

# Religion & Human Flourishing

A THREE-REPORT SERIES



REPORT

1

## The Religion & Mental Health Connection

### What Does the Best Science Reveal?

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# Contents

<b>Religion &amp; Human Flourishing Executive Summary.....</b>	<b>3</b>
Scope & Methodological Approach .....	<b>3</b>
Overview of Findings Across Domains .....	<b>4</b>
Mental Health .....	<b>5</b>
Physical Health .....	<b>5</b>
Social and Relational Health .....	<b>5</b>
Policy Implications and Recommendations.....	<b>6</b>
Conclusion.....	<b>6</b>
<b>REPORT 1 - The Religion &amp; Mental Health Connection..</b>	<b>7</b>
On the Risks and Benefits of Religious Involvement .....	<b>7</b>
Growth in Evidence-Based Study of Religion .....	<b>8</b>
The Religion and Mental Health Connection .....	<b>9</b>
Religion and Psychological Coping with Stress .....	<b>9</b>
Religion, Depression, and Anxiety .....	<b>10</b>
Religion and Personality Traits and Disorders.....	<b>11</b>
Religion and Positive Emotion .....	<b>11</b>
Religion and Suicide.....	<b>12</b>
Religion and Substance Abuse and Addiction .....	<b>13</b>
Religion, Bipolar Disorder, and Schizophrenia .....	<b>14</b>
Conclusion: Religion’s Connection with Measurable Mental Health Outcomes .....	<b>16</b>
Appendix A: Notable Findings from High Quality Scientific Studies.....	<b>19</b>
Appendix B: Plausible Reason for Strong Religion and Mental Health Connections .....	<b>25</b>
References .....	<b>28</b>
Executive Summary Endnotes .....	<b>39</b>
The Religion & Mental Health Connection Endnotes .....	<b>41</b>

# Religion & Human Flourishing

## Executive Summary

Over the past several decades, religion has moved from the center of American public life toward the margins. Most Americans now say religion is losing influence, and participation has declined across much of the developed world.<sup>1</sup> At the same time, many Americans have shifted sources of identity and moral meaning away from religious commitments toward politics, popular culture, science, or some combination of the three.<sup>2</sup> As this shift continues, it invites closer examination of how changes in religious involvement relate to individual well-being—including mental and physical health—as well as to family relationships and broader social life. Drawing on thousands of the most rigorous medical and social science studies available,<sup>3</sup> this three-report series provides a clear, evidence-based answer. Religious involvement is most often associated with significant benefits across domains—including linkages to better mental health, improved physical health, and stronger family and community connections.<sup>4</sup> Taken together, the evidence suggests that religion remains a powerful but frequently overlooked resource for human flourishing, one whose role merits greater attention in research and policy discussions.

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### Scope and Methodological Approach

This executive summary synthesizes findings from the three-part series *Religion and Human Flourishing*, published by the Wheatley Institute at Brigham Young University. Each report draws primarily on the findings of the *Handbook of Religion and Health, 3rd ed. (2024)*, authored by Harold G. Koenig, Tyler J. VanderWeele, and John R. Peteet—scholars who have played a central role in shaping the scientific study of religion and health since the publication of the first *Handbook* in 2001.<sup>5</sup>

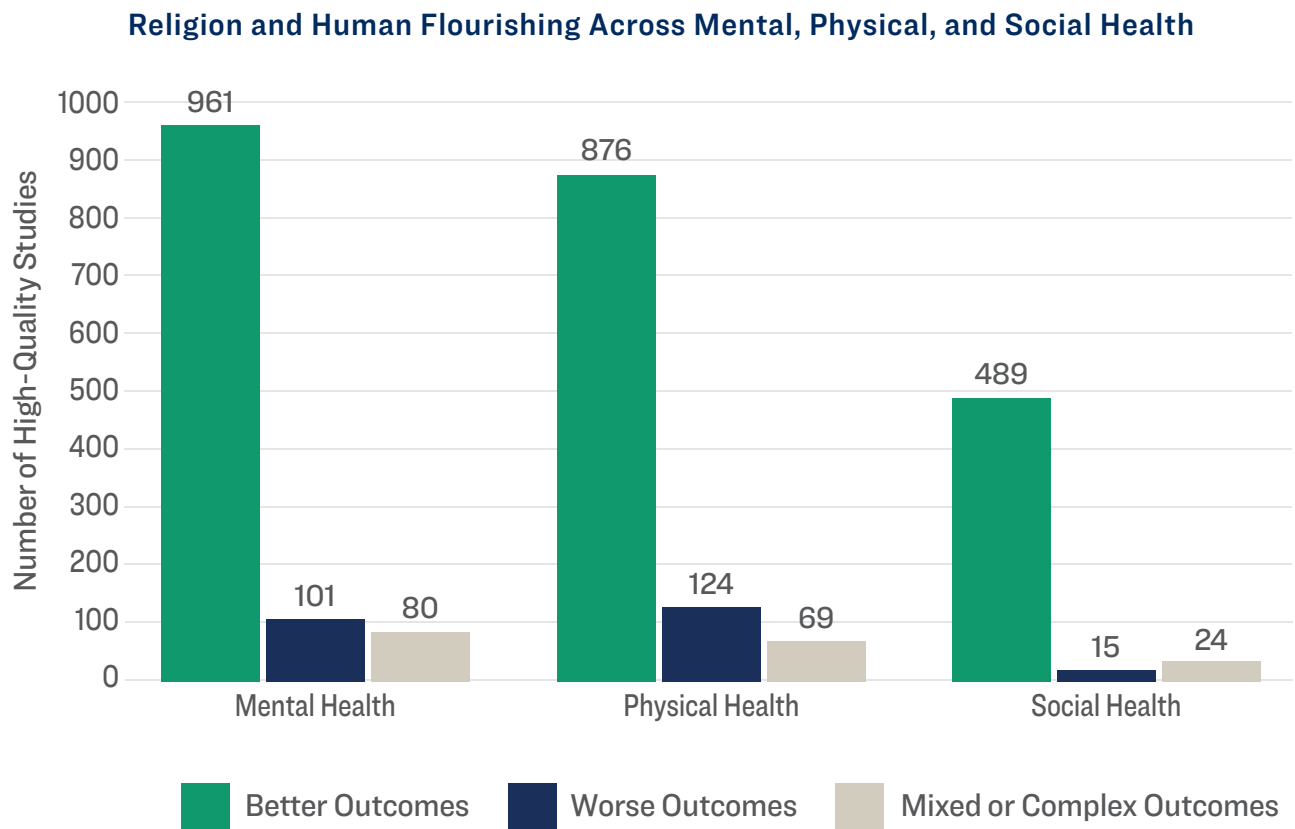
The research literature expanded rapidly from the first edition in 2001, which reviewed just over 1,200 studies,<sup>6</sup> and the second edition in 2012, which cataloged approximately 2,800 studies from a single decade alone.<sup>7</sup> By the time of the third edition in 2024, tens of thousands of peer-reviewed studies on religion and health were available.<sup>8</sup> Faced with this dramatic growth, Koenig and his coauthors undertook an extensive screening process, systematically focusing on studies meeting stringent methodological criteria, including large samples, careful statistical controls, and clinically or socially meaningful outcomes.<sup>9</sup>

Because many studies report null findings, this series focuses specifically on studies reporting statistically significant associations, allowing for clearer comparisons between beneficial and harmful relationships between religion and mental, physical, and social health. The result is a careful, high-confidence synthesis of what the strongest available scientific evidence reveals about religion and human flourishing.

## Overview of Findings Across Domains

Across the three reports, we examine at least two dozen distinct mental, physical, and social health phenomena. At a broad level, the evidence consistently points in one direction: religious involvement is far more often associated with beneficial outcomes than harmful ones.<sup>10</sup>

To illustrate the distribution and strength of findings across domains, Figure 1 presents a comparative summary of high-quality studies examining relationships between religion and mental health, physical health, and social and behavioral health. The largest number of positive findings appears in the literature on mental health, followed by the research on physical health—reflecting the size and maturity of those research fields. Although the corpus on social and relational health includes fewer total studies overall, it shows a striking pattern: positive findings overwhelmingly outnumber negative ones, with comparatively little evidence of harm. Figure 1 demonstrates that across all three domains—whether measured by the volume of evidence or by the balance of outcomes—religious involvement is far more often associated with better outcomes than negative ones.



**Figure 1.** Comparison of high-quality studies reporting positive, negative, and mixed associations between religious involvement and outcomes across mental health, physical health, and social and behavioral health domains. Counts reflect studies meeting the inclusion criteria outlined in the 2024 *Handbook*.

## Mental Health

The first report, *The Religion and Mental Health Connection*, reviews the highest-quality studies on religious involvement and its relationship to psychological well-being, emotional functioning, and psychiatric outcomes. Studies reporting positive associations between religious involvement and mental health (961) outnumber those reporting negative associations (101) by nearly 10:1.<sup>11</sup>

The strongest evidence links religious involvement to lower suicide risk,<sup>12</sup> better coping with stress,<sup>13</sup> reduced substance abuse and addiction,<sup>14</sup> and higher levels of hope, meaning, and life satisfaction.<sup>15</sup> Although harmful or coercive forms of religion do exist,<sup>16</sup> the overall pattern across the best available studies is clear: religious belief and practice are overwhelmingly associated with better mental and emotional well-being.

## Physical Health

The second report, *The Religion and Physical Health Connection*, focuses on the most carefully designed studies across fifteen physical health domains. Across all domains examined, positive associations (876) substantially outnumber negative ones (124), with an overall ratio of approximately 7:1.<sup>17</sup>

Religious participation is consistently associated with lower mortality risk,<sup>18</sup> dramatically lower rates of cigarette smoking,<sup>19</sup> reduced substance abuse,<sup>20</sup> and improved outcomes related to cardiovascular disease,<sup>21</sup> and other chronic conditions.<sup>22</sup> When studied rigorously, religious involvement shows meaningful and measurable links to improved physical health and longevity.

## Social and Relational Health

The third and final report, *The Religion and Social Health Connection*, reveals the strongest pattern of all. Drawing on 528 of the most rigorous studies identified in the *2024 Handbook*, 489 (93%) reported positive associations between religion and social health, compared with only 15 (3%) reporting negative associations—a ratio of approximately 31:1.<sup>23</sup>

The evidence linking religiosity to lower crime and delinquency is especially strong, with a positive-to-negative ratio of 69:1.<sup>24</sup> Studies also show robust associations between religious involvement and greater social support,<sup>25</sup> higher rates of volunteering and charitable giving,<sup>26</sup> stronger marriages, lower divorce rates, reduced domestic violence, and greater family stability.<sup>27</sup> Research further suggests that religious involvement is associated with more positive views of children,<sup>28</sup> along with higher fertility<sup>29</sup>—indicating a potential role in sustaining family life and long-term social continuity.

**Studies reporting positive associations between religious involvement and mental health (961) outnumber those reporting negative associations (101) by nearly 10:1.**

## Policy Implications and Recommendations

1. **Recognize religious participation as a health-supporting factor.** Strong evidence links sustained religious participation with better mental health, healthier behaviors, lower addiction rates, stronger social ties, and longer life. Public health and social service frameworks should recognize religious involvement as a voluntary, evidence-supported contributor to individual and community well-being.
2. **Create choice-based links between health care and faith communities.** Health and social service systems should offer opt-in pathways for individuals who want faith-based support as part of care or recovery. Basic faith literacy for professionals can improve trust, engagement, and outcomes without compromising clinical standards or religious pluralism.
3. **Partner with religious organizations where evidence of health benefits is strongest.** Faith communities are well positioned to support prevention and recovery efforts related to substance use, suicide, family stability, and social support. Governments and health systems should include religious organizations as partners in cross-sector efforts to address these challenges.
4. **Craft policy around protection of the freedom to practice religion.** The benefits documented in this research depend on individuals' ability to practice their faith freely. Policies and institutional practices should therefore reasonably accommodate religious expression and safeguard religious freedom across traditions.
5. **Base policy decisions on evidence, not assumptions.** Policy discussions about religion and health should be grounded in rigorous research rather than stereotypes or isolated anecdotes. The best available evidence shows that religious involvement is far more often associated with positive outcomes for individuals, families, and communities.

## Conclusion

Across mental, physical, and social domains, the best available scientific evidence consistently shows that religious involvement is associated with improved outcomes for individuals and for society. While religion is not a cure-all, and harmful expressions do exist, the overall pattern is neither mixed nor evenly divided. Instead, across hundreds of high-quality studies, positive associations outweigh negative ones by wide margins.

As societies confront rising rates of mental illness, addiction, social fragmentation, and family instability, the evidence suggests that **religion remains a consequential and often underrecognized contributor to human flourishing**. Understanding how, when, and why religion promotes well-being is therefore not only an academic concern but a matter of broad social importance.

# The Religion & Mental Health Connection

## What Does the Best Science Reveal?

Today, 80% of Americans say religion is losing influence in American life.<sup>8</sup> Sociologist Christian Smith's book-length study *Why Religion Went Obsolete: The Decline of Traditional Religion* (2025) provides data that support this perception. One international study in the last decade that examined national levels of religiosity found that the United States ranked 14% lower in religiosity than formerly communist Russia.<sup>9</sup> Many Americans have replaced religious commitments and identity with devotion to aspects of politics, popular culture, science, or all three.<sup>10</sup>

Religion has been a controversial issue in popular media for decades. Unfortunately, shock is a more effective hook than carefully measured and well-established scientific findings about religion. As a result, we have a cultural susceptibility to listen to loud voices coming from various (and often extreme) cultural and political perspectives instead of making the effort to understand what rigorous analyses of scientific data reveal.<sup>11</sup>

In an effort to combat extremes and the misinformation they can produce, we ask a central question: As we begin the second quarter of the 21st century, **what do the best medical and social science studies tell us about religion and mental, physical, and social health?** In this report, the first in a three-part series on religion and health, we draw on findings from medicine, psychology, family studies, and sociology that examine religion's connection with mental health. Report 2 will address physical health, and Report 3 will address social health.

## On the Risks and Benefits of Religious Involvement

Systematic reviews of the best of thousands of published empirical studies indicate that the majority report positive correlations between religion and various forms of health. Even so, some research studies on religion and health yield null, complex, or mixed findings.<sup>12</sup> As this report will show, there are also some studies that point to negative aspects of religion and mental health.

So is there bad religion? In the views of some influential voices, there was (and is) no other kind. Sigmund Freud derided religion as humankind's universal obsessional neurosis. Indeed, Rodney Stark, a leading sociologist of religion, observed that Freud once referred to religion as an "intoxicant," a "poison," and "childishness to be overcome"—all within the span of a single page.<sup>13</sup> Karl Marx, the influential coauthor of *The Communist Manifesto*, called religion the "opiate of the masses." A third voice, prominent psychologist Albert Ellis, described religion as a form of psychopathology or mental illness.<sup>14</sup> In recent years, the "Four Horsemen of New Atheism" (Richard Dawkins, Daniel Dennett, Sam Harris, and Christopher Hitchens) have argued that religion is not only silly superstition and deserving of ridicule but is also dangerous<sup>15</sup> and thus deserving of strident attack.

Even some leading scholars with predominantly positive views of religion have acknowledged some real dangers. One of the great figures in 21st century Judaism, the late Rabbi Jonathan Sacks, posited that "*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.*"<sup>16</sup> One leading social scientist of religion, Davidollahite, has similarly observed that religion has been a force for both profound good and profound harm:

Throughout history and across faiths and cultures, religion has led to both good and evil—to peace and war, to liberation and slavery, to justice and oppression, to kindness and killing, to love and hate, to charity and greed, to hospitality and terrorism, and to familial joy and familial sorrow. Religion influenced both Mother Teresa of Calcutta and Osama bin Laden; both the Inquisition and the Red Cross; both the horror of 9/11 and the healing of the Muslim relief agency Red Crescent; both the violent fanaticism of members of the Ku Klux Klan and the peaceful patience of Martin Luther King, Jr., and Mahatma Gandhi; both interfaith violence in the Middle East, Africa, and India and interfaith cooperation after natural disasters from various faith-based relief agencies.<sup>17</sup>

## Growth in Evidence-Based Study of Religion

In terms of religious harms, the horror of 9/11 in 2001 was one focal point of Rabbi Sacks' book-length study *Not in God's Name: Confronting Religious Violence*. In that same year, Harold Koenig and colleagues produced the first of three editions of the *Handbook of Religion and Health* (2001, 2012, 2024). This handbook series published by Oxford University Press has systematically catalogued the most rigorous science regarding religion's helps and harms. This work allows the careful, empirical reader to move beyond dogmatic claims (from either religionists or anti-religionists) to assess how, when, and why religion appears to help or harm individual, family, and community flourishing.

After a slow and laborious commencement, the scientific field of religion and health has expanded exponentially over the past four decades. In the foreword of the first edition of the *Handbook of Religion and Health*, pioneering researcher Jeff Levin wrote that “there was a time [circa 1985] . . . when those of us actively investigating the linkages between religion and health could have fit around a single conference table. A very small one.”<sup>18</sup> The first edition of the *Handbook* presented systematic coverage of “more than 1,200 studies and 400 research reviews conducted in the twentieth century.”<sup>19</sup> The second edition of Koenig and colleagues' *Handbook of Religion and Health* (2012) mentioned about 2,800 studies from the decade of 2000–2010, representing an exponential increase in the field. By the release of the third edition (2024), however, the scope and quantity of related work had exploded.

Google Scholar searches conducted in September 2025 on “religion and health peer-reviewed studies” yielded the following number of studies for the post-1985 years indicated:

- **1985–1994:** 2,980
- **1995–2004:** 16,600
- **2005–2014:** 19,900
- **2015–2025:** 17,400

Given the staggering scope of the now-available research,<sup>20</sup> Koenig and his coauthors, Harvard professors Tyler VanderWeele and John Peteet, chose to emphasize the most methodologically rigorous studies available.<sup>21</sup> Anchored in the *Handbooks of Religion and Health* series, this report, *The Religion and Mental Health Connection*, is representative of the best-available quantitative studies.

## The Religion and Mental Health Connection

In the latest (2024) edition of the *Handbook of Religion and Health*, which includes mental, physical, and social health, Harold Koenig and colleagues devoted nine chapters to the relationship between religion and mental health. Of the most rigorous studies reporting significant findings, 83.4% reported positive correlations between religion and mental health (961 of 1,152), while 8.8% (101) reported negative findings (e.g., unhealthy connections), and 7.8% (90) reported complex or mixed findings. In the aggregate, among the best available religion and mental health studies to date, significant positive findings outnumber negative findings by a ratio of almost 10:1.<sup>22</sup> Focal topics include coping, depression, anxiety, personality traits and disorders, positive emotion, drugs and substance abuse, bipolar disorder, and schizophrenia.

A key question arises: Why is religion typically related to better mental health outcomes? One answer is that religion often encourages positive coping, as outlined next.

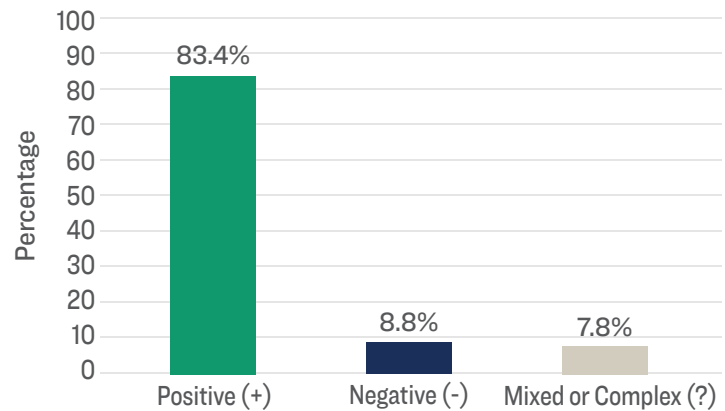
### Religion and Psychological Coping with Stress

A consistent finding in the literature is that religion serves as a vital resource for coping with stress, providing individuals and families with frameworks of meaning, strength, and support in the face of adversity. Kenneth Pargament, the leading scholar of religion and psychological coping, identified three distinct approaches to religious coping. These include:

- (1) the **self-directing approach**, where [individuals] or families recognize the existence of God or a higher power but choose not to involve the Divine in coping with the stressor [e.g., “I got this”];
- (2) the **deferring approach**, where an individual or family “passes the burden” to God and the entire coping responsibility is deferred to the Divine [e.g., “I give it to you, God”];
- and (3) the **collaborative approach**, wherein the coping responsibility is shared between the family and their God [e.g., “You and me together, God”].<sup>23</sup>

Beyond identifying different coping styles, Pargament (1997) also distinguished between positive/helpful and negative/harmful forms of religious coping. This distinction has become central to the field, shaping how researchers understand the ways religion can either support or hinder psychological adjustment to stress. Positive religious coping has been connected “with a secure attachment to God, a belief that life has meaning, and a spiritual connection with close family and friends”; while “negative religious coping has been associated with a detachment from one’s God, feelings that one has been abandoned by God, and avoiding one’s religious institution or congregation.”<sup>24</sup> Negative religious coping sometimes includes believing that God has allowed a stressor as a form of punishment, so Pargament and colleagues developed a detailed, 105-item instrument (R-COPE) that identifies both positive and negative religious coping responses.<sup>25</sup> This tool and its variations have assisted the scientific study of religion and coping over the last 25 years, including many of the 103 high-quality studies on coping selected by Koenig.

FIGURE 2: Significant Findings in High-Quality Studies on Religion and Mental Health by Outcome (%)



An examination of the findings of the best available studies revealed that 87 reported connections between religion and positive coping (86%), while 7 reported negative findings (7%)—a 12:1 positive-to-negative ratio.<sup>26</sup> These patterns reinforce Pargament’s central insight: religion, like many tools, can be used in ways that can help or harm.<sup>27</sup>

As we close this brief section on religious approaches to coping with stress, it is worth noting that a Gallup poll found the United States to be one of the most stressed countries in the world.<sup>28</sup> Remarkably high levels of stress in the United States lead us to our next topics of related consideration: depression and anxiety.

## Religion, Depression, and Anxiety

Two of the most common mental health challenges in the U.S. are depression and anxiety. Because they are both highly prevalent and often occur together, we consider them side by side, with particular attention to how religion may impact both of these mental health concerns.

According to the U.S. Centers for Disease Control, nearly one in five adults reported symptoms of anxiety (18.2%) or depression (21.4%) during 2022—an increase of about 2.5% since 2019.<sup>29</sup> In terms of severity of symptoms related to anxiety, the CDC has noted that 11.4% of the U.S. population were categorized as having mild anxiety symptoms, 3.9% as moderate, and 2.8% as severe.<sup>30</sup> For depression, the numbers were slightly higher in all three categories of severity; namely, 13.9% were categorized as having mild depressive symptoms, 4.6% as moderate, and 2.9% as severe.<sup>31</sup>

Based on Koenig and colleagues’ systematic review of 247 high-quality studies on religion and depression that reported significant findings, 183 noted better mental health among the more religious (74%), while 27 reported worse levels of depression among the more religious (11%)—a nearly 7:1 positive-to-negative ratio.<sup>32</sup>

While clinical-level anxiety is almost as prevalent as depression, there are only about one-third as many high-quality studies examining the religion–anxiety connection. From the 85 high-quality religion–anxiety studies that reported significant findings, 59 noted lower levels of anxiety among the more religious (69%), while 17 reported negative findings (20%)—a 3.5:1 positive-to-negative ratio.<sup>33</sup>

Faith communities can directly impact depression and anxiety, and “given the role that social support plays in buffering stress and preventing or relieving anxiety symptoms,” religious involvement has also been repeatedly associated with greater marital stability and satisfaction, as well as healthier family functioning.<sup>34</sup> Individuals in stronger marriages and families appear to be less susceptible to chronic depression and anxiety. Notably, “reduction of childhood trauma from family violence, parental divorce, [or the] stress of being raised by a single parent . . . could influence susceptibility to anxiety disorder later in life.”<sup>35</sup>

Indeed, environmental factors that contribute to serious depression include “poverty, adverse sociodemographic circumstances, habits and lifestyle, negative family relationships, intimate partner violence, parental divorce, chronic health problems with accompanying physical disability, physical trauma, natural disasters, and [stress].”<sup>36</sup> Studies show that religious involvement can help with many of these challenges—sometimes by promoting prevention (e.g., encouraging healthy lifestyle choices and discouraging substance abuse) and sometimes by aiding coping (e.g., faith community support after a trauma or disaster).<sup>37</sup> In short, religion may both help prevent and alleviate several of the factors associated with depression.<sup>38</sup>

## Religion and Personality Traits and Disorders

For several decades, psychologists and psychiatrists tended to view personality traits (e.g., extraversion or introversion, persistence, cooperativeness) and personality disorders as relatively fixed—even as “lifelong and unchangeable.”<sup>39</sup> However, a meta-analysis has revealed small to moderate changes confirming that change is possible across the lifespan and that religious involvement may be an influential factor in some cases.<sup>40</sup> Indeed, research by Koenig and others has indicated neuroplasticity and potential for change and growth across time, and that “religiosity may assist in the maturing of personality traits over time, even after age 55.”<sup>41</sup>

Research increasingly suggests that religious involvement may not only buffer against harmful personality disorders such as sociopathy and emotional instability but also contribute to positive personality growth in compassion and forgiveness across the lifespan. Koenig and colleagues’ systematic review of 93 high-quality studies on religion and personality traits found that 70 reported links between greater religious involvement and lower rates of problematic traits or disorders (75%),<sup>42</sup> while 17 reported higher rates among the more religious (18%)—a roughly 4:1 positive-to-negative ratio.<sup>43</sup>

Researchers have noted that religious involvement may promote and instill “moral standards, a healthy self-image, humility, and a focus on the well-being and rights of others”—all of which can protect against antisocial tendencies.<sup>44</sup> Additionally, many religious beliefs discourage or even prohibit “behaviors that lead to unstable emotions,” while religion tends to encourage and extoll “tendencies that lead to emotional stability (forgiveness, altruism, honesty, dependability).”<sup>45</sup> Indeed, religiosity is also positively associated with a broad range of prosocial virtues, including “self-discipline . . . , cooperativeness . . . , altruism/generosity . . . , compassion . . . , forgiveness . . . , and gratitude.”<sup>46</sup> Positive personality traits such as these are widely recognized as protective factors that promote mental health.

In the next section, we briefly overview established connections between higher levels of religiosity and well-being, life satisfaction, happiness, hope, optimism, and other phenomena associated with elevated mental health.

## Religion and Positive Emotion

The overwhelming majority of research has reported beneficial connections between religion and positive emotions. Koenig and colleagues’ systematic review of 251 high-quality studies on religion and “positive emotion” found that 233 (93% of the studies) reported positive correlations between greater religious involvement and a range of beneficial outcomes,<sup>47</sup> including life satisfaction, happiness, hope, self-esteem, and optimism.<sup>48</sup> Conversely, only nine high-quality studies (4%) have found negative correlations.<sup>49</sup> The composite yields a 26:1 positive-to-negative ratio. What are some factors that potentially contribute to this remarkable imbalance?

Social support plays a vital role in mental health, and religious communities often provide such support in abundance. Koenig and colleagues note that “social support has been related to greater well-being, . . . especially when that support comes from diverse sources, including both family and unrelated friends as might be found within a religious community.”<sup>50</sup> In this way, healthy religious involvement not only strengthens family bonds but also creates a broader network of supportive relationships rooted in shared values.<sup>51</sup>

Religious participation also contributes through the practice of regular worship. Koenig et al. report that “frequency of religious attendance is strongly correlated with psychological well-being.”<sup>52</sup> A vital note from a social justice perspective is that research further indicates that racial, ethnic, and religious minorities experience especially pronounced gains in well-being in connection with active religious involvement.<sup>53</sup> As with other phenomena, in terms of positive emotion, religion appears to give the most to those who are most in need.

Religious communities often provide a built-in structure for meaningful engagement. As Koenig and colleagues observe, religious communities encourage members to “engage in religious and other community activities that benefit others.”<sup>54</sup> This faith community engagement “provides opportunities for service . . . that may further enhance self-esteem, reduce loneliness, and bond people together,” offering emotional benefits that extend well beyond the individual.<sup>55</sup>

While much of the research highlights the social dimensions of religion—community support, family networks, and opportunities to serve—Koenig and colleagues also emphasize the role of belief itself. Indeed, some people feel “religion may fill a void in life that nothing else can.”<sup>56</sup> In the words of Blaise Pascal, the “infinite abyss can be filled only with an infinite and immutable object; in other words, by God himself.”<sup>57</sup>

Viewed holistically, healthy religion provides more than social connection. It offers a community of social support, opportunities to serve others, sacred rituals and practices, and beliefs about God and life that enhance meaning, purpose, and gratitude. From a scientific vantage, these combined influences yield a vital benefit explored in the next section: those with healthy religious involvement are significantly less vulnerable to suicidality.

## Religion and Suicide

In 1897 Emile Durkheim’s book-length study *Suicide* compared and contrasted suicide rates of Catholics, Protestants, and Jews and was among the first modern efforts to systematically measure connections between religion and the observable social world.<sup>58</sup> The pioneering study had several flaws but laid the groundwork for more sophisticated research over the next 125 years. Today, a significant number of multinational studies have found that “suicide rates are inversely related to country religiosity,” with the strength of these correlations ranging from moderate to large.<sup>59</sup>

Of the 76 high-quality studies on religion and suicide selected by Koenig and colleagues, 68 studies (89%) reported lower rates of suicide among the more religious,<sup>60</sup> while 6 studies (8%) found higher suicidality among the more religious (an 11:1 positive-to-negative ratio).<sup>61</sup>

In many studies of religion and suicide—including several of the strongest examples discussed in Appendix A—significant protective benefits emerge among highly religious women and men who attend services weekly or multiple times a month. Protective benefits were typically lesser or insignificant for occasional attenders, consistent with the observations of one research team that “those persons with significant commitment to their faith seem to attain a ‘threshold’ where measurable benefits are discernible and often substantive, while nominal faith community members or occasional attendees do not.”<sup>62</sup>

This pattern has been confirmed in other major studies. In one of the most comprehensive explorations of U.S. teenagers and religion, sociologists Christian Smith and Melinda Lundquist Denton concluded:

A modest amount of religion . . . does not appear to make a consistent difference in the lives of U.S. teenagers. *It is only the more serious religious teens, the Regulars and the Devoteds, whose outcomes are more consistently and significantly more positive than those of their entirely religiously Disengaged peers.*<sup>63</sup>

In short, it is not nominal affiliation but committed religious involvement that appears to matter most. The positive correlates of devoted religious participation are evident across multiple dimensions of psychological health, including markedly lower suicide rates. But why?

Religious beliefs provide protections through both direct and indirect pathways. Direct paths include religious beliefs, teachings, and doctrines that explicitly oppose suicide or promote the value of life.<sup>64</sup> Indirect paths include the probability that “religious beliefs and practices may . . . prevent suicide by reducing states that lead to suicide.” These harmful states include but are not limited to “depression, anxiety, hopelessness, pessimism, meaninglessness, alcohol and drug abuse/addiction, social isolation, loneliness, disability [and] chronic health problems.”<sup>65</sup>

Indeed, faith community involvement tends to promote connections and relationships, including marriage and parenting, but expanding well beyond immediate family through broader networks of belonging.<sup>66</sup> These social and psychological benefits are evidenced in population trends: rising suicide rates have coincided with declining church attendance.<sup>67</sup> Specifically, VanderWeele et al. extrapolated that about 40% of the increase in the U.S. suicide rate can be attributed to reduced weekly religious participation.<sup>68</sup>

Taken together, the evidence indicates that the following are robustly associated with lower suicidality: (a) religious beliefs that affirm the value of life and explicitly discourage suicide, (b) regular religious practices and rituals, and (c) active participation in a faith community. To restate, Koenig and colleagues’ review of 76 high-quality studies<sup>69</sup> reported a more than 11:1 positive-to-negative ratio linking higher religiosity to lower suicide. As impressive as this ratio is, our next topic—religion and substance abuse—yields a positive ratio that is larger by a factor of four.

## Religion, Substance Abuse and Addiction

From the 271 highest-quality studies on the religion and substance abuse connection that reported significant findings, 256 studies (94%) found that religion correlated with lower rates of substance abuse and addiction,<sup>70</sup> while only 6 studies (2.2%) found religion to be correlated with higher rates<sup>71</sup> of substance abuse—a 43:1 ratio in favor of religion being linked with healthier patterns.<sup>72</sup> This overwhelmingly positive ratio across the studies Koenig et al. reviewed is the most pronounced among the mental health phenomena covered in this report.

The topic of substance abuse and addiction is the only phenomenon that will be addressed in all three Religion and Health reports: (1) the present report, *The Religion and Mental Health Connection*, as well as the forthcoming reports, (2) *The Religion and Physical Health Connection*, and (3) *The Religion and Social Health Connection*. This repeated treatment and attention are due to the direct and significant impact substance abuse has on mental health, physical health, familial health, and societal health. Indeed, the wide-ranging deleterious impacts of substance abuse have commanded volumes—including an Oxford handbook that identifies adolescent substance abuse as perhaps *the* leading public health problem in the United States.<sup>73</sup>

Given the breadth and depth of the psychological, physical, relational, and societal damage associated with substance abuse and addiction, pronounced attention in the related science has been devoted to identifying potent sources of prevention. Also of focal interest is the issue of the most effective remediations when substance abuse and addiction has occurred.<sup>74</sup> A point of significance and consideration is that religion has been repeatedly identified as both a leading preventative force for many and a rehabilitative help for some.<sup>75</sup> In connection with substance abuse generally, Koenig et al. have summarized, **“In almost no other area of mental health (except perhaps suicide) is there more evidence that religion makes a difference than in alcohol and drug use problems.”**<sup>76</sup>

Addictions and disorders involving opioids, cocaine, and methamphetamine have surged “to almost epidemic” levels during a period of growing secularization, when the “internal controls” and supports of religion are fading.<sup>77</sup> Taken together, the findings suggest that religious beliefs, regular practice, and faith community ties provide real guardrails—shaping norms, offering accountability, and reducing isolation—that help lower the risks of both substance abuse and addiction.<sup>78</sup>

Substance abuse and addiction are forms of negative and deleterious coping. Religion, through both beliefs and practices, not only offers but exhorts prayer, ritual, worship, and study of sacred texts as potentially positive coping methods.<sup>79</sup> Regardless of whether these religious coping strategies directly yield positive results, such approaches are preferable to and substantially less damaging than substance abuse and addiction.<sup>80</sup>

The pattern is clear: “Religious involvement affects virtually every factor that influences the development and persistence” of substance abuse and addiction.<sup>81</sup> Further, the correlations between high religiosity and lower rates of substance abuse and addiction in the vast majority of high-quality studies (a 43:1 positive-to-negative ratio) are likely tied to other mental health benefits previously documented in this report. Relatively low rates of alcohol and drug abuse among the more religious also relate to lower rates of several harms and disorders, including but not limited to suicide, gambling, negative coping, violence, criminality, unemployment, and incarceration<sup>82</sup>—as well as several physical health conditions that will be discussed in the second report in this series.

Religion shapes the social environment and peer networks in ways that matter: it helps curb negative peer influence, reduces access to alcohol and drugs, and supplies positive role models.<sup>83</sup> Religious involvement in families is associated with stronger two-parent households and healthier parental monitoring.<sup>84</sup> Conversely, well-established risk factors for substance use disorders include childhood maltreatment, low parental monitoring, neglectful parenting, parental drug use, poor parental adjustment, parental divorce, early onset of drinking, and substance-using peers—and all of “these risk factors have been shown to be inversely related to religious involvement.”<sup>85</sup>

## Religion, Bipolar Disorder, and Schizophrenia

Despite the generally positive connections between religion and mental health, there were two mental health phenomena with significantly more mixed, complex, or negative correlations than the other six mental health phenomena in the most recent *Handbook of Religion and Health*. These two phenomena least likely to be helped by religious involvement included bipolar disorder and schizophrenia.<sup>86</sup> Notably, both bipolar disorder and schizophrenia involve more pronounced biological components than the phenomena with stronger positive correlations between them and religious involvement (e.g., positively coping with stress).

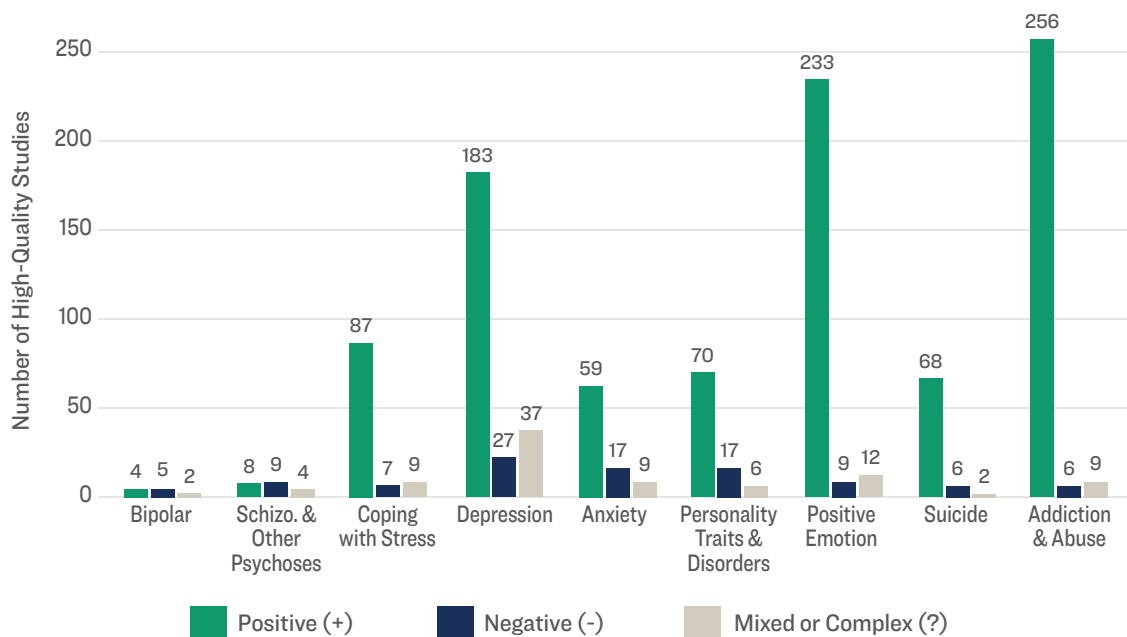
The mental phenomena of (a) bipolar disorder and (b) schizophrenia (and other psychoses) contrast in two respects from other frequently researched aspects of mental health such as depression, anxiety, and suicidal thoughts. First, bipolar disorder and schizophrenia have been studied significantly less than other mental health phenomena reviewed by Koenig et al. Specifically, Koenig et al. identified only 11 high-quality studies on bipolar disorder and religion, with only 21 on schizophrenia (and other psychoses).<sup>87</sup> This niche of research is underdeveloped compared with several other phenomena (e.g., Koenig et al. review 247 high-quality studies on religion and depression).

Further, bipolar disorder and schizophrenia appear to be the only two mental health phenomena for which more studies have found a marginally negative relationship with religion (versus positive). Specifically, of the 11 high-quality studies on bipolar disorder and religion, 4 studies reported significant positive findings (36%),<sup>88</sup> while 5 reported negative findings (45%).<sup>89</sup> Of the 21 high-quality studies on schizophrenia (and other psychoses) and religion, 8 studies were positive (38%)<sup>90</sup> and 9 were negative (43%).<sup>91</sup> The negative majorities here are narrow but are anomalous compared to the heavily positive-to-negative ratios seen in most other phenomena explored in this report.<sup>92</sup> Overall, conclusions regarding religion and bipolar disorder are “principally speculative as the quality of the available data is poor.”<sup>93</sup> The body of research on religion and schizophrenia is similarly weak.<sup>94</sup>

There is a notable complexity that arises with bipolar disorder and religion. Namely, Koenig et al. note a variability based on “the religiosity of the country, . . . with some indication of worse outcomes among highly religious persons in secular regions (Europe and the Far East) and somewhat better outcomes in more religious areas (North and South America).”<sup>95</sup> This may indicate that highly religious persons who are bipolar and already struggle mentally may suffer a *compounded difficulty* living in a region where religiosity is a further source of marginalization. In other words, the research may be showing the compounding of personal difficulties (including living in a secular community while the individual values religiosity) leading to worse results, rather than showing that religiosity itself is harmful.

The small number of high-quality studies on bipolar disorder and schizophrenia yield a tentative and nascent picture, but it is a picture that seems to indicate that some mental health phenomena may have fewer positive relationships with religious involvement.

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



# Conclusion:

## Religion's Connection with Measurable Mental Health Outcomes

In this first report of a three-part series, we examine the relationship between religious involvement and psychological health. The limited early literature on religiosity and bipolar disorder, as well as on schizophrenia and other psychoses, is heterogeneous—often mixed, sometimes relatively negative, and methodologically complex.<sup>96</sup> By contrast, across higher-quality studies the balance of evidence favors salutary associations between religious involvement and other mental health issues: depression and anxiety ( $\approx 7:1$  positive-to-negative study ratio), personality traits and disorders ( $\approx 4:1$ ), suicide ( $\approx 11:1$ ), coping with stress ( $\approx 12:1$ ), positive emotion ( $\approx 26:1$ ), and substance abuse and addiction ( $\approx 43:1$ ). Taken together, the best available evidence indicates that religious beliefs, practices, and participation in faith communities are—far more often than not—linked to improved mental health outcomes. Because Google Scholar searches on “religion and health” reported tens of thousands of peer-reviewed papers, we narrowed our review to the most careful, detailed, and methodologically nuanced studies as synthesized in Koenig, VanderWeele, and Peteet’s *Handbook of Religion and Health* (2024). Across the mental health domains summarized above, this winnowed, higher-quality corpus reports 968 studies finding beneficial associations between religious involvement and mental health and 101 finding adverse associations—an overall positive-to-negative ratio of about 10:1. Our summary reflects the conclusions of that curated, higher-rigor set rather than the broader, mixed-quality universe of publications.

As we have seen in the present report, except in cases of bipolar disorder and schizophrenia—where findings are more 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 mental health phenomena—including (a) suicide, (b) coping with stress, (c) substance abuse and addiction, and (d) positive emotion—the positive scientific case for religion as a correlate and promoter of health is not only apparent but overwhelming. As we will see in two subsequent reports in this three-part series, in addition to correlating with desirable mental and psychological health outcomes, religiosity has been repeatedly correlated with significant positive outcomes in physical health and societal and relational health domains as well.

A close look across health research suggests a **threshold effect**: the benefits of religion concentrate among those with sustained, high engagement. Hundreds of studies link religious involvement to better mental health, stronger physical health (including lower cancer rates), and longer life,<sup>97</sup> with measurable advantages appearing as early as childhood and adolescence.<sup>98</sup> Family-level gains are also documented, including greater marital stability, quality, and satisfaction—and stronger parent-child relationships.<sup>99</sup> As the authors of one related volume concluded, “Those persons with significant commitment to their faith seem to attain a ‘threshold’ where measurable benefits are “discernible and often substantive,” but “nominal . . . or occasional attendees do not.”<sup>100</sup> In practice, this threshold often corresponds to weekly (or more frequent) service attendance, with associated health benefits observed from adolescence into older adulthood and across racial and ethnic groups and faith traditions.<sup>101</sup>

“Those persons with significant commitment to their faith seem to attain a ‘threshold’ where measurable benefits are “discernible and often substantive,” but “nominal . . . or occasional attendees do not.”

Public opinion polls, book-length analyses, and global forecasts paint conflicting pictures of religion’s trajectory—from reports that religion is experiencing a “resurgence”<sup>102</sup> to claims that traditional faith is “obsolete” or in “demise.”<sup>103</sup> Our report does not adjudicate those predictions. Our aim is to present the empirical record: serious religious commitment and participation are consistently associated with substantial, multifaceted benefits for mental health. *Those who are deeply devoted to their religious faith are most likely to reap deep mental health benefits.* From a health-promotion perspective, the now-voluminous literature examined in this three-part series provides science-based support for active religious involvement, with salutary effects that are mental, physical, and relational, extending across individual, marital, family, community, and societal levels.

## Accordingly, we offer several closing considerations:

- **Coping with stress:** Greater religious involvement supports meaning-making and healthier coping, helps reduce states that precipitate crises, and increases strength and support in the face of adversity.
- **Depression and anxiety:** Religious engagement is associated with fewer depressive symptoms, including markedly lower alcohol use among the highly religious, which likely contributes to better mood outcomes. Increased religious practice and participation are linked to calmer emotion regulation and reassurance through beliefs, rituals, and community supports, corresponding to lower anxiety among those who engage more with religion. Together, ties within a faith community, biological processes and gene–environment pathways shaped by higher levels of support, and meaning-centered practices like prayer, worship, and service buffer against despair and limit the conditions that fuel depression and anxiety.
- **Personality traits and disorders:** High religious involvement aligns with greater self-control, altruism, cooperativeness, and prosocial behavior—and fewer indicators of personality pathology.
- **Positive emotion:** High religious participation correlates with higher gratitude, meaning, life satisfaction, and overall well-being, as reflected in positive emotions.
- **Suicide:** Religion operates through direct norms (promoting teachings that affirm the value of life) and indirect pathways (reducing depression, anxiety, substance misuse, loneliness). Declines in weekly attendance account for roughly 40% of recent increases in U.S. suicide rates,<sup>104</sup> and faith community involvement helps to counter isolation.<sup>105</sup>
- **Substance abuse and addiction:** Significant empirical evidence demonstrates that religion provides internal controls, shapes prosocial peer networks, and supports strong families and parental monitoring.<sup>106</sup> Neuroscience findings also suggest that religious experiences activate the same reward and salience circuitry implicated in addiction,<sup>107</sup> potentially reducing vulnerability to substance abuse for the religious by providing nonchemical sources of reward and meaning.

## By extension, we offer a few policy considerations:

- **Recognize religion as a protective factor.** Recognize regular religious participation as a voluntary, evidence-supported pathway for higher levels of mental health and for addressing addictions, alongside established secular mental health interventions.
- **Build patient-choice bridges between health and psychological services and religious communities.** Create standardized, opt-in referral pathways from healthcare and behavioral health to community supports—including diverse faith communities—to foster belonging, meaning, and practical help.
- **Scale prevention partnerships where evidence is strongest.** Equip congregations across traditions to collaborate with drug treatment providers and medical personnel on suicide and substance-use prevention and recovery through training, guidance, peer support, and family-strengthening initiatives.
- **Advocate for policies and practices that build religious pluralism.** The benefits of religious living that are identified in this report are contingent on the freedom of individuals and groups to freely practice and express their faith commitments. Legal protections and cultural norms that safeguard religious freedom for all and recognize the benefits that religion brings to individuals and society will increase the likelihood of such benefits.

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# Appendix A:

## Notable Findings from High Quality Scientific Studies

In Appendix A, we offer a closer look at notable findings and a few of the best available studies on religion and the mental health phenomena discussed in the body of the report. These phenomena respectively include: (a) bipolar disorder; (b) schizophrenia (and other psychoses); (c) psychological coping with stress; (d) depression and anxiety; (e) personality traits and disorders; (f) positive emotion; (g) suicide; and (h) substance abuse and addiction.

### Notable Findings on Religion and Bipolar Disorder

Many of the more notable findings regarding the relationship between religion and bipolar disorder do not address bipolar directly but instead highlight benefits of religiosity—including substantially lower depression scores. For example, Stroppa and Moreira-Almeida (2013) found that both intrinsic religiosity and positive religious coping were related to lower levels of depression and that those reporting no religious affiliation were more than four times as likely to be depressed. Further, positive religious coping was related to significantly better psychological and environmental quality of life. A second study five years later by the same researcher again found that positive religious coping was linked with lower depression scores, as well as better physical, mental, and social quality of life.<sup>108</sup> However, a complexity emerged. Consistent with Pargament’s valences of religious coping (1997)—that positive forms of religious coping yield benefits while negative forms of religious coping yield harm—Stroppa et al. (2018) noted negative correlations with regard to negative religious coping (e.g., “I have this struggle because God is punishing me”).

Another key finding to emerge from samples across multiple, high-quality studies has been that individuals with bipolar disorder who are more religious show a lower probability of suicidal attempts.<sup>109</sup> This is particularly significant given that the suicide rate among those suffering with bipolar is “20–30 times that of the general population.”<sup>110</sup>

A study by Gawad et al. (2018) reflected some of the complexity of the religion–bipolar relationship by noting a potentially harmful association: study participants who scored high on intrinsic religiosity were over 50% *more likely* to have psychotic symptoms. However, on the helpful side: (a) the more religious were 41% *less likely* to have suicidal ideation, and (b) higher levels of religious attendance were related to *fewer* past suicide attempts.

### Notable Findings on Religion and Schizophrenia (and Other Psychoses)

The limited number of quality studies examining religion in connection with schizophrenia (and other psychoses) includes a study by Benda (2002a) with a sample of 600 homeless U.S. veterans in an inpatient detoxification program, which found that higher religiosity predicted a lower likelihood of readmission for either substance abuse or psychiatric illness. Another study from Rosmarin et al. (2013) with 47 psychiatric patients found that *negative* religious coping was *positively* related to a variety of symptoms, including intensity of suicidal ideation. Conversely, positive religious coping related to lower depressive symptoms but did not relate to or seem to affect psychosis. In a third study (N=139), a randomized controlled trial by Ofori-Atta et al. (2018), findings indicated that psychotropic medication yielded better outcomes compared to the control group who simply attended a prayer camp. However, psychiatric symptoms also *decreased* in the prayer camp control group even without medication.

In an experimental study, 31 Hindu persons with psychotic disorders (23 with schizophrenia) stayed at a Hindu temple for about six weeks and experienced a reduction of psychotic symptoms equivalent to those on antipsychotic medication.<sup>111</sup>

In a Netherlands-based study of 337 children with and without auditory or visual hallucinations (AVHs), moderately religious participants were more than twice as likely to have auditory or visual hallucinations than nonreligious participants (24.5% vs. 11.0%), while the rate of highly religious youth with AVHs was only slightly higher than nonreligious youth.<sup>112</sup>

As with bipolar disorder, the research on schizophrenia and religion is scant and quite mixed. Koenig et al. (2024) have emphasized that “much less research is available on religion and psychotic disorders than on other mental health disorders,” calling for care in drawing any strong conclusions at present.

## **Notable Findings on Religion and Psychological Coping with Stress**

Various aspects of religion appear to positively impact coping: (a) by reducing the number of stressors in one’s life; (b) by encouraging helpful perceptions and interpretations of stressors that do arise; and (c) by providing resources to meet inevitable stressors (e.g., social, spiritual, psychological, and financial resources).<sup>113</sup>

Koenig et al. (2024) have addressed religious coping in connection with an array of contexts and challenges. Three positive findings among scores to date include: (a) 98% of 1,011 adults identified Allah as their primary source of comfort in war-torn Afghanistan;<sup>114</sup> (b) Turkish mothers of children in the ICU reported significant reduction in ICU-specific stressors through praying and studying sacred texts;<sup>115</sup> and (c) studies by Tsai et al. (2016, 2017) reported that U.S. war veterans with higher religiosity experienced higher levels of post-traumatic growth and improvement over time.

In addition to the 103 high-quality studies identified by Koenig et al. on religion and coping, there are expansive, book-length volumes that discuss and document religious coping expansively,<sup>116</sup> as well as more specific expressions that address topics ranging from coping with racism<sup>117</sup> to coping with natural disasters like Hurricane Katrina.<sup>118</sup> Recurring concepts across studies on religious coping typically circle back to the touchstone of positive and negative valence offered by Kenneth Pargament, reminding us that many tools (including religion) can be used to help or harm.

## **Notable Findings on Religion, Depression, and Anxiety**

Among the more notable positive findings from the 183 studies reporting lower depressive symptoms<sup>119</sup> stands Van Voorhees’ (2008) report from a year-long study of 4,791 adolescents, which noted that having a religious affiliation, praying at least weekly, and attending religious youth group services at least once a month were all related to lower probability of new-onset depression.

In a six-year-long, ten-nation European study of 9,068 adults over 50 years old, Croezen et al. (2015) found that of five different forms of social participation examined, only religious organizational involvement predicted a significant decrease in depression across time.<sup>120</sup> Koenig et al. further observed, “Interestingly, involvement in political . . . organizations predicted an increase in depressive symptoms.”<sup>121</sup>

In a follow-up study with the same ten-nation sample as Croezen et al. (which had by then expanded to 14,255 participants), Ahrenfeldt et al. (2017) found that “crisis religiousness”—defined as praying only, without any accompanying religious activities—was correlated with more depression; while “restful religion”—defined as praying while also being involved in a religious community and religious education—was correlated with lower depression.

In a study that followed 48,984 nurses over a 16-year period, Li et al. (2016) found that those who attended religious services weekly (or more frequently) had 25% lower probability of depression than those who never or almost never attended. In another study involving tens of thousands, Chen et al. (2020a) found in a combined (three-cohort) sample of more than 90,000 that weekly (or more frequent) religious attendance predicted fewer depressive symptoms.

In a much smaller but intensive study with 47 psychiatric patients, Rosmarin et al. (2013) found that positive religious coping predicted significant decline in anxiety, while negative religious coping was not related to any psychological improvement. This finding seems to reinforce Pargament’s position that it is important to attend to how religion is utilized.

## **Notable Findings on Religion and Personality Traits and Disorders**

In an early but high-quality longitudinal study with 100 adults ages 55–80, Koenig et al. (1990) examined connections between religious coping and personality traits across four waves (over six years total). They found that “compared to those not using religion as a coping behavior, those who used religion to cope consistently across all three events scored significantly lower at Wave 4” on egoistic traits including “dominance, aggressiveness, hostility, [and] rebelliousness” and higher on more relational traits including “responsibility, strong superego, concern over moral standards and strength of character,” indicating that “religiosity may assist in the maturing of personality traits over time, even after age 55.”<sup>122</sup>

In a cross-sectional study of religiosity and borderline personality disorder (PD) traits in 429 Iranian medical students (95% of whom were Shia Muslim), Hafizi et al. (2014) found that overall religiosity and each of the religiosity measures used were “inversely related to overall [Borderline Personality Disorder] traits . . . [and that] religiosity was associated with less anger, less instability of mood, less feelings of emptiness, and less self-harm behaviors.”<sup>123</sup> In a high-quality cross-sectional study on religion and hostility and aggression, Salas-Wright et al. (2014) examined an unusually large sample of adolescents (N=90,202) and found that “all religious measures were associated with less violence,” even after adjusting for “age, race, family income, education, substance abuse, depression, anxiety, and risk taking.”<sup>124</sup> A study by Inozu et al. (2020) on religion and OCD among Muslim college students in Turkey (N = 273) reported that “a 2-item measure of religious commitment was associated with significantly more OCD symptoms.”<sup>125</sup> However, in 2018 Ghafoor et al. reported that “religious activity assessed by a 19-item scale was inversely related to OCD personality symptoms in 200 psychiatric patients with OCD in Pakistan.”<sup>126</sup> By juxtaposing two studies, we see that employing more refined and nuanced measures (e.g., comparing 19 items versus only 2) can yield different results.

## Notable Findings on Religion and Positive Emotions

Five notable studies involving psychological well-being and positive emotion include Kent and colleagues' study of a national random sample of 1,024 adults 65 years and older. While many such studies focus on church attendance and prayer, Kent et al. examined secure attachment to God and a sense of forgiveness from God and found that

a significant positive interaction emerged between secure attachment to God and . . . forgiveness from God . . . on life satisfaction. [Specifically], only among those with high attachment to God was forgiveness by God or transactional forgiveness from God related to greater life satisfaction.<sup>127</sup>

In a U.S. national random sample of 1,635, Jung (2018) explored the impact of childhood adversity on positive and negative affect—and whether religiosity and spirituality were helpful over the long-term, extending into middle-adulthood. “Both religiosity and spirituality buffered the negative effects of childhood adversity on positive affect over time.”<sup>128</sup>

In a Germany-based study with a national random sample of 5,446, Lechner and Leopold (2015) examined the potentially helpful effect of religious attendance in softening the negative effects of unemployment on life satisfaction. While life satisfaction declined for both attenders and nonattenders who were unemployed, life satisfaction decreased measurably less during the first year of unemployment for those attending religious services weekly or more. These findings carried into the second and third years of unemployment as well, leading the researchers to posit that “religious attendance on a weekly basis can mitigate the psychological impact of unemployment.”<sup>129</sup>

Chen and VanderWeele (2018) employed a longitudinal sample of 5,681–7,458 adolescents who were followed for 8 to 14 years. Those who attended religious services at least once per week reported a significantly greater “sense of mission in life,” as did those who prayed at least once per day. Similarly, weekly attenders and those who prayed daily also reported greater life satisfaction and greater positive affect, contrasted with those reporting they never attended and those who never prayed.<sup>130</sup>

While the above study focused on adolescents, a study that explored correlates of religious attendance in one of the largest samples to date (N=92,008) followed young, middle-aged, and older U.S. adults for between 3 and 12 years. As with adolescents, higher religious attendance also predicted greater sense of purpose in life, positive affect, and life satisfaction among adults, even after multiple controls were applied.<sup>131</sup>

## Notable Findings on Religion and Suicide

From the highest quality studies identified by Koenig and colleagues (2024), notable findings on religion and suicide include a longitudinal study by Svob and colleagues (2018) involving 112 parents and 214 children. The study concluded that parents' religiosity served as a protective or preventative factor for their children. Namely, high parental religiosity or perceived importance of spirituality predicted a nearly 40% decrease in children's suicidal ideation or attempts, even independent of the children's own religious or spiritual reports. These findings suggest possible intergenerational influences of religiosity that warrant further exploration beyond suicide prevention.

A report by Kleiman and Liu (2014) found that in a random national sample of 20,014 over a 16-year period there was a 94% lower likelihood of death from suicide among adults attending religious services at least 24 times a year compared to infrequent attendees. In another longitudinal study—one that tracked 4,914 Israeli adults over a 25-year period—Burshtein et al. (2016) found that nonreligious or secular Israelis were 8.5 times more likely to commit suicide than Israelis who were at least partially religiously observant.

Given the relative wealth of longitudinal studies exploring religion and suicide, we overview just three more. In a massive (combined) sample of almost 110,000 in the health professions (66,492 women; 43,141 men), Chen et al. (2020b) reported that women who attended religious services weekly were 75% less likely to die by suicide by the 16-year follow-up. For men, weekly attenders (versus nonattenders) were 48% less likely to die by suicide over a 26-year period. Similarly, VanderWeele et al. (2016b) examined another atypically massive sample (N=89,708 women) and found that weekly worship service attenders were 84% less likely to commit suicide (over a 15-year period) than women who never attended services. This 12-fold decrease in suicide, and similar reports in other studies, prompted Koenig (2016) to offer further commentary on this striking finding, which we recommend to researchers.

## Notable Findings on Religion, Substance Abuse and Addiction

We briefly overview a few of the highest-quality studies that have been identified by Koenig and colleagues (2024) in a developmental manner, moving from younger to older samples. Notable findings regarding religion and substance abuse or addiction have included Chen and VanderWeele's (2018) prospective study lasting 8–14 years with an adolescent sample (N=5,681 to 7,458), which found that youth who attended religious services at least weekly were less likely to use marijuana and illicit drugs, and less likely to misuse prescription drugs. A similar preventative effect was found among youth who prayed or meditated at least once a day compared with those who never prayed or meditated.

Koenig et al. (2024) note that “despite economic prosperity and abundant resources, rates of SUD [Substance Use Disorders] in the United States are among the highest in the world.”<sup>132</sup> Even within the U.S., however, economically depressed areas can provide fruitful ground for studying the religion and health connection. Green and colleagues' (2010) 10-year prospective study of 725 African American young adults (32–43 years) in a low-income area of Chicago found that infrequent religious attenders were over eight times more likely to develop a drug use disorder than frequent religious attenders.

Terry-McElrath and colleagues (2017) studied a large, national random sample of U.S. adults (N=9,831) from age 18 to age 50. Adults with low religious commitment were significantly more likely than highly religious adults to be in the “heavy user class” for marijuana use. This finding holds added importance given marijuana's status as a gateway drug that precedes abuse of harder drugs for many.<sup>133</sup>

Nordfjærn and colleagues (2018) found in a 5-year prospective study with 2,671 Norwegian adults (age 40 and older) that religiosity (measured by church membership and self-reported importance of religion) predicted greater abstinence and less consumption of alcohol. The researchers concluded that religiosity was an important predictor of alcohol use (and avoidance) during the second half of life (ages 40–80).

The preceding brief reviews of four studies highlight the negative correlation of religiosity with higher levels of drug use, abuse, and addiction. Two of many high-quality studies connecting religiosity and rehabilitation are now overviewed. First, Jang (2019) followed 1,289 youth from juvenile and adult court systems for 10 years. The researcher found that subjective and objective religiosity were both related to less marijuana use at baseline, but neither form of religiosity predicted desistance from marijuana use during follow-up. However, if study participants increased in both religious attendance and subjective religiosity, these changes significantly predicted cessation or reduction of marijuana use over time.<sup>134</sup>

In another recovery and rehabilitation study, Kelly and colleagues (2020) utilized a review of 27 studies (with 10,565 total participants) and concluded, “There is high-quality evidence that [religiously based Alcoholics Anonymous and Twelve-Step Facilitation] are more effective than other established treatments, such as CBT [cognitive behavioral therapy], for increasing abstinence.”<sup>135</sup> Further, religiously based Alcoholics Anonymous and Twelve-Step programs were found to be more cost effective.

Koenig et al. (2024) further concluded that “12-step programs that explicitly use religion as a key aspect of treatment (e.g., Alcoholics Anonymous . . . ) appear to be effective in reducing substance use and increasing abstinence.”<sup>136</sup> On substance abuse generally, Koenig et al. summarized, “In almost no other area of mental health (except perhaps suicide) is there more evidence that religion makes a difference than in alcohol and drug use problems.”<sup>137</sup>

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# Appendix B:

## Plausible Reasons for Strong Religion and Mental Health Connections

In the body of Report 1, we offer a select few of the many hypothetical pathways, or plausible reasons, for the strong connections between religion and various mental health phenomena. Here in Appendix B we offer additional insights into: (a) religion and coping; (b) religion, depression, and anxiety; (c) religion and positive emotion; (d) religion and suicide; and (e) religion, substance abuse, and addiction, respectively.

### Religion and Coping

Based on 87 high-quality studies showing a strong positive link between religion and positive coping—nearly a 12:1 ratio over negative findings—researchers have suggested several explanations. First many who are highly religious claim their primary attachment or sense of connection is to God. If possessions, circumstances, and health are perceived as less important than attachment to God, stressors may be framed as less of a problem, since the person’s “primary attachment—relationship with God—remains unaffected” regardless of circumstances.<sup>138</sup> In other words, they feel loved and cared for in spite of the difficulties they may encounter.

Second, religious beliefs as well as religious practices (like prayer, meditation, and studying sacred texts) are coping strategies that are almost always available, even when other strategies fail.<sup>139</sup> When therapists are unavailable, medication has run out, and medical science is coming up short, sacred beliefs and sacred practices remain accessible. For example, an individual experiencing a panic attack may have religious methods to deal with the stress (e.g., thoughts such as “God won’t abandon me” or “No matter what happens, everything is in God’s hands”).

Third, available data indicate that, for many diverse persons of faith, positive religious coping is correlated with greater health, greater quality of life, and greater length of life.<sup>140</sup> But there is an additional consideration even beyond the good that religious approaches may offer. This consideration is the bad that is prevented. To frame this latter point directly, however effective or ineffective the practices of prayer, meditation, or studying of sacred texts may be, any of these coping strategies is preferable to frequently employed destructive coping strategies, including alcohol and drug abuse, gambling, high-risk behavior, violence, or self-harm.<sup>141</sup>

### Religion, Depression, and Anxiety

One explanation for the generally lower levels of depression and anxiety among the highly religious involves correspondingly high levels of social support related to increased depth and breadth of relationships due to faith community involvement.<sup>142</sup> In addition to deep and broad social support available within many faith communities,

pastoral care . . . can be very helpful and may be one of the most common forms of intervention for minor mental health problems in the United States. Indeed, more than 350,000 clergy in the United States spend an average of 15 hours per week providing counseling.<sup>143</sup>

Religion appears to also influence depression at the biological and genetic level through gene–environment interactions. Koenig and colleagues posit that “religion may also impact depressions that are primarily biological or genetic in etiology due to increasingly recognized gene–environment interactions.”<sup>144</sup> For example, a person born into a family context where multigenerational religious involvement has promoted avoidance of substance abuse might reap biological, genetic, and environmental advantages that prevent and protect against depression. Religious beliefs and healthy religious practices (e.g., positive religious coping) can provide valuable meanings, motivations, behaviors, and rituals that combat against the anomie and despair that tend to exacerbate depression and anxiety.<sup>145</sup>

## Religion and Positive Emotion

Religions are often portrayed by their adherents as paths to happiness or roads to joy. While some might suggest that this messaging may lead adherents to overreport positive emotion, related research does not support this take.<sup>146</sup> Indeed, the consistent evidence suggests that the benefits of religious involvement extend well beyond a notion of inflated self-perceptions.

Part of the explanation lies in the broad range of life factors tied to religious practice. Koenig and colleagues highlight connections between religiosity and satisfaction with achieving goals, optimism, educational and employment opportunities, stable marriages, supportive social networks, and good physical health.<sup>147</sup> A key piece of this picture is social support, which has long been linked with greater mental health. Religious communities often provide diverse forms of support—not only from family but also from friends and fellow believers—while encouraging healthy family relationships and offering a network of people who share relational values. Together, these factors help explain why religiosity so often aligns with positive emotional outcomes.

## Religion and Suicide

One possible explanation for the recurring linkage between religiosity and significantly lower suicidality (suicidal thoughts, plans, attempts, and death by suicide) is that religious persons may underreport suicidality due to stigma. Stigma may indeed play some role in these large, reported differences, but it likely explains only a portion of the variability.<sup>148</sup> Beyond this, three dimensions of religious experience—beliefs, practices, and faith community—each appear to offer meaning making as well as potential protection against suicide.<sup>149</sup>

In connection with faith community involvement, high-quality research underscores the strong social component of suicide risk, with loneliness and isolation repeatedly implicated. In a meta-analysis, Calati et al. (2019) found that key social factors correlated with increased suicide included being unmarried, socially isolated, and alienated from others. Faith community involvement tends to promote connections and relationships, including marriage and parenting, that expand well beyond immediate family through broader networks of belonging.

While religion is on average connected to better mental health in multiple domains, some have questioned whether these benefits apply to groups who may have particular difficulties with religion, such as LGBTQ+ individuals. Indeed, some research has cataloged various difficulties LGBTQ+ individuals have experienced in religion. While the research base in this area is relatively nascent and emerging, a meta-analysis on religion and mental health of LGBTQ+ individuals is in line with the overall research, finding a positive association between religion and mental health for LGBTQ+ individuals.<sup>150</sup>

## Religion, Substance Abuse, and Addiction

One contributor to lower substance abuse among the highly religious is the teaching across many denominations within the Abrahamic traditions that “the body is a temple,” a house for the spirit or soul that should be honored and respected.<sup>151</sup> For many, this is a sacred belief that serves a preventative function. Further, some faiths explicitly prohibit the use of alcohol, tobacco, and marijuana—thereby striving to close potential gateway pathways to illicit drugs.<sup>152</sup>

Beyond beliefs and practices, social forces play a major role in the religion–substance use relationship. Koenig et al. note that “there is ample research showing that positive social environments, strong families, and involvement in prosocial peer groups play a critical role in protection against the development of [Substance Use Disorders].”<sup>153</sup> Faith communities often cultivate precisely these conditions—positive social climates, strong families, and prosocial peer networks.

The plausible explanations just offered involve prevention. In connection with rehabilitation and recovery from substance abuse and addiction, Koenig et al. posit that

one of the most important ways that religiosity could [help with] . . . recovery is by surrounding the vulnerable individual with a community of peers and friendship networks who do not use or abuse alcohol/drugs. . . . Religious communities typically discourage or prohibit the use of addictive substances by members, thus providing an alternative support system.<sup>154</sup>

A central concern in addiction research is the U.S. opioid epidemic: overdose mortality rose from 33.3 deaths per million in 2000 to 130.7 per million in 2016—a nearly fourfold increase in just 16 years.<sup>155</sup> Neuroscience offers a possible mechanism. Using fMRI, Ferguson et al. reported that “the reward and salience circuits affected by opioids—the nucleus accumbens, ventromedial prefrontal cortex, and frontal attentional regions—are also activated during religious experiences and devotional practices.”<sup>156</sup> Koenig et al. suggest this overlap “may have implications for the kind of intervention necessary to recapture the hijacked reward systems,” including “life-changing religious experiences.” In their view, “establishing or re-establishing a connection with God . . . for some may be the only experience capable of replacing the cravings associated with opioid addiction.”<sup>157</sup>

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# Executive Summary Endnotes

- 1 In its *Religion and Public Life Survey (2024)*, the Pew Research Center reports that approximately 80% of Americans say religion is losing influence in American life. See also Christian Smith, *Why Religion Went Obsolete: The Decline of Traditional Faith in America* (Oxford University Press, 2025), which documents long-term declines in religious participation and institutional authority across the United States and other industrialized societies.
- 2 David Zahl, *Seculosity: How Career, Parenting, Technology, Food, Politics, and Romance Became Our New Religion and What to Do about It* (Fortress Press, 2019), examines how religious identity and moral formation have increasingly been displaced by political, cultural, and scientific commitments in contemporary societies.
- 3 Harold G. Koenig, Tyler J. VanderWeele, and John R. Petzet, *Handbook of Religion and Health*, 3rd ed. (Oxford University Press, 2024).
- 4 Koenig et al., *Handbook of Religion and Health (2024)*.
- 5 Harold G. Koenig, Michael E. McCullough, and David B. Larson, *Handbook of Religion and Health*, 1st ed. (Oxford University Press, 2001); Harold G. Koenig, Dana E. King, and Verna Benner Carson, *Handbook of Religion and Health*, 2nd ed. (Oxford University Press, 2012); Koenig et al., *Handbook of Religion and Health (2024)*.
- 6 Koenig et al., *Handbook of Religion and Health (2001)*, appendix, 675–862.
- 7 Koenig et al., *Handbook of Religion and Health (2012)*, 607–964.
- 8 Koenig et al., *Handbook of Religion and Health (2024)*, 675–862.
- 9 Koenig et al., *Handbook of Religion and Health (2024)*, 675–862, lists thousands of rigorous studies that were selected and prioritized due to large samples, (often) longitudinal designs, careful controls, and clinically or socially meaningful outcomes.
- 10 See Figure 1.
- 11 See Figure 1.
- 12 Tyler J. VanderWeele, Shanshan Li, Alexander C. Tsai, and Ichiro Kawachi, “Association Between Religious Service Attendance and Lower Suicide Rates Among US Women,” *JAMA Psychiatry* 73, no. 8 (2016): 845–51.
- 13 See Loren D. Marks and David C. Dollahite, *Psychology of Religion and Families* (Routledge, 2026).
- 14 See, for example, Ying Chen and Tyler J. VanderWeele, “Associations of Religious Upbringing with Subsequent Health and Well-Being from Adolescence to Young Adulthood: An Outcome-Wide Analysis,” *American Journal of Epidemiology* 187, no. 11 (2018): 2355–64.
- 15 See Koenig et al., *Handbook of Religion and Health (2024)*, 745–60.
- 16 See Jonathan Sacks, *Not in God’s Name: Confronting Religious Violence* (Schocken, 2015), 234.
- 17 See Figure 1.
- 18 See, for example, Matthew Pantell, David Rehkopf, Douglas Jutte, S. Leonard Syme, John Balmes, and Nancy Adler, “Social Isolation: A Predictor of Mortality Comparable to Traditional Clinical Risk Factors,” *American Journal of Public Health* 103, no. 11 (2013): 2056–62.; Eric S. Kim and Tyler J. VanderWeele, “Mediators of the Association Between Religious Service Attendance and Mortality,” *American Journal of Epidemiology* 188, no. 1 (2019): 96–101; Tyler J. VanderWeele, Jeffrey Yu, Yvette C. Cozier, Lauren Wise, M. Austin Argentieri, Lynn Rosenberg, Julie R. Palmer, and Alexandra E. Shields, “Attendance at Religious Services, Prayer, Religious Coping, and Religious/Spiritual Identity as Predictors of All-Cause Mortality in the Black Women’s Health Study,” *American Journal of Epidemiology* 185, no. 7 (2017): 515–22.; Ellen Idler, John Blevins, Mimi Kiser, and Carol Hogue, “Religion, a Social Determinant of Mortality? A 10-Year Follow-Up of the Health and Retirement Study,” *PLoS One* 12, no. 12 (2017): e0189134.; Shanshan Li, Meir J. Stampfer, David R. Williams, and Tyler J. VanderWeele, “Association of Religious Service Attendance with Mortality Among Women,” *JAMA Internal Medicine* 176, no. 6 (2016): 777–85.
- 19 See Koenig et al., *Handbook of Religion and Health (2024)*, 776–81.
- 20 See Koenig et al., *Handbook of Religion and Health (2024)*, 719–36.
- 21 See Koenig et al., *Handbook of Religion and Health (2024)*, 400, 403.
- 22 See Koenig et al., *Handbook of Religion and Health (2024)*, 835–37.
- 23 See Figure 1.
- 24 See Koenig et al., *Handbook of Religion and Health (2024)*, 760–64, for the 69 studies reporting a positive association; the one reporting a negative association was Charlie L. Reeve and Debra Basalik, “A State Level Investigation of the Associations Among Intellectual Capital, Religiosity and Reproductive Health,” *Intelligence* 39, no. 1 (2011): 64–73.

- 25** See Koenig et al., *Handbook of Religion and Health* (2024), 770–76.
- 26** See Koenig et al., *Handbook of Religion and Health* (2024), 770–76.
- 27** See Marks and Dollahite, *Psychology of Religion and Families*.
- 28** Haya Stier and Amit Kaplan, “Are Children a Joy or a Burden? Individual- and Macro-Level Characteristics and the Perception of Children,” *European Journal of Population* 36, no. 2 (2020): 387–413.
- 29** Loren D. Marks, David C. Dollahite, and Joanna Jacob Freeman, “Faith and Prayer in Family Life,” in *Successful Marriages and Family Life*, ed. Alan J. Hawkins, David C. Dollahite, and Thomas W. Draper (BYU Studies, 2011), 185–95.

# Endnotes

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- 2 Shima Baughman, J.D., Woodruff J. Deem Professor of Law, BYU Law School; distinguished fellow, Wheatley Institute.
- 3 Harold G. Koenig, MD, MHSc, professor of psychiatry and behavioral sciences, associate professor of medicine, Duke University Medical Center; editor in chief, *International Journal of Psychiatry in Medicine*
- 4 Justin Dyer, PhD, professor, BYU Department of Religious Education; editor in chief, *BYU Studies*.
- 5 Sam Hardy, PhD, professor, BYU Department of Psychology.
- 6 Paul Lambert, DLS, Religion & Human Flourishing Initiative Director, Wheatley Institute.
- 7 Nicole Schraedel, student scholar, Wheatley Institute.
- 8 Pew Research Center, 2024.
- 9 Gallup, 2015; Pecoraro et al., 2016.
- 10 Zahl, 2019.
- 11 Margolis, 2018; see also <https://news.gallup.com/opinion/polling-matters/510464/politics-religion.aspx>
- 12 Koenig et al., 2001, 2012, 2024.
- 13 Freud, 1927, p. 88; Stark & Bainbridge, 1996.
- 14 Ellis, 1980.
- 15 In one recent review, social scientists Marks and Dollahite (2026) refer to the influential definitions of religion by Marx, Freud, Ellis, and others as “BAD-RAP (Bogus And Dangerous-Religion As Psychopathology) hypotheses” because religion is conceptualized by these authors as bogus (the “opiate of the masses”), dangerous (“a poison,” “a childishness [to] overcome”), and as “psychopathology” (mental illness). See also Prothero, 2010.
- 16 Sacks, 2017, p. 234, emphasis in original.
- 17 Dollahite et al., 2018, p. 219.
- 18 Levin, “Foreword,” in Koenig et al., 2001, p. viii.
- 19 Koenig et al., 2001, preface.
- 20 Although the raw numbers of studies are staggering, most of these studies likely include religion and health as two of many variables—without specifically focusing on the religion–health connection.
- 21 In most of the third edition’s 34 chapters, the researchers’ discussions coalesce around rigorous, large-sample studies. The volume’s 188-page appendix reviews roughly 3,000 studies, but only studies garnering a rating of 8 or higher on a 10-point scale are included.
- 22 Most of the studies reported in the *Handbook of Religion and Health* (Koenig et al., 2024) are correlational studies that do not definitively establish causal relationships between religion and the more than 25 health-related phenomena considered. While correlation does not prove causation, it is notable that a large number of rigorous studies—with different samples, done by different scientists across decades—tend to find recurring positive correlations (Koenig et al., 2001; Koenig et al., 2012; Marks & Dollahite, 2026).
- 23 Marks & Dollahite, 2017, pp. 216–217; Pargament, 1997.
- 24 Marks & Dollahite, 2017, p. 217; Pargament & Raiya, 2007.
- 25 Pargament et al., 2000; Pargament & Raiya, 2007.
- 26 See Koenig et al. (2024, pp. 681–688) for all 87 studies with positive findings. The 7 studies reporting negative findings include: Dzivakwe & Guarnaccia, 2014; Hank & Schaan, 2008; Mitchell et al., 1993; Pargament et al., 2004; Pienaar et al., 2007; Rostosky et al., 2010; Sprung et al., 2012. Two coping studies reported complex findings (McIntosh et al., 2020; Mohr et al., 2010); and 7 reported mixed findings (Gall et al., 2011; Henderson, 2016; Koenig et al., 1998d; Pargament et al., 1992; Pargament et al., 1998; Winter et al., 2015).
- 27 For notable findings on religion and psychological coping with stress, see Appendix A. For plausible reasons for how strong religion and health connections relate to coping, see Appendix B.
- 28 Gallup, 2019a; Koenig et al., 2024, pp. 45–46.
- 29 Terlizzi & Zablotsky, 2024, p. 1.
- 30 Terlizzi & Zablotsky, 2024, p. 3.
- 31 Terlizzi & Zablotsky, 2024, p. 5.

- 32** See Koenig et al. (2024, pp. 689–704) for a comprehensive list of these 183 studies reporting positive findings and the 27 studies with negative findings. Two religion–depression studies reported complex findings (Kim-Spoon et al., 2012; Manne et al., 2003). Thirty-five religion/depression studies reported mixed findings (see Koenig et al., 2024, pp. 689–704, for a comprehensive list of these studies).
- 33** See Koenig et al. (2024, pp. 711–716) for a comprehensive list of these 59 positive studies and the 17 negative studies. Two religion–anxiety studies reported complex findings (Amjadian et al., 2020; McIntosh et al., 2011; Wink & Scott, 2005). Seven religion–anxiety studies reported mixed findings (Baetz et al., 2006; MacLeod et al., 2019; McFarland, 2010; Sternthal et al., 2010; Sternthal et al., 2012; Thege et al., 2013). Koenig et al. (2024, p. 131) highlight that the reality that many studies “report lower anxiety among the more religious is particularly surprising given that anxiety is such a powerful motivator of religious belief and behavior. This ‘reverse-causation’ dynamic would lead us to expect a positive association between religiosity and anxiety (reported in only 1 of 10 studies), particularly in cross-sectional research.” For notable findings on religion, depression, and anxiety, see Appendix A.
- 34** Koenig et al., 2024, p. 131.
- 35** Koenig et al., 2024, p. 131.
- 36** Koenig et al., 2024, p. 71.
- 37** Cherry et al., 2009; Cherry, 2015, 2020.
- 38** For plausible reasons for strong religion and health connections relating to depression and anxiety, see Appendix B.
- 39** Koenig et al., 2024, p. 190; see also West & Graziano, 1989.
- 40** Koenig et al., 2024, p. 190; Roberts et al., 2017.
- 41** Koenig et al., 2024, p. 203; Koenig et al., 1990. For “Notable Findings on Religion and Personality Traits/Disorders,” see Appendix A.
- 42** See Koenig et al. (2024, pp. 736–745) for a comprehensive list of these 70 positive studies and the 17 negative studies.
- 43** Six religion/personality traits and disorders studies reported mixed findings (Aghababaei et al., 2015; Browne et al., 2014; Entringer et al., 2021; Oates, 2013; Schnall et al., 2012).
- 44** Koenig et al., 2024, p. 198.
- 45** Koenig et al., 2024, p. 197.
- 46** Koenig et al., 2024, p. 208; see also pp. 197–199 for numerous additional “hypothetical pathways” between personality disorders and religion.
- 47** See Koenig et al. (2024, pp. 745–760) for 233 positive studies.
- 48** One study on religion and positive emotion has reported complex findings (Domínguez & López-Noval, 2021) and 11 have reported mixed findings (Ai et al., 2005a, 2005b; Ellison et al., 2001; Gallardo-Peralta, 2017; Krause, 2005; Meanley et al., 2016; Mrus et al., 2006; Préau et al., 2013; Speed & Fowler, 2017; Wilt et al., 2016; Ysseldyk et al., 2016).
- 49** Six high-quality studies with negative findings include: Bormann et al., 2006; Dorji et al., 2017; Ellison & Taylor, 1996; Janz et al., 2014; Patterson & Price, 2012; Sprung et al., 2012. Three other studies (Ellison et al., 2001; Gallardo-Peralta, 2017; Krause, 2005) had mixed/negative findings. We have counted these in both “mixed” and “negative” categories, for a total of nine negative studies. For notable findings on religion and positive emotions, see Appendix A.
- 50** Koenig et al., 2024, p. 216.
- 51** For plausible reasons for strong religion and health connections relating to positive emotion, see Appendix B.
- 52** Koenig et al., 2024, p. 215.
- 53** Marks & Dollahite, 2026; Taylor et al., 2004.
- 54** Koenig, 2024, p. 218; see also Smith & Davidson, 2014.
- 55** Koenig et al., 2024, p. 218; see also Smith & Davidson, 2014.
- 56** Koenig et al., 2024, p. 218.
- 57** Pascal, 1966, p. 75.
- 58** Most notably, Durkheim found that individuals embedded in stronger religious and social communities were less likely to die by suicide—with Protestants showing the highest rates, Catholics lower, and Jews the lowest of all—highlighting the protective role of communal bonds.
- 59** Koenig et al., 2024, p. 109.
- 60** See Koenig et al. (2024, pp. 705–711) for a comprehensive list of these 68 positive studies.
- 61** The six negative studies include: Dany et al., 2015; Hourani et al., 2012; Huang et al., 2020; Lawrence et al., 2016; McClintock et al., 2016; Zhang et al., 2011. Two religion and suicide studies reported mixed findings (Portnoff et al., 2017; Sisask et al., 2010). For notable findings on religion and suicide, see Appendix A.
- 62** Marks & Dollahite, 2017, p. 258.
- 63** Smith & Denton, 2005, p. 233, emphasis added.

- 64 Koenig et al., 2024.
- 65 Koenig et al., 2024, p. 119.
- 66 Koenig et al., 2001, 2012, 2024; Marks & Dollahite, 2026; Taylor et al., 2004.
- 67 Koenig et al., 2024.
- 68 VanderWeele et al., 2016b. For plausible reasons for strong religion and health connections relating to suicide, see Appendix B.
- 69 Koenig et al., 2024.
- 70 See Koenig et al. (2024, pp. 719–736) for 256 studies with positive findings.
- 71 High-quality studies with negative findings include: Burke et al., 2017; Herman-Stahl et al., 2007; King et al., 2013a; McClintock et al., 2016; Moro et al., 2011; Thomas et al., 2018. Note: McClintock is listed three times in the Koenig et al. (2024) appendix with separate subsamples but is just one study.
- 72 Two studies on substance abuse and addiction reported complex findings (Eitle, 2011; Lee et al., 2014). Seven reported mixed findings (Atkins & Hawdon, 2007; Benjet et al., 2007a, 2007b; Blay et al., 2008; Carrico et al., 2017; Hodge et al., 2011; King et al., 2013a).
- 73 Zucker & Brown, 2019.
- 74 Patel & Preedy, 2022.
- 75 Koenig et al., 2001, 2012, 2024. For notable findings on religion and substance abuse and addiction, see Appendix A.
- 76 Koenig et al., 2024, p. 164.
- 77 Koenig et al., 2024, p. 186; Smith, 2025.
- 78 Koenig et al., 2024.
- 79 For plausible reasons for strong religion and health connections relating to substance abuse and addiction, see Appendix B.
- 80 Marks & Dollahite, 2026; Pargament, 1997.
- 81 Koenig et al., 2024, p. 175.
- 82 Koenig et al., 2024; Stark, 2012.
- 83 Koenig et al., 2024, p. 175.
- 84 Koenig et al., 2024, p. 175; see also Marks & Dollahite, 2026.
- 85 Koenig et al., 2024, p. 175.
- 86 Koenig et al., 2024, ch. 6 (bipolar disorder), ch. 9 (schizophrenia).
- 87 Koenig et al., 2024.
- 88 The four studies that found a relationship between higher religiosity and lower levels of bipolar disorder include: Caribé et al., 2015a; Dervic et al., 2011; Stroppa et al., 2018; Stroppa & Moreira-Almeida, 2013.
- 89 The five studies that found a relationship between higher religiosity and higher levels of bipolar disorder include: Azorin et al., 2013; Cruz et al., 2010; Gawad et al., 2018; Mizuno et al., 2018; Ouwehand et al., 2019. One study on bipolar disorder had complex findings (Grover et al., 2016), and one study had mixed findings (Baetz et al., 2006).
- 90 The eight include: Benda, 2002a, 2002b; Caqueo-Urizar et al., 2016; Dwidiyanti et al., 2020; Kos et al., 2019; Peltier et al., 2017; Raguram et al., 2002; Serfaty et al., 2020; Thygesen et al., 2013.
- 91 The nine studies include: Anderson-Schmidt et al., 2019; Gawad et al., 2018; Kovess-Masfety et al., 2018; Lewis-Fernandez et al., 2009; Ofori-Atta et al., 2018; Oh et al., 2018; Oh et al., 2019; Noort et al., 2020; Siddle et al., 2002a. Four studies on schizophrenia (and other psychoses) had mixed findings (AbdelGawad et al., 2017; Danbolt et al., 2011; Loch et al., 2019; Mohr et al., 2012).
- 92 For more detailed reports on notable findings on bipolar disorder, see Appendix A.
- 93 Koenig et al., 2024, p. 99.
- 94 For notable findings on schizophrenia and other psychoses, see Appendix A.
- 95 Koenig et al., 2024, 102.
- 96 Koenig et al., 2024.
- 97 Koenig et al., 2001, 2012, 2024.
- 98 Mahoney, 2019; Smith & Denton, 2005; Smith & Snell, 2009.
- 99 Bengtson et al., 2013; Mahoney, 2010.
- 100 Marks & Dollahite, 2026, p. 297.
- 101 Koenig et al., 2024; Marks & Dollahite, 2026.
- 102 Brierly, 2023.
- 103 Smith, 2025.
- 104 VanderWeele, 2016b.
- 105 Calati et al., 2019.
- 106 Koenig et al., 2024.
- 107 Ferguson et al., 2018.

- 108 Stroppa et al., 2018.
- 109 Caribé et al., 2015a; Dervic et al., 2011.
- 110 Koenig et al., 2024, p.101.
- 111 Raguram et al., 2002.
- 112 Steenhuis et al., 2016.
- 113 See Marks & Dollahite, 2026.
- 114 Scholte et al., 2004.
- 115 Küçük et al., 2018.
- 116 DeSteno, 2022; Koenig, 2018; Pargament, 1997.
- 117 Skipper et al., in press; Taylor et al., 2004.
- 118 Cherry, 2009; 2015; 2020.
- 119 See Ronneberg et al. (2016) for a high-quality study with some contrasting findings.
- 120 See also Fancourt & Steptoe (2018) for a similar finding.
- 121 Koenig et al., 2024, p. 79, emphasis in original.
- 122 Koenig et al., 2024, p. 203.
- 123 Koenig et al., 2024, p. 205.
- 124 Koenig et al., 2024, p. 206.
- 125 Koenig et al., 2024, p. 207, emphasis added.
- 126 Koenig et al., 2024, p. 207, emphasis added.
- 127 Kent et al., 2018; Koenig et al., 2024, p. 220.
- 128 Koenig et al., 2024, p. 220.
- 129 Lechner and Leopold, 2015, p. 166.
- 130 Chen & VanderWeele, 2018.
- 131 Chen et al., 2020a.
- 132 Koenig et al., 2024, p. 170.
- 133 Patel & Preedy, 2022.
- 134 Koenig et al., 2024.
- 135 Kelly et al., 2020, p. 2.
- 136 Koenig et al., 2024, p. 185.
- 137 Koenig et al., 2024, p. 164.
- 138 Bradshaw & Kent, 2018; Koenig et al., 2024, p. 62.
- 139 Koenig et al., 2001, 2012, 2024; Pargament, 1997.
- 140 Koenig et al., 2001, 2012, 2024.
- 141 Koenig et al., 2001, 2012, 2024; Pargament, 1997.
- 142 Koenig et al., 2012, 2024; Marks & Dollahite, 2026; Taylor et al., 2004.
- 143 Koenig et al., 2024, pp. 87–88; see Weaver, 1995.
- 144 Koenig et al., 2024, p. 71.
- 145 Hoffman, 2012.
- 146 Regnerus and Uecker (2007) summarize that “while social desirability and embarrassment modestly diminish the likelihood of self-reporting some sensitive behaviors, they are neither associated with religiosity nor do they undermine apparent religious effects” (p. 145).
- 147 Koenig et al., 2024; see also Horwitz, 2022, p. 217.
- 148 Koenig et al., 2024.
- 149 Marks & Dollahite, 2017.
- 150 Lefevor et al., 2021.
- 151 Marks, 2005.
- 152 Koenig et al., 2001, 2012, 2024.
- 153 Koenig et al., 2024, 172.
- 154 Koenig et al., 2024, p. 175.
- 155 Gomes et al., 2018; Koenig et al., 2024, p. 168.
- 156 Koenig et al., 2024, pp. 168–169; citing Ferguson et al., 2018.
- 157 Koenig et al., 2024, p. 169.