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Leaving my religion: Understanding the relationship between religious disaffiliation, health, and well-being

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ABSTRACT

Religious disaffiliation—leaving the religious tradition in which one was raised for no religious affiliation in adulthood—has become more common in recent years, though few studies have examined its consequences for the health and well-being of individuals. We use an innovative approach, comparing the health and subjective well-being of religious disaffiliates to those who remain affiliated using pooled General Social Survey samples from 1973 through 2012. We find that religious disaffiliates experience poorer health and lower well-being than those consistently affiliated and those who are consistently unaffiliated. We also demonstrate that the disadvantage for those who leave religious traditions is completely mediated by the frequency of church attendance, as disaffiliates attend church less often. Our results point to the importance of the social processes surrounding religious disaffiliation and emphasize the role of dynamics in the relationship between religious affiliation and health.

1. Introduction

Research on the sociology of religion has focused on how modes of religious affiliation and participation intersect with other dimensions of social life. Sociologists have noted that religious individuals exhibit better health and well-being outcomes, have lower death rates in old age, and report higher subjective well-being ("happiness") than the less religious or nonreligious (George et al., 2002; Idler et al., 2003; Sullivan, 2010). Since 1990, there has been a rapid rise in the fraction of Americans claiming no religious affiliation, and a substantial portion of this growth reflects an increase in disaffiliation among Mainline Protestants and white Catholics (Putnam and Campbell, 2010). According to the General Social Survey in 2012, 20% of all American adults claimed no religious affiliation, and 75% of those with no religion report being raised in a religious tradition. Religious disaffiliation has become increasingly common in the United States, and the processes surrounding its causes and consequences have received more attention recently (Schwadel, 2014; Vargas, 2012). Religious disaffiliation represents a particularly important process in religious change since it may be associated with significant changes in the social relationships surrounding religious affiliation, practice, and behavior (Uecker et al., 2007). In turn, these changes may have implications for health and well-being and can improve our understanding of the relationship between religious participation and health.

Little research has focused on the individual implications of leaving a religious tradition, and the few existing studies attempt to link life course events to changes in religious affiliation, identifying the social experiences that lead individuals

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to leave religious congregations. The primary existing study that has examined the relationship between religious switching and health is the work of Scheitle and Adamczyk (2010). They demonstrate that switching from high-cost religions—those that induce a greater commitment—is associated with poorer reported health. Our study extends this consideration to a greater examination of religious disaffiliation itself, and examines subjective well-being in addition to health. We use a nationally-representative survey to examine the association between religious disaffiliation and health. Instead of simply comparing the religious and non-religious, we investigate the health and well-being of individuals who *leave* the religions in which they were raised, examining all religious traditions together as well as focusing on specific religious denominations in the United States. We demonstrate that religious disaffiliates experience poor health and lower subjective well-being than their counterparts who remain affiliated. We find that this effect is strongest for Evangelical Protestants and Catholics and does not exist for Mainline Protestants. We suggest that these disadvantages largely reflect the loss of the social benefits of religion following disaffiliation, but also find evidence for a role of the spiritual aspects among Evangelical Protestants. Like Scheitle and Adamczyk (2010), we find that disaffiliates from high-cost religions report poorer health. However, they do not report lower subjective well-being, as disaffiliates from other religious groups do.

2. Background

2.1. Religious affiliation, health, and well-being

The religious tend to have significantly better health than the non-religious; Jews, Mainline Protestants and Catholics tend to live longer than those affiliated with no religion (Sullivan, 2010). The relationship between religion and health holds across many measures of religious participation, but the most consistent findings refer to active religious engagement (Dupre et al., 2006). Religious individuals also report that they are happier than the non-religious. Although this relationship reflects a similar process to the relationship between religion and health, well-being is likely to emphasize different dimensions of religious involvement (Childs, 2010; Ellison, 1991). This is an important area of study for sociologists since the most promising explanations for the health and well-being advantage associated with religion are social in nature (Shor and Roelfs, 2013).

First, it is possible that the relationship between religion and health is not causal, and instead reflects observed or unobserved differences between religious and non-religious individuals. Happier and healthier people may be more likely to participate in religion and may reap greater benefits from the social aspects of religious involvement (Miller and Thoresen, 2003). While negative health events may increase religiosity (McFarland et al., 2013), they may also serve as barriers to religious participation, particularly if functional disability limits the ability to attend religious services (Benjamins et al., 2003). Previous research has shown that reverse causation accounts for only a small portion of the religion–health relationship (Oman et al., 2002).

Second, the relationship may be causal, with religion directly leading to better health and well-being. Religious participation may bring positive emotional benefits as a means to cope with stressful or adverse life events (Nooney and Woodrum, 2002; Pollner, 1989). There is some evidence that individuals use prayer as a means of coping with stress (Pargament et al., 2004), although these benefits differ considerably by race and socioeconomic circumstances (Krause, 2003). Overall, the health or psychological well-being benefits of prayer depend considerably on images of God as either personal or remote (Bradshaw et al., 2008, Bradshaw et al., 2010).

Finally, the relationship may be causal but the effect of religious participation may be indirect. For instance, religion may provide strict behavioral directives regarding lifestyle factors that have effects on physical health. In addition to exhorting members to practice behavioral temperance, church congregations may also monitor members' behavior in which religious social networks influence healthy behavior change (Scheitle and Adamczyk, 2010). Social networks may have generalized health and well-being benefits as well. Those individuals with strong networks of social ties and support feel a stronger sense of integration into social life, avoiding the negative emotional and socio-psychological effects of social group isolation (Seeman et al., 2004). Social relationships have a notable positive impact on physical and mental health, and a great deal of research has been devoted to the underlying mechanisms (Umberson and Montez, 2010). Here, sociologists of religion have an important role in linking religious involvement to health and well-being, since religion plays an important role in individuals' social embeddedness and social integration, providing for many a crucial source of both strong and weak social ties (McClure, 2013).

Religious attendance is often used as a proxy for the social characteristics of religious involvement (Dupre et al., 2006; Sullivan, 2010). Attendance at religious services is inherently social, and qualitative research suggests that many individuals place a high value on the social relationships developed through church-based social networks (Banerjee et al., 2014; Holt and McClure, 2006). The social benefits of attendance are the primary determinants of improvements of well-being for those who attend frequently (Childs, 2010), but these benefits may not occur specifically during attendance (Idler et al., 2009). Individuals do not receive most of their social ties benefits from the actual act of attending, but instead from the friendship and acquaintance networks that derive therefrom (Rote et al., 2013), as well as from secular activities such as volunteering and civic engagement (Lewis et al., 2013). However, as a proxy of the social aspects of religion, attendance is one of the primary reasons for better health and well-being among the religious (Strawbridge et al., 2001).