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Religiosity and Well-Being among Older Jewish Israelis: Findings from SHARE

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Abstract

This study examined the correlates of religiosity among Jewish Israelis aged 50 and older. Based on the second wave of Survey of Health, Ageing and Retirement in Europe, the findings show that almost half the Jewish respondents never pray and that, on average, prayer frequency is lower among Jewish Israelis than it is among most of their European counterparts. Multivariate logistic analyses revealed that those who pray more often have more health conditions, are less able to make ends meet financially and have fewer years of education. However, when facing ill health those who pray more often display a relatively lesser decline in their sense of well being.

Introduction

This article looks at religiosity among older Jewish Israelis. We examine the extent of religious practice among older Jewish adults in Israel and the role of religiosity in relation to well being in late life. The main purpose of the inquiry is to estimate just how important the Jewish religion is in the lives of older Israeli Jews and to derive from the analysis a better understanding of why this may be important.

In order to address these questions, the study makes use of a significant new data base, namely, the Israeli sample in the Survey of Health, Ageing and Retirement in Europe (SHARE). Aging is clearly a multifaceted phenomenon, the understanding of which requires a broad base of knowledge and information. The SHARE survey, which operates in some 20 European countries and in Israel, provides just such a data base. It is a multidisciplinary, cross-nationally harmonized panel study of older adults. The wide range of topics covered in the survey, including many variables that reflect the key economic, health-related and social aspects of late life, provides a unique opportunity to view religiosity in relation to a plethora of relevant factors.

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In the study that is described in the following pages we look at the literature on the nature and the extent of religiosity within the Jewish population in the State of Israel. We also execute a multivariate statistical analysis that seeks to provide answers to the research questions that stand at the heart of the inquiry. Our goal is to provide new insights regarding what it means to be Jewish in Israel, to reach a better understanding of for whom religion constitutes a central part of their lives, and to get an idea as to the dynamics of religiosity, that is, the ways in which religious practice and spirituality seem to affect the aging process.

Literature review

Religiosity among Jews in Israel reflects not only spirituality, but also social and political attitudes. A survey conducted in 2009 found that the level of religiosity was connected to socio-demographic factors, particularly income and education, to different attitudes towards democracy and to the definition of “who is a Jew,” as well as to the status of women in society (Arian, 2009). Smootha (2006) argues that the Jewish religion itself does not stand in the center of Israeli consciousness but rather the tight connection to Jewish culture, its legacy, language and customs. Thus, many Jews living in Israel developed a Jewish identity without being religious, which may cause tension between secular, traditional and ultra-orthodox Jews.

According to data from the Israeli Central Bureau of Statistics, 44 percent of Jewish-Israeli adults define themselves as secular 23 percent as non-religious traditional Jews, 14 percent as traditional-religious and 19 percent as religious (Brodsky, Shnoor & Be’er, 2014). A similar division reigns among Jews aged 65 and older, so that 45 percent define themselves as secular, 26 percent as non-religious traditional, 15 percent as traditional-religious and 15 percent as religious. Thus, most of the older Jewish population living in Israel is not religious, per se (Brodsky, Shnoor & Be’er, 2014).

Older Israeli Jews may be considered as a special group when talking about religiosity. They differ from the younger population because they constitute part of the “founding generation”, that is, a) Zionist pioneers who immigrated in 1924–1939, b) Holocaust survivors who arrived after the Second World War, or c) those born in the early years of the state. The “founders” rejected the religious Jewish identity of the Diaspora and sought to create a “New Jew” reflective of a strong and irreligious people (Almog, 1997; Greenberg & Katz, 2006; Conforti, 2009).

This trend was especially dominant among the Holocaust survivors, many of whom had abandoned religion and faith in God (although some survivors did strengthen their religious beliefs afterwards) (Greenberg & Katz, 2006). It should also be noted that immigrants who arrived after the establishment of the State of Israel, many of whom came from Asia and North Africa, differed widely from the pioneers who were already in Israel in regard to socio-economic factors and religiosity levels. For these and other reasons, older Israeli Jews tend to differ more among themselves in terms of religiosity, than their Jewish counterparts in the Diaspora.

Differences in religiosity can also be seen when comparing Israeli Jews to American Jews. The latter tend to define themselves more often than the former as religious or traditional, and less often as secular. (Oren, Levin-Epstein & Yaar, 2003). One possible explanation for this difference is the prevalence of the Conservative and Reform movements among American Jews (Lugo, Cooperman, & Smith, 2013). This stands in contrast to Israel in which the Conservative and Reform movements are not officially acknowledged by religious authorities (Smoocha, 2006). Thus, being religious in Israel is mainly in relation to the Orthodox movement, possibly limiting the affiliation of Israeli Jews with religion.

Religion, health and mental health

The relationship between religion and mental health has been studied extensively, with findings pointing to a positive relationship. Religion is related to positive emotions, well-being, self-esteem and social support, and it has an inverse relationship to depression and substance abuse (Koenig, 2012; Pargament, 2001). In addition, studies show that in many countries religion can be a powerful coping mechanism in the face of stress and hardship (Koenig, King, & Carson, 2012). A meta-analysis of the relevant literature concluded that religious coping strategies lead to positive psychological adjustment in the face of stressful events, for example, experiencing stress-related growth, spiritual growth, life satisfaction, positive affect and higher self-esteem (Ano & Vasconcelles, 2005). Religion also has an important role for coping with a wide array of serious medical conditions and encouraging psychological growth from these experiences (Koenig, Larson, & Larson, 2001).

Koenig (2012) hypothesizes a number of mechanisms through which this positive influence is achieved. One is that religion provides resources for dealing with negative life situations, and gives the believer a sense of meaning and purpose, an optimistic worldview, hope and control. Religious beliefs can also influence the cognitive appraisals of difficult situations so they will seem less stressful. This is especially relevant to people with medical conditions, since such conditions might make it difficult for them to rely on other more health-dependent resources, such as hobbies. Another mechanism of note is that most religions encourage social gatherings for worship and encourage family life which can, in turn, provide social support when facing difficult times (Koenig, 2012; Koenig et al., 2012).

Old age, religion, health and mental health

The association between religion and mental health is particularly important for older people, as they face increasing stressors in the form of deteriorating health. Studies have found a positive association in this population, using different measurements of religiosity and mental health. For example, higher levels of religiosity were related to better mental health in two residential communities in Massachusetts (Meisenhelder & Chandler, 2002). Greater church attendance was related to less depressive symptoms in samples of older people in North Carolina and Alabama (Mitchell & Weatherly, 2000; Sun et al., 2012), and higher intrinsic religiosity was related to a decline in depressive symptoms, over a four-year period, among adults aged 65 and older in Alabama (Sun et al., 2012). Krause (2003) found that older Christian Whites and African Americans who derive a sense of meaning in life from religion have higher self-esteem, optimism and life satisfaction.

Some studies report a negative association between religion and mental health among older persons, for instance, that prayer frequency is associated with poorer well-being and higher odds of depression (Hank & Schaan, 2008; Roff, Durkin, Sun, & Klemmack, 2007). However, these particular findings may actually support the studies mentioned above, insofar as they reflect the use of religion for coping. That is, older people who face stress turn to religion and prayer for comfort (Hank & Schaan, 2008).

This contention is supported by several other studies which show that older people cope better in difficult situations when they utilize religion. Therefore, higher religiosity level is associated with fewer depressive symptoms among elderly persons coping in different stressful situations, such as hospitalization (Koenig, George, & Titus, 2004), psychiatric conditions (Hayward, Owen, Koenig, Steffens, & Payne, 2012) and disabilities (Idler & Kasl, 1992). High religiosity also buffers the effect of poor physical health on the sense of control, but only for women (Wink, Dillon, & Prettyman, 2009). In addition to aiding in the face of physical hardship, religion helps to cope with financial difficulties. According to Krause and Hayward (2014), older adults who faced financial hardship experienced better health and well-being when they had greater trust in God.

Jews and mental health

Most of the studies in the field of religion and mental health are based on Christian populations, but different religions may be related to different associations between the two phenomena. A recent body of work indicates that for Jews, both in Israel and elsewhere, religion is also related to better well-being (Levin & Prince, 2011). For Diaspora Jews, affirming the importance of God in one's life and attendance at synagogue were both found to be associated with greater happiness (Levin, 2012b). Moreover, using religion and trust in God for coping with difficult events were related to lower depression and anxiety (Krumrei, Pirutinsky, & Rosmarin, 2013; Rosmarin, Pargament, & Mahoney, 2009). Research on the Jewish-Israeli population found that religiosity, measured with different indicators, is linked to better life satisfaction (Levin, 2012b, 2013c), less stress and a healthier life style (Shmueli & Tamir, 2007), better well-being (Levin, 2011, 2013b) and happiness (Levin, 2013b, 2014).

While there is a growing interest in the relation between Judaism and mental health among Israeli-Jews, few studies have looked specifically at older Israeli Jews. Two such analyses based on the first wave of the Survey of Health, Aging and Retirement in Europe (SHARE) found that synagogue attendance was related to less depression, better life quality, more optimism and better health, while higher prayer frequency had inverse associations, that is, more depression, poorer life quality, less optimism and worse health. The investigator suggested that prayer is used as a coping mechanism in the face of poorer mental health and deteriorating health, while synagogue attendance might serve as a protective factor or might confound with functional health (Levin, 2012a, 2013a). However, as both studies only examined main effects, the mechanism through which religion is actually related to mental health can only be speculated.

Other studies on Israeli-Jews and mental health have also focused on the main effects of religion. In the current study, therefore, we would like to examine these effects more deeply in order to see if religiosity indeed acts as a coping mechanism for the older population,

protecting the practitioners from the influence of harsh situations. A similar approach was used by Pirutinsky et al. (2011) who looked at intrinsic religiosity, measured by means of an intrinsic religiosity subscale assessing the presence of religion in one's life. The study showed that among Jews with low intrinsic religiosity, lower physical health was related to more depression, while this relationship did not exist for those with high intrinsic religiosity. This indicates that religion may be helpful in buffering the negative effects of deteriorating health, but the findings are limited to the measurements of intrinsic religiosity and depression, and mainly to the population of American Jews (which consisted of 83% of the study participants).

Common measures in the study of religion and mental health include depression, anxiety, self-esteem and well-being (Koenig, 2012). In the current research, we focus on the positive potential of old age, as older people enjoy healthier and longer lives than ever before. With more free time and more disposable income they can continue to develop themselves and pursue their interests (Higgs, Hyde, Wiggins, & Blane, 2003). This active side of old age can be measured with the CASP scale of quality of life in old age. The scale's creators claim that quality of life consists of four domains: control, autonomy, self-realization and pleasure. While the first two reflect the conditions that need to be fulfilled for someone to be able to participate freely in society, the latter two reflect the active side of old age which can be pursued once these requirements have been met (Higgs et al., 2003). Accordingly, self-realization and pleasure have been found to load on a single factor in a factor analysis of the CASP scale (Creech, Hallam, Varvarigou, McQueen, & Gaunt, 2013; Sexton, King-Kallimanis, Conroy, & Hickey, 2013). This active part is a meaningful element of well-being in old age, and its maintenance is important in times of stress.

Based upon this review, the current study has several aims. First, we wish to describe the current state of religiosity among older Israeli Jews. Second we aim to examine the factors that are related to religiosity in this population. Third, we seek to clarify the role of religiosity vis a vis the mental health of older Jews in Israel, particularly in states of poor health. Toward this end, we hypothesize that in the face of deteriorating physical health, religiosity is associated with somewhat better mental health.

Methods

Data and Sampling

The present study is based on data from the Survey of Health, Ageing and Retirement in Europe (SHARE), in which Israel has participated since 2005. The survey interviews respondents aged 50 years and older as well as their partners of any age. The current analysis used data from the second wave of the survey in Israel, collected in the years 2009–2010. We limited most of the analysis to the respondents who were interviewed in Hebrew (67%), most of whom were assumed to be Jewish. We excluded recent immigrants from the former Soviet Union (after 1989) who were interviewed in Russian, insofar as some of them are not Jewish according to strict Jewish law (Halacha) and several are only partly Jewish or their Jewish identity is of a non-religious character (Remennick, 2002). The Arabic speaking Israeli respondents, all of whom are Muslim or Christian, were also excluded. Finally, we focused on respondents aged 50 and over and excluded younger spouses, as the former were

drawn through probability sampling and the findings related to them may be generalized to the larger population. The final study sample thus consisted of 1,637 respondents.

Study Variables

The main variable of interest in the study was a measure of religiosity, operationalized as prayer frequency. This variable served as the outcome of interest in the first part of the analysis, and as a key independent variable in the second part. Participants were asked “Thinking about the present, how often do you pray?”, and they could choose one of six response options – (1) “Never” (2) “Less than once a week” (3) “Once a week” (4) “A couple of times a week” (5) “Once daily” (6) “More than once a day”. Thus, a higher score means a higher prayer frequency.

A second major independent variable was ill health, measured as the number of health conditions from which the respondent suffered in the 12 months prior to the interview. Respondents were asked to cite the health conditions that they had experienced from among a list of 12 possible conditions, such as swollen legs, sleeping problems and falling down. The ill health variable was calculated as a count of the cited conditions and its score ranged from 0–12, with a higher score indicating more such conditions.

The study also controlled for five background socioeconomic variables. These were age, gender, years of education, marital status and subjective economic status. Age and years of education were both entered as continuous variables. Gender was a dichotomous variable (0=“male”, 1=“female”). Marital status was also a dichotomous variable, in which the score of 1 reflected respondents with a partner, that is, they were either married and living with their partner or in a partner relationship. Respondents classified as 0 were divorced, widowed, never married or married but not living with their partner.

Economic status was taken into account using a subjective indicator. Respondents were asked “Thinking of your household’s total monthly income, would you say that your household is able to make ends meet...”. They answered with one of the following four response options: (1) “With great difficulty” (2) “With some difficulty”; (3) “Fairly easily” (4) “Easily”.

The dependent variable in the second part of the analysis, well-being, was a calculated self-realization/pleasure score drawn from part of the 12-item CASP scale which measures quality of life. The CASP scale is made up of twelve statements divided into four sub-scales – autonomy, control, self-realization and pleasure. Each statement is measured on a 4-point Likert scale showing how often it is relevant in the respondent’s life: (1) “Often”, (2) “Sometimes”, (3) “Not often”, or (4) “Never”. The CASP is a validated scale with a good level of internal consistency (Wiggins, Netuveli, Hyde, Higgs, & Blane, 2008).

The self-realization/pleasure score that was used in the current analysis is the average of the self-realization and pleasure sub-scale scores combined. The items were recoded such that a higher score reflects a greater frequency of self-realization and pleasure. Examples of items from the scale include “I feel that life is full of opportunities” (self-realization scale) and “On balance, I look back on my life with a sense of happiness” (pleasure scale). We

considered cases as missing if they had three or more missing items on the 6-item measure. The self-realization/pleasure subscale obtained a good level of internal consistency ($\alpha = 0.83$).

In order to test whether the self-realization/pleasure score does consist of a separate subscale in the study population we carried out a factor analysis with an orthogonal rotation (varimax). Our results point to a different sub-scale for self-realization/pleasure, similarly to previous findings in other populations using CASP-12 (Creech et al., 2013; Sexton et al., 2013). In the analysis three extracted components were retained having met the criteria of an eigenvalue greater than one. The three factors were: 1) self-realization/pleasure; 2) a control subscale with one variable from the autonomy subscale (“you can do the things that you want to do?”); 3) two variables from the autonomy subscale (“family responsibilities prevent you from doing what you want to do?”; “shortage of money stops you from doing the things you want to do?”). The three retained factors accounted for a cumulative 56% of the variance in the dataset. Further results are available upon request.

Statistical Analysis

The analysis proceeds in several stages. First the sample is described, showing sample means and standard deviations for continuous variables and percentages for categorical variables. We also note the average prayer frequency among Israeli Jews aged 50 and above and compare it to the same in several European countries.

We then execute two multivariate analyses. The first seeks to identify the variables associated with religiosity. It employs an OLS regression, in which prayer frequency is regressed on the background and sociodemographic variables. The second multivariate analysis attempts to understand the factors related to well being among older Israeli Jews, and specifically, the association of religiosity with self-realization/pleasure. Toward this end we undertake a hierarchical OLS regression, using three models to find the associations between religiosity and self-realization/pleasure, controlling for the other study variables as well as for the interaction between prayer frequency and ill health.

Results

Sample Description

The description of the study sample can be seen in Table 1. The sample consists of a majority of women and of respondents who have a partner. The average age among respondents is 67 years, and the average of years of education is 12 years. The respondents report, on average, two health conditions and rate only minor difficulty regarding the household’s ability to make ends meet (mean=2.8). Their average score on the self-realization/pleasure subscale is 3.4, indicating a relatively high appraisal of self-realization/pleasure.

Turning to religiosity, we note that the average frequency of prayer is less than weekly (mean=2.4). Specifically, of the 1,567 participants who described their prayer frequency, 49% never pray, 16% pray less than once a week, 12% pray once a week, 3% pray a couple of times a week, 10% pray once daily and 10% pray more than once a day.

Comparison with Europe

Figure 1 presents the average prayer frequency for Jewish Israeli respondents aged 50 and above in comparison with the same in the European countries that participated in wave 2 of SHARE. The graph reveals that the Hebrew speaking Israeli respondents have low prayer frequency relative to many of their counterparts in the European countries. The Israeli Jews pray less often, on average, than everyone except the respondents in Denmark, Sweden and the Czech Republic. This may be because such a large percentage do not pray at all, lowering the overall average. The highest prayer frequency among the SHARE countries is reported by respondents from Ireland, followed by those from Poland and Greece.

Comparing the three language groups within Israel—Hebrew, Arabic and Russian—turns up additional differences. A one way analysis of variance (ANOVA) showed that there are significant differences between the three groups in regard to prayer frequency ($F(2,2324)=404.01, p<.001$), and a post hoc test with a Bonferroni correction showed that all three groups were different from each other ($p<.001$). Among the Arabic speaking Israeli respondents, 70% pray more than once a day and only 7% never pray. In addition, Arab-Israelis pray more frequently, on average, than respondents in all the SHARE countries. In stark contrast, among the Russian speaking Israeli respondents, 68% never pray and only 4% pray more than once a day. On average, the recent immigrants to Israel from the former Soviet Union are the least religious of all the SHARE respondents. The Hebrew speaking respondents in Israel fall between these two extremes, with an average rate of prayer closer to the lower end of the frequency distribution in Europe.

Multivariate Analyses

The first multivariate analysis regressed religiosity on the background and sociodemographic variables using an OLS regression model. The results are presented in Table 2. They show that higher frequency of prayer is associated with having fewer years of education, being male, married, having more health conditions and more trouble making ends meet. There was no significant association of prayer frequency with age. However, we should note that the variables in the model explain only 5% of the variance.

In the second multivariate analysis the self-realization/pleasure outcome was regressed on the study variables using a hierarchical OLS regression model. The results are presented in Table 3. In Model 1, self-realization/pleasure was regressed exclusively on prayer frequency. As may be seen, the association between the two variables was not significant, initially. In Model 2, we added the background and sociodemographic controls to the regression. After taking the control variables into account, the association between religiosity and self-realization/pleasure became significant and positive. That is, a higher frequency of prayer was associated with greater self-realization/pleasure. All the control variables had significant associations with self-realization/pleasure as well, such that greater self-realization/pleasure was linked with having more years of education, lower age, being female, having a partner, fewer health conditions and finding it easier to make ends meet. The variables in the model accounted for 32% of the explained variance in the self-realization/pleasure outcome.

In Model 3 we entered a variable measuring the interaction between prayer frequency and the number of health conditions. As may be seen in table 3, the association with the interaction was significant, indicating that for people who pray more often there is a weaker negative association between detrimental health conditions and self-realization/pleasure. The graph of this interaction is presented in Figure 2. It shows that the negative relationship between ill health and self-realization/pleasure is mitigated by the more often one prays. The addition of this interaction term clarified the association but added only a minor amount to the explained variance.

We note also that the association between prayer frequency and self-realization/pleasure, independent of its interaction with ill health, is no longer significant in Model 3 after entering the interaction term. This indicates that for older people with no ill health conditions, prayer frequency is not related to self-realization/pleasure. This is in contrast to the associations with the control variables, which remain significant.

In order to compare our results to those that may be seen among non-Jewish respondents in Europe, we conducted the same OLS regression for the sample of European countries (not shown). (We excluded France, in which only 72 respondents answered the question regarding prayer frequency). The analysis revealed a quite different pattern of results compared to those obtained in the Jewish-Israeli sample. In the first model, in which self-realization/pleasure was regressed on prayer frequency alone, the association was significant. It remained significant in the next two models, even after adding the sociodemographic variables and the interaction with health conditions. However, in contrast to the results obtained in the Jewish-Israeli sample, the interaction variable was not significant.

Discussion

The current study focused on older Jewish-Israeli adults and found them to be quite varied in their praying habits. While almost half of them never pray, the rest range from praying less than once a week to praying more than once a day. Those who pray more often appear to be in a worse state, in terms of health conditions and financial well-being, and they have fewer years of education. They are also more likely to be male and to be married. However, prayer frequency is not related to well being per se, measured here as self-realization/pleasure. The results also showed that older Jewish-Israelis are less religiously observant, on average, than most of their non-Jewish counterparts in Europe (and much less religiously observant than older people from the Arab population in Israel).

The findings also indicate that when facing hardship in the form of detrimental health conditions, older Jewish-Israelis who pray more often have a relatively lesser decline in self-realization/pleasure. This implies, according to Higgs et al. (2003), that they might be better able to enjoy their lives and to continue developing their interests despite their health limitations, compared to their secular counterparts. This aspect of life quality is particularly important to maintain when facing deteriorating physical conditions, as the latter has a potentially devastating influence on emotional well-being. The lesser decline may also stem from greater social support which is encouraged by religion (Koenig, 2012), for instance the

Jewish requirement for a quorum of at least ten adults for certain religious obligations, called a “minyan” (Moskovitz, 2002). Religion can also assist in dealing with hardship by providing the believer a sense of meaning and purpose (Koenig, 2012).

The findings in our study are in accordance with the empirical literature on the same phenomenon among older Christians elsewhere in the world (mainly in the United States). The general literature shows that among those facing physical or financial adversities, religion is related to better mental health, either through a relatively moderate decline in mental health or through a complete lack of such a decline (Hayward et al., 2012; Idler & Kasl, 1992; Koenig et al., 2004; Krause & Hayward, 2014; Pirutinsky et al., 2011; Wink et al., 2009). The current study added to this field of inquiry with additional evidence that religion may be a helpful coping mechanism in the Jewish-Israeli older population as well (Levin, 2013a). Moreover, while previous studies have demonstrated this association in regard to depression, life satisfaction and a sense of control, the current study showed such an effect on self-realization/pleasure, a key factor of quality of late life.

The results from the current analysis indicate that religion is of particular importance for older Jewish Israelis who face detrimental health conditions, and that those who use prayer as a coping mechanism may be better able to maintain their quality of life and their ability to enjoy life. This is highly relevant information for those who are responsible for the care of older people. When physical decline comes on, as a result of debilitating illness, caregivers can help maintain a sense of active living by encouraging their religiously observant care recipients to pray. However, we must not forget that the majority of older Jewish-Israeli are not religiously observant and they are unlikely to adopt a religious perspective so late in life, even when facing illness. For them, therefore, the efficacy and the potential of prayer to mitigate the effects of illness in old age would seem to be quite minimal.

A few limitations of the current study should be acknowledged. One limitation is the cross-sectional nature of the analysis, which does not allow for making causal explanations. A future study should use longitudinal data to examine the chain of events that link between Jewish religiosity, health and quality of life. Another limitation might be our exclusive use of a single indicator for measuring religiosity, that is, prayer frequency. Religion is a multidimensional construct that includes beliefs, practices and behaviors, and there are other aspects of the phenomenon that can be measured (Koenig et al., 2012).

However, prayer frequency is the main variable in the SHARE survey which relates to religiosity, leading to our somewhat focused operationalization of the construct. Moreover, the advantages of having a diverse variable set that reflects a wide range of control variables along with the very large sample that SHARE offers for analysis outweigh the limitations inherent in the use of a single variable to capture religiosity. Future studies may address this shortcoming by utilizing a different data base, perhaps one with more religion-oriented content, such as the International Social Survey Programme (ISSP) (Levin, 2014). Future research may also examine the mediating variables of the religion-health interaction, in the spirit of the study by Pirutinsky et al. (2011). They found social support to be a mediating factor for the influence of religiosity and physical health on depression, but only among non-Orthodox Jews.

In sum, this inquiry sheds new light on the nature and the concomitants of religiosity among older Jews in Israel in the current era. We found that religiosity may indeed have an ameliorative role in the face of illness, but only among the observant. Given that most of the older Jews of Israel belong to the less observant cohort of the founding generation of the State, the potential trials and tribulations of very old age may not be lessened for most of them by religious practice or spirituality.

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Figure 1.
Prayer frequency in Europe and Israel: Country averages

Figure 2.
The interaction of prayer frequency and health conditions in relation to the self-realization/pleasure score

Table 1

Prayer frequency and background characteristics of the sample: Descriptive statistics

Analysis Variable	Mean (SD)	Percent
Prayer frequency	2.40 (1.75)	
Self-realization/pleasure	3.37 (0.63)	
Gender (female)		56.14
Marital Status (partner)		76.26
Age	67.30 (9.72)	
Education (years)	12.23 (4.44)	
Number of health conditions	1.93 (2.15)	
Making ends meet	2.77 (1.01)	

Table 2

The correlates of prayer frequency among older Jewish Israelis: OLS regression Predicted variable: Prayer frequency

	Coefficient	Std. Error	Beta
Education (years)	−0.036 **	0.011	−0.090
Age	0.000	0.005	0.004
Gender (female)	−0.225 *	0.091	−0.063
Marital Status (partner)	0.231 *	0.113	0.055
Health conditions ¹	0.087 ***	0.023	0.106
Making ends meet ²	−0.216 ***	0.049	−0.124
Constant	3.290 ***	0.426	
Adjusted R Squared	0.053		

Notes:

p < .001,

**
p < .01,

*
p < .05;

n =; Variable ranges:

¹
0–11;

²
1–4;

n = 1432

Table 3
Prayer frequency, health conditions and self-realization/pleasure: Hierarchical OLS regression Predicted variable: self-realization/pleasure

	Model 1			Model 2			Model 3		
	Coefficient	Std. Error	Beta	Coefficient	Std. Error	Beta	Coefficient	Std. Error	Beta
Prayer frequency ¹	-0.008	0.009	-0.024	0.027***	0.007	0.077	-0.002	0.010	-0.006
Education (years)				0.016***	0.003	0.115	0.016***	0.003	0.112
Age				-0.007***	0.001	-0.116	-0.008***	0.001	-0.118
Gender (female)				0.080**	0.028	0.064	0.086**	0.028	0.069
Marital Status (partner)				0.125***	0.035	0.083	0.133***	0.035	0.088
Health conditions ²				-0.118***	0.007	-0.396	-0.158***	0.011	-0.529
Making ends meet ³				0.083***	0.015	0.134	0.084***	0.015	0.135
Interaction: health conditions X prayer frequency							0.014***	0.003	0.190
Constant	3.399***	0.027		3.468***	0.136		3.548***	0.137	
Adjusted R Squared		-0.000			0.321			0.328	

Notes:

p < .001,

**
p < .01,

*
p < .05;

n=; Variable ranges:

¹
1-6;

²
0-11;

³
1-4;

n= 1432