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Religious Attendance, Healthy Lifestyles, and Perceived Health: A Comparison of Baby Boomers with the Silent Generation

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Abstract
Baby boomers are aging, and their health is an important concern. Research has suggested that (1) aging boomers are more vulnerable to mental and physical health problems than their parents' generation; (2) adoption of healthy lifestyles is critically important for the health of the aging population; and (3) religious attendance, often found to be associated with health-related outcomes, is lower among aging boomers than their parents' generation. In this research, we use a large national dataset to examine (1) whether the baby boom generation lags behind their parents' generation in adoption of healthy lifestyles and perceived health; and (2) if it does, whether the lag might possibly be attributed to lower religious attendance. We analyzed data collected by University of Michigan's Health and Retirement Study from the silent generation in 1994 and from the baby boom generation in 2010 when both generation cohorts were at about the same age (age 49–64 years). The results indicated that (1) the baby boom generation lagged behind the silent generation in adoption of three healthy lifestyles (not smoking, not drinking excessively, and not being overweight or obese) and in perceived health; (2) the lag may be partially attributed to lower religious attendance in the baby boom generation. We also discuss implications for the health of the baby boom generation and for promoting healthy lifestyles and health to the baby boom generation.

Keywords Baby boom generation · Silent generation · Religious attendance · Perceived health · Healthy lifestyles

Introduction

The baby boom generation, a population cohort born after World War II, is important for research on aging, spirituality, and health (Knapp and Pruett 2006; MacKinlay 2014; MacKinlay and Dundon 2012). In the USA, for example, the 79 million baby boomers born between 1946 and 1964 are one of America's largest population cohorts (US Census Bureau 2014). With the boom generation aging, America's population is getting

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significantly older: in 1970, only 9.8% of US residents were aged 65 and over; the figure was 13% in 2010 and is projected to be more than 20% by 2030 (Colby and Ortman 2014). Accelerated aging of the population will present unique challenges to America's healthcare system and large-scale societal programs such as social security and medicare (Barry and Blow 2016).

In this paper, we explore whether baby boom generation's health-related lifestyles and perceived health may be partially attributed to their religious attendance (Chung et al. 2016; Krause 2015). On the one hand, research has documented that baby boomers have higher rates of obesity, hypertension, and chronic diseases, poorer mental health status, more disability, and lower self-rated health than members of the previous generation at the same age (e.g., King et al. 2013; Moyle et al. 2014; West et al. 2014), and are more downbeat about their overall quality of life than are adults who are younger or older (Pew Research 2008). There is also ample research evidence that many chronic diseases are lifestyle related and preventable (e.g., Chakravarty et al. 2012; King et al. 2013; Moyad and Low 2008; Shaw and Agahi 2012). Even people who newly adopt a healthy lifestyle in middle age will experience prompt health benefits (King et al. 2007, 2009). The key to successful health care lies in increased adoption of healthy lifestyles, often defined as not smoking, not drinking excessively, being physically active, and not being overweight or obese (Chakravarty et al. 2012; King et al. 2013).

On the other hand, research has well documented the linkages between religious attendance and health-related outcomes (e.g., Benjaminsa and Brown 2004; Krause 2003; Salmoirago-Blotcher et al. 2011; Tait et al. 2011). Under the influence of the countercultural movement in the 1960s–1970s, many baby boomers dropped out of religious institutions as they rebelled against the "establishment" including the religious establishment (Hoge et al. 1994; Roof and Johnson 1993). Roof and Johnson (1993, p. 293) pointed out: "Trauma surrounding the civil rights movement and later the Vietnam War, and the changing moral, sexual, and familial values of the countercultural years, all combined to produce a youthful defection from the religious establishment." A 1993 research reported that about 67% of baby boomers left formal religion, including 42% who left and had not returned and 25% who left for some time and had returned (Boomer Generation Central 2016). These figures are close to other research estimates that 52% of baby boomers attended church and 48% did not (Hoge et al. 1994). Although more aging boomers are returning to religious institutions (New York Times 2012), Pew Research (2015) found that religious attendance was markedly lower with only 38% of baby boomers attending religious service at least once a week compared with 51% of the silent generation.

Given the above evidence, more research is needed to explore (1) whether the aging baby boom generation lag behind their parents' generation in adoption of healthy lifestyles and perceived health; and (2) if it does, whether the lag might possibly be attributed to lower religious attendance. In this research, we use a large national dataset to address these questions.

Methods

Data Collection

Data were extracted from University of Michigan's Health and Retirement Study (HRS) Project to test our research hypotheses. HRS is a large-scale longitudinal research project

which conducts biennial interviews and surveys of a representative sample of the aging American since 1992. Supported by the National Institute on Aging (part of the National Institutes of Health) and the Social Security Administration, HRS is designed to provide reliable data on the decisions, choices, and behaviors of Americans as they age and respond to changes in public policy, the economy, and health. HRS data are appropriate for this research because the HRS project interviewed the silent generation and the baby boom generation and the survey questionnaires included questions that can address our research concerns.

Two datasets were extracted from the databases of the HRS Project, one from the 1994 HRS surveys of respondents in the silent generation born between 1930 and 1945 (hereafter referred to as the silent generation dataset) and another from the 2010 HRS surveys of respondents in the baby boom generation born between 1946 and 1964 (hereafter referred to as the baby boom generation dataset).

The datasets included only survey respondents aged between 49 and 64 in the year of the HRS surveys. In the 1994 HRS surveys, a total of 10,115 people in the silent generation who were aged between 49 and 64 years were interviewed and surveyed. In the 2010 HRS surveys, of the 10,223 people in the baby boom generation who were aged between 49 and 64 years, only a subset of the sample were interviewed and surveyed with the questions relevant to our research (e.g., 5746 were asked the smoking question).

Research variables extracted and recoded were demographics (age, gender, education, marital status, and race/ethnicity), religious attendance, perceived health, and adoption of four healthy lifestyles (not smoking, not drinking excessively, being physically active, and not being overweight or obese). In the silent generation dataset, 1389 respondents had missing data points. In the baby boom generation dataset, 1354 respondents had missing data points. After excluding respondents with missing data points, the silent generation dataset had 8726 respondents (86.27% of the total sample) and the baby boom generation dataset had 4392 respondents (76.44% of the total sample).

Primary Measures

Perceived health (HEALTHY) was measured by asking respondents to assess their own health (poor, fair, good, very good, or excellent). Perceived health was then recoded as *not healthy* (= poor or fair) or *healthy* (= good, very good, or excellent).

Not smoking (NSMOKE) was coded as a binary variable (*a smoker*; *not a smoker*) depending on whether a respondent was a smoker currently or not a smoker currently (never smoked or smoked but quitted).

Not drinking excessively (NDRINKEX) was coded as a binary variable (*drinking excessively*; *not drinking excessively*) according to HRS and CDC definitions of binge drinking and heavy drinking.

Physically active lifestyle (ACTIVE) was coded as a binary variable (*not physically active*; *physically active*) depending on whether or not a respondent had more than 12 times of physically moderate or rigorous activity in a month according to federal government recommendations (Chakravarty et al. 2012; King et al. 2007).

Not being overweight or obese (NOBESE) was measured by first calculating the BMI index of a respondent based on his/her body weight and body height and then recoded as *not overweight or obese* (BMI index less than 25) or *overweight or obese* (BMI index greater than 25).

Religious attendance (ATTEND) was measured as frequency of attending religious service in the past year (more than once a week, once a week, two or three times a month, one or more times a year, or not at all). Religious attendance was then recoded as *not attending* (attending religious service one or more times a year, or not attending at all) and *attending* (attending religious service two or three times a month, once a week, or more than once a week).

The demographic profiles of the two samples are reported in Table 1.

Statistical Analysis

First, descriptive statistics of the sample were obtained. Inspection of the descriptive statistics provides an initial check of the data. When appropriate, Chi-square analyses were performed to obtain more specific differences between the silent generation and the baby boom generation in perceived health, adoption of healthy lifestyles, and religious attendance.

Finally, two regression models that included generation cohort, religious attendance, and demographic variables were used to empirically address the two research questions. In regression model 1, the criterion was adoption of healthy lifestyles, a summary score of four healthy lifestyles which ranged between 0 and 4, had a mean of 2.18, and was normally distributed. Predictor variables included were generation (the silent generation or the baby boom generation), religious attendance (attending or not attending), the interaction between generation and religious attendance, and demographic variables of gender (male, female), age (49–54, 55–59, 60–64), education (high school or below, college or above), race/ethnicity (white, not white), and marital status (married or not married).

Table 1 Demographic profiles of the samples

		Silent generation	Baby boomers
Sample size	*n*	8726	4392
Age		49–64	49–64
Gender	Male	3772 (43.2%)	2183 (49.7%)
	Female	4954 (56.8%)	2209 (50.3%)
Education	< HS	2427 (27.8%)	1105 (25.2%)
	HS	3147 (36.1%)	2137 (48.7%)
	College	2346 (26.9%)	864 (19.7%)
	> College	806 (9.2%)	286 (6.5%)
Marital	Married	6530 (74.8%)	2394 (54.5%)
	Not married	2196 (25.2%)	1998 (45.5%)
Race	White	6336 (72.6%)	2313 (52.7%)
	African-Americans	1429 (16.4%)	1299 (29.6%)
	Latino	798 (9.1%)	582 (13.3%)
	Other	163 (1.9%)	198 (4.5%)

Regression model 2 was logistic regression as the criterion, perceived health, was dichotomously coded as healthy or not healthy. Predictor variables included were generation (the silent generation or the baby boom generation), religious attendance (attending or not attending), the interaction between generation and religious attendance, demographic variables of gender (male, female), age (49–54, 55–59, 60–64), education (high school or below, college or above), race/ethnicity (white, not white), and marital status (married or not married).

Results from Descriptive Statistics and Chi-Square Analyses

The descriptive statistics of the silent generation and the baby boom generation are reported in Table 2.

As can be seen in Table 2, 76.6% of the silent generation and 65.8% of the baby boom generation perceived themselves as healthy, indicating that baby boomers who perceived themselves as healthy were 11.1% less than in the silent generation ($\chi^2 = 172.44$, $p < 0.001$). With regard to adoption of healthy lifestyles, baby boomers lagged behind in three healthy lifestyles: (1) The proportion of those who did not smoke was 76.0% in the silent generation and 59.1% in the baby boom generation—a significant difference of 16.9% ($\chi^2 = 398.76$, $p < 0.001$); (2) the proportion of those who did not drink excessively was 92.6% in the silent generation and 72.2% in the baby boom generation—a significant difference of 20.4% ($\chi^2 = 999.33$, $p < 0.001$); (3) the proportion of those who were not overweight or obese was 35.3% in the silent generation and 24.6% in the baby boom generation—a significant difference of 10.7% ($\chi^2 = 152.99$, $p < 0.001$). As a silver lining, baby boomers were more physically active: the proportion of people who were physically active was 20.7% in the silent generation and 34.8% in the baby boom generation—a significant difference of 14.1% ($\chi^2 = 303.54$, $p < 0.001$). These results seem to suggest that the aging boom generation lagged behind the silent generation in terms of perceived health and adoption of three healthy lifestyles (not smoking, not drinking excessively, and not being overweight or obese).

Table 2 also indicated that religious attendance is higher in the silent generation (56.3% attending) than in the baby boomer generation (43.7% attending)—a statistically significant difference of 12.5% ($\chi^2 = 185.97$, $p < 0.001$). The descriptive statistics by religious attendance and generation cohort are reported in Table 3.

Table 2 Descriptive statistics of the silent generation and the baby boom generation

	Silent generation ($n = 8726$)		Baby boomers ($n = 4392$)	
	Yes	No	Yes	No
ATTEND	4917 (56.3%)	3809 (43.7%)	1919 (43.7%)	2473 (56.3%)
HEALTHY	6685 (76.6%)	2041 (23.4%)	2891 (65.8%)	1501 (34.2%)
NSMOKE	6632 (76.0%)	2094 (24.0%)	2597 (59.1%)	1795 (40.9%)
NDRINKEX	8080 (92.6%)	646 (7.4%)	3169 (72.2%)	1223 (27.8%)
ACTIVE	1809 (20.7%)	6917 (79.3%)	1527 (34.8%)	2865 (65.2%)
NOBESE	3079 (35.3%)	5647 (64.7%)	1082 (24.6%)	3310 (75.4%)

ATTEND attending religious service, *HEALTHY* perceived health, *NSMOKE* not smoking, *NDRINKEX* not drinking excessively, *ACTIVE* being physically active, *NOBESE* not being overweight or obese

Table 3 Descriptive statistics by religious attendance and generation cohort

		Attending		Not Attending	
		Silent generation (n = 4917, 56.3%)	Baby boomers (n = 1919, 43.7%)	Silent generation (n = 3809, 43.7%)	Baby boomers (n = 2473, 56.3%)
HEALTHY	Yes	3809 (77.5%)	1300 (67.7%)	2876 (75.5%)	1591 (64.3%)
	No	1108 (22.5%)	619 (32.3%)	933 (24.5%)	882 (34.7%)
NSMOKE	Yes	4114 (83.7%)	1279 (66.6%)	2518 (66.1%)	1318 (53.3%)
	No	803 (16.3%)	640 (33.4%)	1291 (33.9%)	1155 (46.7%)
NDRINKEX	Yes	4684 (95.3%)	1524 (79.4%)	3396 (89.2%)	1645 (66.5%)
	No	233 (4.7%)	395 (20.6%)	413 (10.8%)	828 (33.5%)
ACTIVE	Yes	1044 (21.2%)	666 (34.7%)	765 (20.1%)	861 (34.8%)
	No	3873 (78.8%)	1253 (65.3%)	3044 (79.9%)	1612 (65.2%)
NOBESE	Yes	1699 (34.6%)	425 (22.1%)	1380 (36.2%)	657 (26.6%)
	No	3218 (65.4%)	1494 (77.9%)	2429 (63.8%)	1816 (73.4%)

HEALTHY perceived health, *NSMOKE* not smoking, *NDRINKEX* not drinking excessively, *ACTIVE* being physically active, *NOBESE* not being overweight or obese

First of all, generation cohort differences can be observed in perceived health and adoption of healthy lifestyles regardless of religious attendance. For example, 77.5% of people in the silent generation who attended religious service perceived themselves as healthy, while 67.7% of baby boomers who attended religious service perceived themselves as healthy—the difference of 9.8% was statistically significant ($\chi^2 = 69.12$, $p < 0.001$). Similarly, 75.5% of people in the silent generation who did not attend religious service perceived themselves as healthy while 64.3% of baby boomers who attended religious service perceived themselves as healthy—the difference of 11.2% was statistically significant ($\chi^2 = 91.07$, $p < 0.001$).

On the other hand, regardless of generation cohorts, religious attendance seems to be positively associated with differences in adoption of two healthy lifestyles (not smoking, and not drinking excessively) and perceived health between those who attended religious service and those who did not. Specifically:

Not smoking In the silent generation, the proportion of people who did not smoke was 83.7% among those who attended religious service and 66.1% among those who did not attend religious service, a significant difference of 17.6% ($\chi^2 = 362.97$, $p < 0.001$). Similarly, in the baby boom generation, the proportion of people who did not smoke was 66.6% among those who attended religious service and 53.3% among those who did not attend religious service, a significant difference of 13.3% ($\chi^2 = 79.73$, $p < 0.001$).

Not drinking excessively In the silent generation, the proportion of people who did not drink excessively was 95.3% among those who attended religious service and 89.2% among those who did not attend religious service, a significant difference of 6.1% ($\chi^2 = 116.66$, $p < 0.001$). Similarly, in the baby boom generation, the proportion of people who did not drink excessively was 79.4% among those who attended religious service and 66.5% among those who did not attend religious service, a significant difference of 12.9% ($\chi^2 = 89.47$, $p < 0.001$).

Religious attendance seems to be associated with being physically active in the silent generation ($\chi^2 = 1.72$, $p = 0.19$) or the baby boom generation ($\chi^2 = 0.01$, $p = 0.94$). Religious attendance seems to be negatively associated with not being overweight or obese

in the baby boom generation ($\chi^2 = 11.37$, $p < 0.01$), but this pattern did not hold in the silent generation ($\chi^2 = 2.64$, $p = 0.10$).

Perceived health In the silent generation, the proportion of people who perceived themselves as healthy was 77.5% among those who attended religious service and 75.5% among those who did not attend religious service, a small but statistically significant difference of 2.0% ($\chi^2 = 4.60$, $p < 0.05$). Similarly, in the baby boom generation, the proportion of people who perceived themselves as healthy was 67.7% among those who attended religious service and 64.3% among those who did not attend religious service, a small but statistically significant difference of 3.4% ($\chi^2 = 5.58$, $p < 0.05$).

Results from Regression Analyses

Two regression models that included generation cohort, religious attendance, their interaction term, and demographic variables were used to address the two research questions. Results are reported in Table 4. Model 1 was a multiple regression model and interpretation of its coefficients is relatively straightforward. As Model 2 was a logistic regression model, explanation may be needed in interpreting estimates odds ratios.

An *odds ratio* reflects the probability of having an event of interest compared with not having an event of interest (e.g., Berenson et al. 2009; Hair et al. 2005). The effect of an independent variable is reflected in the magnitude and direction of change in the odds value relative to 1. Therefore, with a one-unit change in an independent variable:

1. If the probability to report being healthy is 0.5 and the probability to report not being healthy is (1 − 0.5), the odds ratio is 0.5/(1 − 0.5) = 1. An odds ratio equal to 1 means the independent variable has no effect since one-unit change in the independent variable will neither increase nor decrease the odds to report being healthy (change in odds value = 1 − 1 = 0%);

Table 4 Parameter estimates of regression models

	Model 1 (criterion = ADOPTION) Standardized coefficient	Model 2 (criterion = HEALTHY) Standardized odds ratio
Predictor variables		
Generation cohort	0.25**	1.23*
Religious attendance	− 0.23**	0.70**
Interaction term	0.05	1.07
Age	0.04**	0.83**
Gender	0.14**	1.03
Education	0.24**	2.64**
Race/ethnicity	0.14**	2.40**
Marital status	− 0.14**	0.65**
R^2	0.11	0.14[a]

ADOPTION adoption of healthy lifestyles, *HEALTHY* perceived health

*$p < 0.01$; **$p < 0.001$

[a]Nagelkerke R^2

2. If the probability to report being healthy is 0.75 and the probability to report not being healthy is 0.25, the odds ratio is 0.75/0.25 = 3. An odds ratio significantly greater than 1 means the independent variable has a positive effect since one-unit change in the independent variable will *increase* the odds to report being healthy by 200% (change in odds value = 3 − 1 = 200%);
3. If the probability to report being healthy is 0.25 and the probability to report not being healthy is 0.75, the odds ratio is 0.25/0.75 = 0.33. An odds ratio significantly smaller than 1 means the independent variable has a negative effect since one-unit change in the independent variable will *decrease* the odds to report being healthy by 67% (change in odds value = 0.33 − 1 = − 67%).

With the above explanation, we now move on to interpret the results of Model 1 and Model 2.

First, we look at the demographic variables. Education had positive effects on adoption of healthy lifestyles and perceived health: One-unit increase in education was associated with 0.24 unit increase in adoption of healthy lifestyles and 164% increase in the odds to report being healthy (odds ratio = 2.64, $p < 0.001$; probability to report being healthy = 0.73). Age had a positive effect on adoption of healthy lifestyles and a negative effect on perceived health such that one-unit increase in age was associated with 0.04 unit increase in adoption of healthy lifestyles and 17% decrease in the odds to report being healthy (odds ratio = 0.83, $p < 0.001$; probability to report being healthy = 0.45). With regard to gender, female respondents were 0.14 unit higher in adoption of healthy lifestyles but were not significantly different than male respondents in the odds to report being healthy. Compared with white/Caucasian respondents, respondents who were not white (African-Americans, Latinos, or other) were 0.14 unit higher in adoption of healthy lifestyles and 140% higher in the odds to report being healthy (odds ratio = 2.40, $p < 0.001$; probability to report being healthy = 0.71). Compared with married respondents, unmarried respondents were 0.14 lower in adoption of healthy lifestyles and 35% lower in the odds to report being healthy (odds ratio = 0.65, $p < 0.001$; probability to report being healthy = 0.39).

More importantly, the regression results directly addressed our research questions. Does the baby boom generation lag behind the silent generation in adoption of healthy lifestyles and perceived health? The results in Tables 2 and 4 provided support to this hypothesis because, (1) in Table 4, compared with the baby boom generation, the silent generation was 0.25 unit higher in adoption of healthy lifestyles and 23% higher in the odds to report being healthy: odds ratio = 1.23, $p < 0.01$, probability to report being healthy = 0.55; and (2) as shown in Table 2, the baby boom generation lagged largely in three healthy lifestyles—not smoking, not drinking excessively, and not being overweight or obese.

Can the baby boom generation's lag be attributed to lower religious attendance? The results in Tables 2 and 4 supported that the baby boom generation's lag may be partially attributed to lower religious attendance because, (1) in Table 4, having accounted for the effects of generation cohort and demographic variables, respondents who did not attend religious service were 0.23 unit lower in adoption of healthy lifestyles and 30% lower in the odds to report being healthy than respondents who attended religious service: odds ratio = 0.70, $p < 0.001$; probability to report being healthy = 0.41; (2) the effect of religious attendance did not depend on generation cohort as the interaction term did not have a significant effect on either adoption of healthy lifestyles or perceived health; and (3) as shown in Table 2, the baby boom generation had a significantly lower proportion of religious attendance and significantly lower adoption of healthy lifestyles.

Discussion

We analyzed a big national dataset and found that (1) the baby boom generation lagged behind the silent generation in perceived health and adoption of three healthy lifestyles—not smoking, not drinking excessively, and not being overweight or obese; and (2) the lag may be partially attributed to lower religious attendance in the baby boom generation. These findings have interesting implications for baby boomers to reap health benefit and for healthcare institutions and public policy makers to promote healthy lifestyles to the baby boom generation.

First, our research results clearly indicate the positive role religious institutions can play for aging boomers to maintain health via lifestyle changes. This is particularly true when more baby boomers, as they age, are returning to church. Religious attendance was found to be associated with not smoking, not drinking excessively, and better perceived health. These results were consistent in both the silent generation sample and the baby boom generation sample. Second, our results also point to the potential for public health programs to partner with religious institutions for preventive health care to more effectively influence health behaviors. For example, while health education programs may motivate baby boomers to take more personal responsibility in maintaining health, religious institutions may play an important role in strengthening self-control and self-regulation needed for actual adoption of healthy lifestyles and health maintenance behaviors (McCullough and Willoughby 2009). Finally, our results also point to the challenges America's healthcare system and societal programs have to face as the boom generation gets older, since healthcare costs and service demand will go up not only because of the bigger cohort size but also because the generation has lower perceived health, lower adoption of healthy lifestyles, and a bigger proportion who do not attend religious service compared with their parents' generation.

Research Limitations

The research findings in this paper were based on the silent generation sample and the baby boom generation sample obtained from the Health and Retirement Study (HRS). Although HRS worked very hard to obtain a nationally representative sample, it is practically difficult to determine whether these samples were representative of the silent generation in 1994 or the baby boom generation in 2010.

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Compliance with Ethical Standards

Conflict of interest The author declares that he has no conflict of interest.

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