The Mental Health Case for Religion

The strongest mental health research connects sustained religious participation with healthier coping and well-being.

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MENTAL HEALTH

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Note: This piece is the first in a three-part series that reviews the best available science on the connections between religiosity and health. Part 1 discusses mental health; Part 2 discusses physical health; and Part 3 discusses social-relational health.

Memes like "God is dead" and "Science is real" have become T-shirt banners of contemporary secularism. These statements make an implicit claim: the more seriously we take science, the less seriously we should take religion. But when the bantering subsides, one serious empirical question remains: What does the best science reveal about whether religion helps or harms us as individuals and as a nation?

Medicine and social science recently reached a landmark with the publication of "The Handbook of Religion and Health," a Duke and Harvard University collaboration. Described as "stunningly ambitious" by former U.S. Assistant Secretary for Health Howard Koh, the text included only the most rigorous 5% of studies conducted on religion and health (about 2,800 out of 60,000).

The bad news is that the volume contains 1,100 oversized pages with small font. The good news is that our multidisciplinary team from BYU and Duke University recently mined these pages and completed three condensed reports on "Religion and Mental Health," "Religion and Physical Health," and "Religion and Social Health," so that you can see the grand scope of the 1,100-page volume without requiring an optometrist visit.

Our Research Team

Our team brought together four disciplinary vantage points. These were medicine, where mental illness bleeds into physical illness; the criminal justice system, where untreated depression, addiction, and isolation harden into costly incarceration; family and human development, where anxiety and trauma reverberate across families long before clinicians intervene; and the workplace, where poorly handled stress and isolation diminish productivity. Each of us wanted to know what the best science revealed about whether religious involvement helped or harmed mental health—or both.

What the Science Reveals

Following the lead of the Duke–Harvard team, our BYU–Duke team divided the best studies into nine mental health foci:

1. Bipolar Disorder
2. Schizophrenia (and other psychoses)
3. Coping with stress
4. Depression
5. Anxiety
6. Personality Traits & Disorders
7. Positive Emotion
8. Suicide

9. Addiction & Substance Abuse

Each scientific study that made the cut for rigor (the top 5%) was examined by the Duke-Harvard team to see if the core findings indicated:

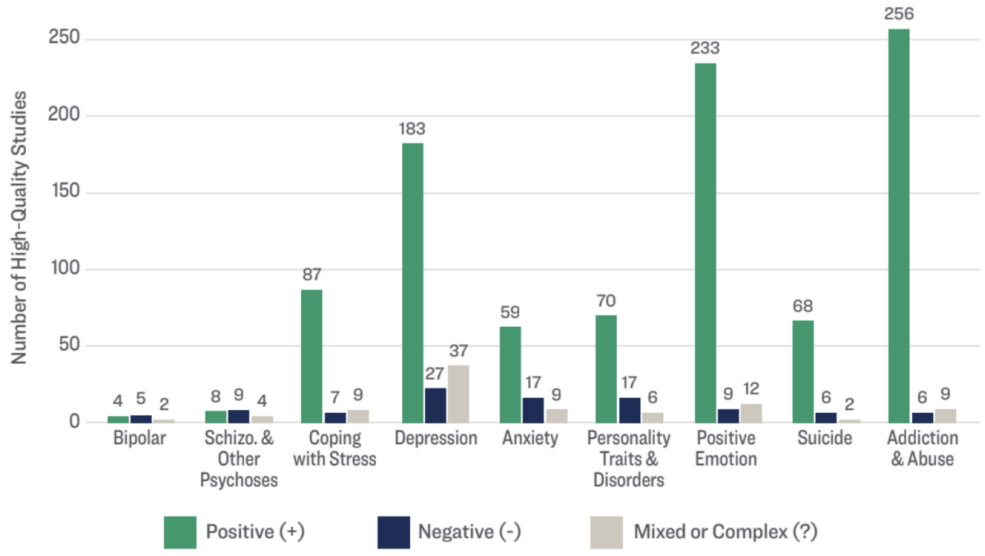
(1) a **positive** association between higher religiosity/religious involvement and improved mental health;

(2) a **negative** association that showed that higher religiosity/religious involvement was connected with decreased mental health; or

(3) **mixed or complex findings**.

Our team revisited these same studies, using the Duke-Harvard system to categorize the core findings. We then tallied the studies by whether the study showed a positive, negative, or mixed relationship between the aspect of mental health and religious involvement. Across the nine mental health phenomena, here is the breakdown of studies:

FIGURE 3: Significant Positive & Negative Findings across Nine Mental Health Phenomena



Our report indicates that the limited findings on religiosity and bipolar disorder is mixed, with a slight tilt toward negative findings. Research on schizophrenia and other psychoses shows a similar pattern. Religion may not be helpful with more severe, biologically-based psychoses, although the number of studies is small and inconclusive.

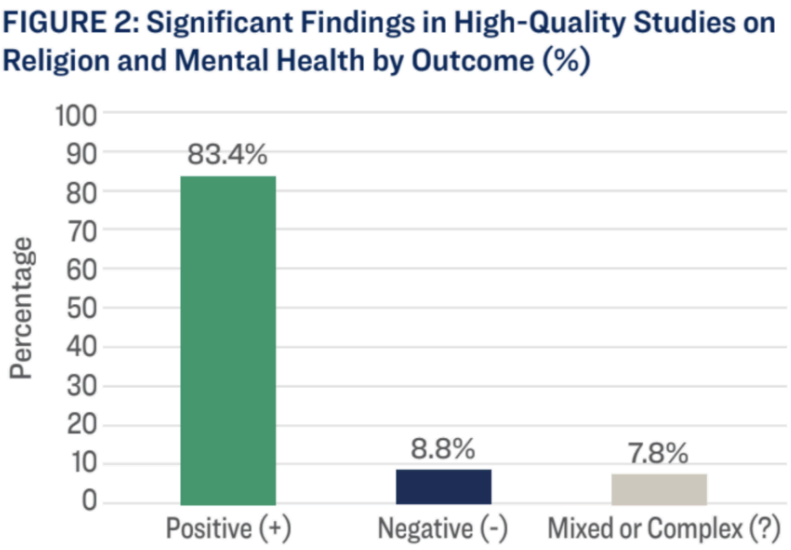
By contrast, the high-quality studies consistently suggest a link between religious involvement and better mental health across seven mental health phenomena. The positive-to-negative study ratios were approximately 7:1 for depression and anxiety, 4:1 for personality traits and disorders, 11:1 for suicide, 12:1 for coping with stress, 26:1 for positive emotion, and 43:1 for substance abuse and addiction.

It is important to clarify that correlation is not causation. However, the handbook authors note that "there is now relatively strong evidence for at least some of the association between religious service attendance and lower suicide rates being causal."

Indeed, research conducted at the Harvard T.H. Chan School of Public Health has used advanced statistical methods to analyze longitudinal data in ways that strengthen causal inference. Although randomized controlled trials remain the gold standard for identifying causal effects, these newer methods can, under appropriate assumptions, provide evidence that approaches the strength of causal conclusions.

Taken together, the best available evidence indicates that religious beliefs, practices, and participation in faith communities are linked to improved mental health outcomes far more often than to adverse outcomes.

Across the mental health domains summarized above, 961 empirical studies found beneficial associations between religious involvement and mental health. Only 101 studies found adverse associations—an overall positive-to-negative ratio of nearly 10:1. In many of the studies reporting adverse associations, the key finding involved what a leading psychologist of religion Kenneth Pargament has called "negative religious coping," for example, framing stressors as punishments from God.



Except in the cases of bipolar disorder and schizophrenia—where findings are mixed—*religiosity in the best studies to date tends to be significantly correlated with positive outcomes across most mental and psychological health phenomena*. In the case of some phenomena—including suicide, coping with stress, substance abuse and addiction, and positive emotion—the scientific case for religion as a correlate of health is overwhelming. As we will see in two subsequent reports in this three-part series, religiosity not only correlates with desirable mental and psychological health outcomes; it has also been repeatedly correlated with significant positive outcomes in physical health and social-relational health domains.

The Threshold Effect: How Much Religion Does It Take?

A close look at the best science on the religion–health connection suggests a "**threshold effect.**" In other words, the benefits of religion appear to be concentrated among those with sustained, high engagement. Hundreds of studies link religious involvement to better mental health, elevated physical health (including lower cancer rates), and significantly longer lifespan. Family-level gains have also been documented, including greater marital stability, higher marital quality and satisfaction, and stronger parent-child relationships.

However, only individuals with "significant commitment to their faith" seem to attain the threshold "where measurable benefits are discernible and often substantive." Occasional attendees do not enjoy the same benefits. In practice, the threshold is *at least*

weekly service attendance, with associated health benefits observed from adolescence into older adulthood and across racial and ethnic groups and faith traditions.

Across the strongest studies on mental health, religious involvement is most powerfully associated with healthier coping with stress, lower rates of depression and anxiety, markedly lower rates of substance abuse, and substantially reduced suicidality.

To restate, addiction and suicide—two of the most devastating drivers of family breakdown and criminal justice involvement—are domains where the positive influence of religion is strongest. Of the 271 of the best studies on the connection between religion and substance abuse, 256 (94%) found a correlation between religion and significantly reduced substance abuse. Regarding rising suicide rates in the U.S., Harvard's Tyler VanderWeele has linked 40% of this tragic increase to declining church attendance.

Our team's hope is fourfold. First, we hope that some who are currently below the threshold of religious participation will consider becoming more involved in their faith communities. Greater involvement may increase their likelihood of receiving significant benefits and contributing to the well-being of others

Second, we hope that persons of "threshold-level" faith will find increased reason for devotion to their sacred communities of care. We hope that these foundational members of diverse faith communities will continue to contribute their time, money, energy, and selves with a heightened awareness of the associated benefits and blessings.

Third, we hope that people will recognize the tremendous public and personal good that religion offers. We hope they will foster enlightened pluralism in which religious individuals and groups can both produce and receive many established benefits.

Fourth—and perhaps most of all—we hope that those who are already deeply aware of the benefits and blessings of lasting fellowship in a religious community will seek to extend that warm and welcoming concern to all—including those with differing beliefs. May we remember the two-fold wisdom of the late Rabbi Jonathan Sacks, who observed, "Religion is at its best when it relies on the strength of…example. It is at its worst when it seeks to impose truth by force."

About the authors

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