their health.

Guided by social identity theory and aiming to advance empirical understanding of linkages among religious participation, self, and psychological well-being, we formulated and examined the following hypotheses:

Hypothesis 1: Individuals who report more frequent formal religious participation will report higher levels of psychological well-being.

Hypothesis 2: Individuals who report more frequent formal religious participation will report having a stronger religious social identity.

Hypothesis 3: Individuals who report having a stronger religious social identity will report higher levels of psychological well-being.

Hypothesis 4: Having a stronger religious social identity will help to account for associations between more frequent formal religious participation and higher levels of psychological well-being.

METHOD

Data

This study used data from the MIDUS. The MIDUS national probability sample that completed both a telephone survey and self-administered questionnaire includes 3,032 English-speaking, noninstitutionalized adults who were between the ages of 25 and 74 when interviewed in 1995. Participation in the survey took place in two parts. Respondents first participated in a telephone interview and then completed a self-administered mailback questionnaire. The overall response rate for the sample that answered both the survey and questionnaire was 60.8% (i.e., 70% of identified respondents completed the telephone interview, and 86.6% of those respondents who completed the telephone interview also completed the mail-back questionnaire).

The MIDUS sample was obtained through random digit dialing, with an oversampling of older respondents and men to ensure the desired distribution on the cross-classification of age and gender. Sampling weights correcting for selection probabilities and nonresponse allow the sample to match the composition of the U.S. population on age, sex, race, and education. For this study, we estimated multivariate regression models with both the weighted and unweighted samples. No substantive differences in results were found; therefore, results from unweighted analyses are reported, because multivariate analyses based on unweighted data provide estimates with more reliable standard errors (Winship & Radbill, 1994). For a detailed technical report regarding field procedures, response rates, and weighting of the MIDUS, see http://midus.wisc.edu.

Measures

Psychological well-being has become increasingly recognized as a multidimensional construct. Theoretical developments suggest that positive and negative affect are not two ends of a bipolar continuum (Bradburn, 1969) and that experiences of psychological well-being extend beyond the minimization of

psychological distress and maximization of happiness (Waterman, 1993). For this study, we examined subjective psychological well-being—the most widely investigated aspect of psychological well-being in social scientific research (Ryan & Deci, 2001). Research on the structure of subjective psychological well-being has supported a model that consists of three dimensions: positive affect, negative affect, and life satisfaction (Diener, Suh, Lucas, & Smith, 1996).

Negative affect and positive affect. Two separate six-item scales new to the MIDUS were used to assess respondents' negative and positive affect (Mroczek & Kolarz, 1998). To assess negative affect, respondents were asked how frequently in the last 30 days they felt (a) so sad nothing could cheer them up, (b) nervous, (c) restless or fidgety, (d) hopeless, (e) that everything was an effort, and (f) worthless. Similarly, to assess positive affect, respondents were asked how frequently they felt (a) cheerful, (b) in good spirits, (c) extremely happy, (d) calm and peaceful, (e) satisfied, and (f) full of life. Respondents answered each of the 12 affect items on a 5-point scale from 1 (*all of the time*) to 5 (*none of the time*). Items were reverse coded and summed such that higher scores indicated more negative or more positive affect. Cronbach's alphas were .87 and .91 for the negative affect and positive affect indexes, respectively. (Table 1 provides descriptives for all analytic variables.)

Life satisfaction. A single item was used to assess respondents' life satisfaction. Respondents were asked, "Using a scale from 0 to 10 where 0 means 'the worst possible life overall' and 10 means 'the best possible life overall,' how would you rate your life overall these days?" Preliminary analyses detected skew in the distribution of respondents' responses to this item, with 64% of the respondents choosing 8, 9, or 10. To partially correct for this skewed distribution while preserving variation on this index, responses were recoded (0–6 = 1, 7 = 2, 8 = 3, 9 = 4, 10 = 5), with higher scores indicating more life satisfaction.

Formal religious participation. A single item was used to measure respondents' *formal religious participation.* Respondents were asked about the frequency they "usually attend religious or spiritual services." Response categories included (a) more than once a week, (b) about once a week, (c) one to three times a month, (d) less than once a month, and (e) never. Respondents who reported usually attending religious services *more than once a week* or *about once a week* were coded 3; respondents who reported usually attending *one to three times a month* were coded 2; respondents who reported attending *less than once a month* were coded 1; and respondents who reported *never* attending religious services were coded 0 on this variable.

TABLE 1
Descriptives for Analytic Variables

Variable	*M*	*SD*	*Range*
Positive affect	3.36	.74	1–5
Negative affect	1 56	.63	1–5
Life satisfaction	2.86	1.23	1–5
Age	47.66	12.95	25–74
Female[a]	51	.50	0–1
Black[a]	.07	.50	0–1
Education[a]			
< 12 years	10	.30	0–1
12 years	.29	.46	0–1
13–15 years	.31	.46	0–1
≥ 16 years	30	.46	0–1
Income (in thousand $)	54.35	47.75	0–300
Employed[a]	.71	.45	0–1
Married[a]	64	.48	0–1
Has a child[a]	.82	.38	0–1
Self-rated health	3.45	.99	1–5
Formal religious participation	1.67	1.18	0–3
Religious social identity	1.72	1.05	0–3

Note. Analyses used unweighted data Source: 1995 National Survey of Midlife in the U.S $N = 3.032$

[a]Dichotomous variables are reported as proportions.

Strength of religious social identity. A single item was used to assess the strength of individuals' religious social identity. Respondents were asked. "How closely do you identify with being a member of your religious group?" ranging from 1 (*very*) to 2 (*somewhat*) to 3 (*not very*) to 4 (*not at all*). Responses were recoded to give this scale a range of 0 to 3. with higher scores indicating having a stronger religious social identity.

Control variables. Previous studies have indicated that a variety of sociodemographic factors are associated with psychological well-being (e.g., Mroczek & Kolarz, 1998). as well as with religiosity (e.g., Peacock & Poloma, 1999). To provide evidence for associations among formal religious participation. religious social identity. and subjective psychological well-being independent of other factors, respondents' age, gender, race, education, income, employment status, marital status, parental status, and self-rated physical health were controlled in all analyses. Dichotomous variables were created for gender (1 = female), race (1 = Black), employment status (1 = currently employed). marital status (1 = currently married), and parental status (1 = has at least one living biological or adopted child). A categorical variable was created to indicate respondents'

educational attainment, including the categories of less than 12 years, 12 years (reference group), 13 to 15 years, and 16 years or more. Age was calculated as years since birth at the time of the telephone survey. Income was computed by combining respondents' personal annual income with that of their spouse (if applicable) and scaled in thousands of dollars. Self-rated health was measured by a standard global self-assessed health question, which asked respondents, "In general, would you say your physical health is . . . ?" ranging from 1 (*very poor*) to 5 (*excellent*).

Data Analytic Sequence

The ordinary least squares method was used to estimate multivariate regression models to test the proposed linkages among the variables. Models were estimated corresponding to each of this study's hypotheses, as well as to Baron and Kenny's (1986) criteria for testing a potential mediating effect. All models included the nine statistical control variables.

To test whether respondents' more frequent formal religious participation was associated with higher levels of psychological well-being (Hypothesis 1), each dimension of subjective psychological well-being (positive affect, negative affect, and life satisfaction) was regressed on the frequency of respondents' formal religious participation. To test whether respondents' more frequent formal religious participation was associated with more closely identifying as a member of one's religious group (Hypothesis 2), respondents' strength of religious social identity was regressed on the frequency of respondents' formal religious participation. To test whether having a stronger religious social identity was associated with higher levels of subjective psychological well-being (Hypothesis 3), as well as whether having a stronger religious social identity mediated associations between more frequent formal religious participation and subjective psychological well-being (Hypothesis 4), a final set of models was estimated in which the well-being variables were regressed on the strength of respondents' religious social identity, as well as the frequency of their formal religious participation.

RESULTS

Frequency of Formal Religious Participation and Psychological Well-Being

To examine evidence for the first hypothesis, models were estimated that regressed respondents' negative affect, positive affect, and life satisfaction on the frequency of their formal religious participation (Table 2, Model 1). Consistent with previous research, these analyses indicated that more frequent religious or spiritual service attendance was associated with higher levels of positive affect

TABLE 2
Estimates for the Effects of Formal Religious Participation and Religious Social Identity on Subjective Psychological Well-Being

	Positive Affect						*Negative Affect*						*Life Satisfaction*					
	Model 1			*Model 2*			*Model 1*			*Model 2*			*Model 1*			*Model 2*		
Variable	*B*	*SE*	*β*	*B*	*SE*	*β*	*B*	*SE*	*β*	*B*	*SE*	*β*	*B*	*SE*	*β*	*B*	*SE*	*β*
Age	.01***	(.00)	.13	.01***	(.00)	.13	−.01***	(.00)	−.17	−.01***	(.00)	−.17	.02***	(.00)	.19	.02***	(.00)	.18
Female	−.09***	(.03)	−.06	−.10***	(.03)	−.07	.11***	(.02)	.09	.04	(.04)	.02	.05	(.04)	.02	.04	(.04)	.02
Black	.16**	(.05)	.05	.14**	(.06)	.05	−.13**	(.05)	−.05	.19*	(.09)	.04	.23*	(.09)	.05	.19*	(.09)	.04
Education[a]																		
< 12 years	.03	(.05)	.01	.03	(.05)	.01	.09*	(.04)	.04	.07	(.08)	.02	.08	(.08)	.02	.07	(.08)	.02
13–15 years	−.03	(.03)	−.02	−.03	(.03)	−.02	−.03	(.03)	−.02	−.00	(.03)	−.00	−.18**	(.06)	−.07	−.23	(.06)	−.09
≥ 16 years	−.07	(.04)	−.04	−.07+	(.04)	−.04	−.03	(.03)	−.02	−.03	(.03)	−.02	−.18**	(.06)	−.07	−.18**	(.06)	−.07
Income	.00	(.00)	.01	.00	(.00)	.01	−.00	(.00)	−.01	−.00	(.00)	−.01	.00***	(.00)	.09	.00***	(.00)	.08
Employed	.04	(.03)	.02	.04	(.03)	.03	−.07**	(.03)	−.05	−.07**	(.03)	−.05	−.05	(.05)	−.02	−.05	(.05)	−.02
Married	.06	(.03)	.04	.05+	(.03)	.04	−.09**	(.03)	−.00	−.08**	(.03)	−.06	.32***	(.05)	.13	.31***	(.05)	.12
Has a child	−.03	(.04)	−.02	−.03	(.04)	−.01	−.00	(.03)	−.00	−.00	(.03)	−.00	−.09	(.06)	−.03	−.08	(.06)	−.03
Self-rated health	.21***	(.01)	.28	.21***	(.01)	.28	−.17***	(.01)	−.27	−.17***	(.01)	−.27	.30***	(.02)	.24	.30***	(.02)	.24
Religious participation	.07***	(.01)	.10	.02	(.02)	.03	−.03***	(.01)	−.06	−.00	(.01)	−.02	.11***	(.02)	.11	.05+	(.03)	.04
Religious social identity	—	—	—	.07***	(.02)	.10	—	—	—	−.04*	(.02)	−.06	—	—		.10***	(.03)	.09
Constant	2.21***			2.15***			2.66***			2.68***			.67***			.62***		
R^2	.10			.11			.12			.13			.14			.15		
Valid *N*	2,817			2,817			2,803			2,803			2,824			2,824		

Note Analyses used unweighted data Source 1995 National Survey of Midlife in the U S $N = 3,032$.
[a]Omitted category is 12 years
*$p = .05$ **$p = .01$ ***$p = .001$ (two-tailed)

($\beta = .10$, $p = .001$), lower levels of negative affect ($\beta = -.06$, $p = .001$), and higher levels of life satisfaction ($\beta = .11$, $p = .001$). These analyses provided consistent evidence in support of Hypothesis 1.

Frequency of Formal Religious Participation and Strength of Religious Social Identity

To examine evidence for Hypothesis 2, a model was estimated that regressed respondents' strength of religious social identity on the frequency of formal religious participation (Table 3). As predicted, more frequent formal religious participation was associated with having a stronger religious social identity, ($\beta = .70$, $p \leq .001$). For every 1 standard-deviation-unit increase in frequency of religious service attendance, the strength of respondents' religious social identity increased by more than two thirds of a standard deviation. These analyses provided evidence in support of Hypothesis 2.

TABLE 3
Estimates for the Effects of Frequency of Formal Religious Participation on Strength of Religious Social Identity

	Religious Social Identity		
Variable	*B*	*SE*	*β*
Age	.00**	(.00)	.05
Female	11***	(.03)	.05
Black	.31***	(.06)	07
Education[a]			
< 12 years	11*	(05)	.03
13–15 years	−.06	(.04)	−.01
≥ 16 years	−.02	(.04)	−.01
Income	.00	(.00)	.01
Employed	.00	(.03)	.00
Married	.06*	(.03)	.03
Has a child	−.05	(.04)	−.02
Self-rated health	−.00	(01)	−.00
Formal religious participation	.63***	(.01)	.70
Constant	.43***		
R^2	.53		
Valid *N*	2,848		

Note. Analyses used unweighted data Source 1995 National Survey of Midlife in the U.S. $N = 3,032$.

[a]Omitted category is 12 years.

*$p = .05$. **$p = .01$. ***$p = .001$ (two-tailed).

Strength of Religious Social Identity and Subjective Psychological Well-Being, and Religious Social Identity as a Mediator

To examine evidence for Hypotheses 3 and 4, respondents' strength of religious social identity was added to the models already including the measure of frequency of formal religious participation (see Table 2, Model 2). Evidence for the mediating effect of religious social identity was found with respect to all three dimensions of well-being investigated. Strength of religious social identity fully accounted for the associations between more frequent formal religious participation and higher levels of positive affect, lower levels of negative affect, and higher levels of life satisfaction. When the measure of religious social identity was added to regression models that already included the measure of frequency of formal religious participation, the coefficients for formal religious participation became much smaller in size and were no longer statistically significant ($\beta = .03$, *ns*, positive affect; $\beta = -.02$, *ns*, negative affect; $\beta = .04$, *ns*, life satisfaction). In addition, in these final models, strength of religious social identity remained a significant predictor of more positive affect ($\beta = .10$, $p \leq .001$), less negative affect ($\beta = -.06$, $p \leq .05$), and more life satisfaction ($\beta = .09$, $p \leq .001$).

In sum, these analyses provided consistent evidence in support of Hypotheses 3 and 4. Having a stronger religious social identity was associated with higher levels of subjective psychological well-being, and strength of religious social identity mediated the associations between more frequent formal religious participation and each dimension of subjective psychological well-being.

DISCUSSION

The purpose of this study was to investigate linkages among individuals' frequency of formal religious participation, strength of religious social identity, and subjective psychological well-being, with particular attention to the possible mediating effects of religious social identity on associations between more frequent formal religious participation and better psychological well-being. Findings from this study support the idea that religious social identity serves as an explanatory factor for associations between more frequent formal religious participation and higher levels of subjective psychological well-being.

Consistent with previous research (Levin & Tobin, 1995), more frequent religious service attendance was associated with higher levels of subjective psychological well-being across all three dimensions of subjective psychological well-being investigated. These associations, however, were explained by the strength of an individual's religious social identity. In other words, more frequent formal

religious participation was associated with having a stronger religious social identity, which, in turn, was associated with higher levels of subjective psychological well-being. Although previous reviews on mediating factors between religion and health have identified a range of potential explanatory factors—including health behaviors, coping, meaning, and social support (George et al., 2002; Oman & Thoresen, 2005)—the findings of our study point to social identity as an additional type of psychosocial factor through which religiosity can promote individuals' psychological well-being.

Results of this study are consistent with social identity theory, which posits linkages between social categories, individuals' identities, and psychological well-being (Hogg, 1996; Hogg & Abrams, 1988; Turner et al., 1987). Having a stronger religious social identity might promote health through processes that theorists previously have posited as ways in which social identity promotes well-being—such as by protecting individuals from the distress of facing social complexities and by enabling individuals to make favorable in-group comparisons. It is possible, however, that social identities derived from participation in religious community might enhance well-being in other ways as well. A religious-group factor that is likely to develop through higher levels of community participation, and that is likely to promote individuals' psychological well-being, might become all the more salient to that person's well-being when the religious group is strongly represented "inside" the individual. For example, identifying more strongly with one's religious group might make the exchange of congregation-based social support more meaningful to individuals; therefore, having a stronger religious social identity can enable individuals to more powerfully experience the health-promoting aspects of congregation-based social support, which is likely to accompany more frequent participation in religious services.

Although this study capitalizes on the strengths of a large, multidisciplinary national survey to investigate its hypotheses, particular aspects of this study limit the extent to which conclusions can be fully drawn. First, although previous studies with more sophisticated designs have suggested that increased religious participation leads to enhanced well-being over time (Strawbridge, Shema, Cohen, & Kaplan, 2001), given the dearth of studies on religious social identity, the extent to which stronger religious identity causes greater well-being and is caused by more frequent formal religious participation remains less certain. Social identity theory itself would posit that group behavior and individual identity are mutually reinforcing (Turner et al., 1987). This idea suggests that it would be unlikely for more frequent formal religious participation to cause individuals' stronger religious social identities without individuals' stronger religious social identities also causing their more frequent formal religious participation. Future research drawing on longitudinal data and developmental theories on religiosity

(see Levenson, Aldwin, & D'Mello, 2005, for examples) would advance understanding of the potentially reciprocal and dynamic relationship between formal religious participation and religious social identity over time.

In addition, this study's measures were limited to what was included in the MIDUS. Although the item used to measure strength of religious social identity has strong face validity (i.e., the measure appears to assess what it is intended to measure), the construct of social identity, as described by social identity theorists, is more complex than this unidimensional measure. For example, Turner and colleagues (1987) discuss social identity as involving the use of social groups for social comparisons and value acquisition, and they posit that the degree to which a person emphasizes intraclass similarities and interclass differences indicates, in part, the salience of one's self-categorization. This study's measure of social identity does not directly capture these aspects of social identity.

Finally, this study's findings are based on a U.S. national representative sample that is purposely heterogeneous, and therefore the findings of this study represent an averaging of associations among the variables. Pathways from formal religious participation to religious social identity to subjective psychological well-being might vary for people belonging to different social groups, such as by age and ethnicity (Paloutzian & Kirkpatrick, 1995). Future studies drawing on additional theories and other bodies of literature are necessary to investigate the extent to which these findings systematically apply more readily to some subgroups of the population than others.

Despite these limitations, this study offers an important contribution to understanding the linkages between religiosity and mental health. The results provide evidence that more frequent formal religious participation is associated with having a stronger religious social identity and that this aspect of identity, in turn, accounts for associations between more frequent formal religious participation and higher levels of subjective psychological well-being. The findings are noteworthy in terms of their addressing a relatively understudied factor within empirical investigations of religiosity and mental health. Results also indicate the promise of continuing to apply and extend well-developed social psychological theory on group processes and individual outcomes to the social scientific study of religion and personal well-being.

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