Religion & Human Flourishing

A THREE-REPORT SERIES

REPORT 3

The Religion & Social Health Connection

What Does the Best Science Reveal?

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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.[1] 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.[2] 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,[3] 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.[4] 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.

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.

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.[5]

The research literature expanded rapidly from the first edition in 2001, which reviewed just over 1,200 studies,[6] and the second edition in 2012, which cataloged approximately 2,800 studies from a single decade alone.[7] By the time of the third edition in 2024, tens of thousands of peer-reviewed studies on religion and health were available.[8] 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.[9]

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. This excludes null findings, which are typical in any body of medical research and which neither support nor undermine the central claim. 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 more than 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.[10]

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 relational 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.

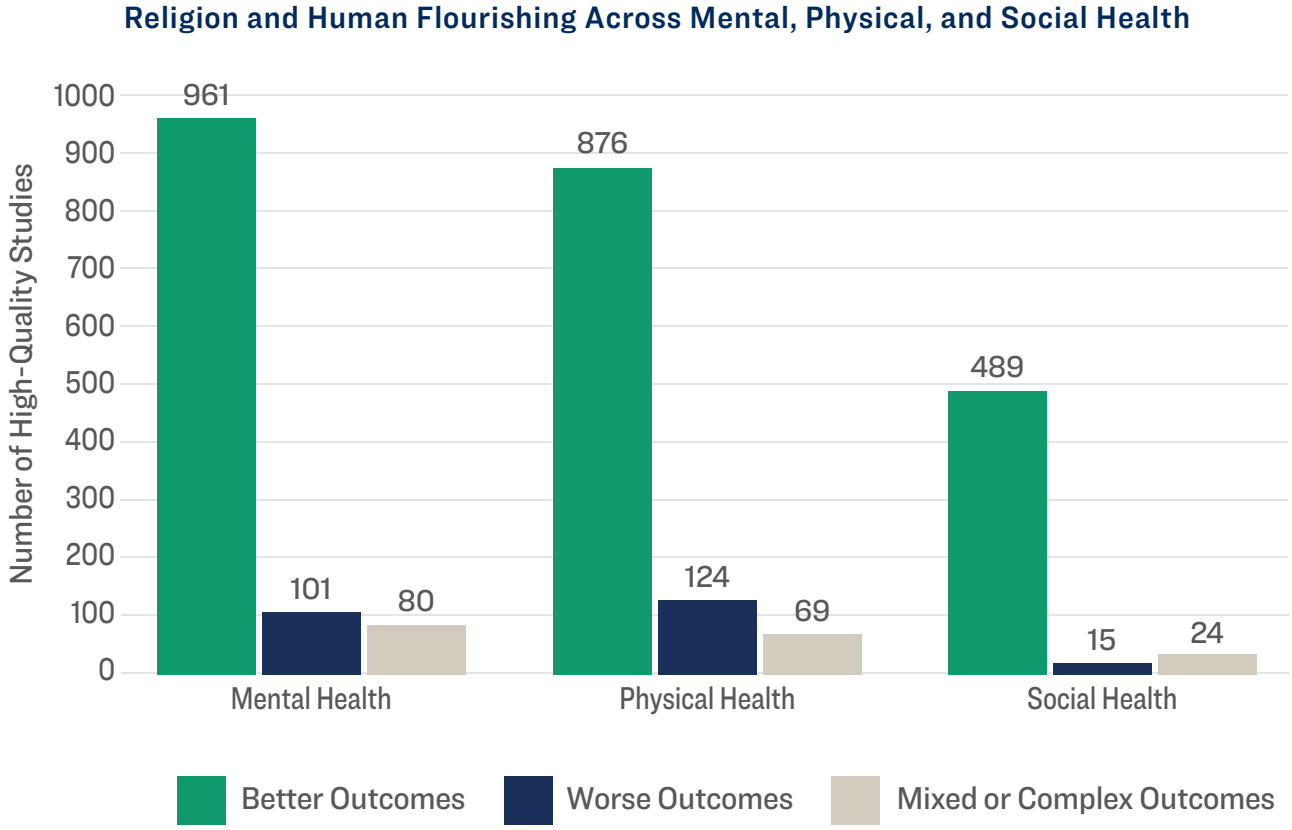

FIGURE 1: Comparison of high-quality studies reporting positive, negative, and mixed associations between religious involvement and outcomes across mental health, physical health, and social and relational health domains. Counts reflect studies meeting the inclusion criteria outlined in the 2024 *Handbook*.

Mental Health

The first report, *The Religion and Mental Health Connection,* reviews the highest-quality studies on religious involvement and their 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 approximately 10:1.[11]

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The strongest evidence links religious involvement to lower suicide risk,[12] better coping with stress,[13] reduced substance abuse and addiction,[14] and higher levels of hope, meaning, and life satisfaction.[15] Although harmful or coercive forms of religion do exist,[16] 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.[17]

Religious participation is consistently associated with lower mortality risk,[18] dramatically lower rates of cigarette smoking,[19] reduced substance abuse,[20] and improved outcomes related to cardiovascular disease[21] and other chronic conditions.[22] 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 33:1.[23]

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

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.

REPORT 3

The Religion & Social Health Connection

What Does the Best Science Reveal?

Do the norms, rituals, and networks associated with world religious communities—Buddhism, Christianity, Hinduism, Judaism, and Islam, among other faiths—strengthen the quality and functioning of human relationships or do they undercut them? In short, what does contemporary faith have to do with social health in countries across the globe? Although most developed nations have taken a more secular turn in recent decades, the majority of individuals and families still report some degree of religious observance, and a significant portion of these report high levels of religious devotion. Does religious devotion still matter in modern societies?

A new landmark study of over 180,000 individuals across five major world religions in 22 countries recently reported that "individuals across religious affiliations are less lonely and less socially isolated than the nonreligious."[8] The same study further found that "believing in and feeling loved by a higher power attenuate the extent to which social isolation and loneliness predict worse physical and mental health." Framed differently, for many of the more than five billion religious people in the world, both congregational participation and a perceived personal connection with God appear to be meaningfully associated with well-being. Particularly for the faithfully devoted, religion is more than a source of identity or meaning; it is a force potent enough to be connected with elevated physical and mental health in measurable ways.[9]

Religion is more than a source of identity or meaning; it is a force potent enough to be connected with elevated physical and mental health in measurable ways.

Despite these trends, any serious assessment of religion must grapple with its capacity both to harm and to heal. As the Hindu mystic Ramakrishna observed, "Religion is like a cow. It kicks. But it also gives milk."[10] History provides ample examples invoked by critics, from Thomas Paine's eighteenth-century warning that "the most detestable wickedness" has been justified in the name of revealed religion[11] to more recent claims by New Atheist leader Sam Harris that religion is "the most prolific source of violence in our history."[12] Yet such portrayals often overstate religion's role in conflict. Historical analyses suggest that only a small fraction of recorded wars, fewer than 7%, can be plausibly classified as primarily religious in motivation.[13] As Rabbi Jonathan Sacks noted, most conflicts arise from struggles over power, territory, and glory rather than theology.[14] A balanced evaluation must move beyond caricatures of religion as either purely destructive or unambiguously benevolent, recognizing both its documented harms and its underexamined capacity to restrain violence, foster social cohesion, and promote human flourishing. Intellectual integrity requires attention to both the "kick" and the "milk"—the "harms and [the] helps."[15]

The *Handbook of Religion and Health*

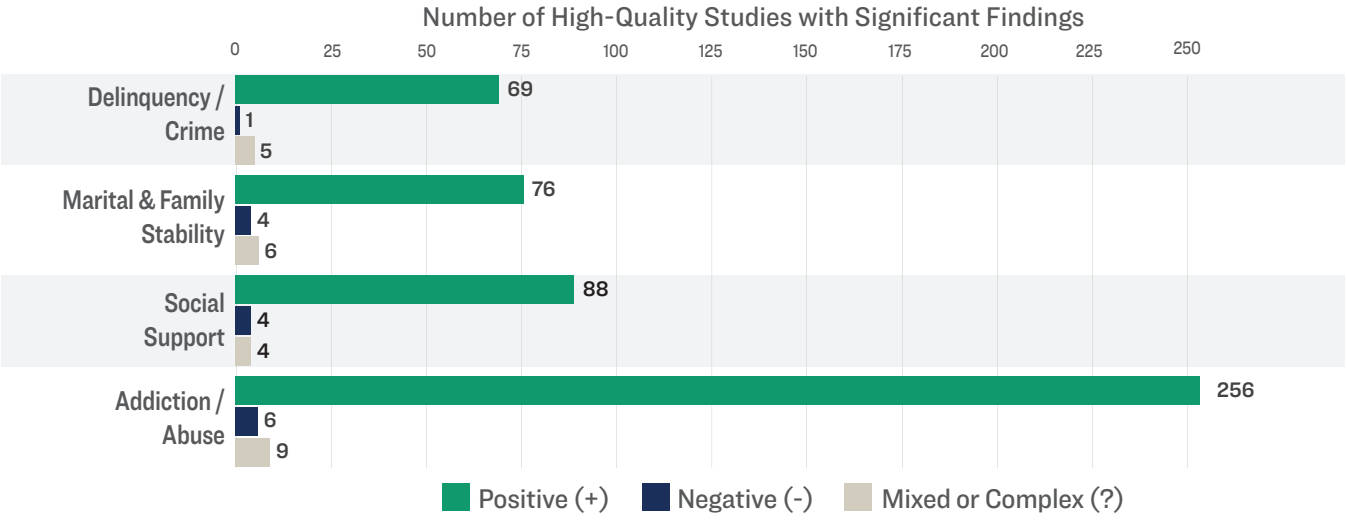
While opinions about whether religion is a force for good or ill are commonly found in social media debates and articles in prominent media outlets, very few of these viewpoints are deeply tied to the scientific research on the matter. This is a striking and notable omission given that research on the associations between religion and social health has expanded and deepened in significant ways in recent years.

The most comprehensive scholarly effort to document both the benefits and harms of religion in medical and social science research is the *Handbook of Religion and Health*, now in its third edition. The first edition, published in 2001 by Harold G. Koenig and colleagues, systematically reviewed more than 1,200 studies and 400 research reviews from the twentieth century. The second edition, released in 2012, expanded substantially, cataloging approximately 2,800 studies published between 2000 and 2010, reflecting the rapid growth of the field. By the third edition in 2024, the volume of relevant research had increased severalfold.[16]

In response to this expansion, Koenig and his coauthors, Harvard professors Tyler VanderWeele and John Peteet, emphasized methodological rigor in the *Handbook of Religion and Health* (2024 edition), limiting their review to only the strongest available studies.[17] Described by Professor Howard Koh as a "stunningly ambitious" effort,[18] this edition provides the empirical foundation for the findings presented in this report. The primary purpose of this report is to make the findings of this authoritative handbook available to a wider audience and to more fully ground social commentary on religion in the best available science.

Across all three reports in our Religion and Human Flourishing series, we emphasize the ratio of studies reporting positive versus negative associations between religion and well-being. Many medical and social science studies yield null findings—identifying no statistically significant (positive or negative) effects—but this series focuses on studies reporting statistically significant relationships. Of the studies that met the *Handbook* authors' stringent inclusion criteria, 528 high-quality studies reported significant findings regarding religion and social health. Of these, 489 (92.6%) identified positive associations, 15 (2.8%) reported negative associations such as unhealthy religious influences, and 24 (4.6%) yielded mixed or complex results. Taken together, the best available evidence indicates that religion is far more often associated with beneficial social and relational outcomes than harmful ones, with positive findings outnumbering negative findings by almost 33:1.[19] (See Figure 2).

FIGURE 2: Significant Positive and Negative Findings Across 4 Social Health Phenomena



At a more granular level, the strength of these associations varies across specific social health domains; depending on the phenomenon examined, the ratio of rigorous studies reporting positive (healthy) versus negative (unhealthy) associations ranges from approximately 19:1 to as high as 69:1.

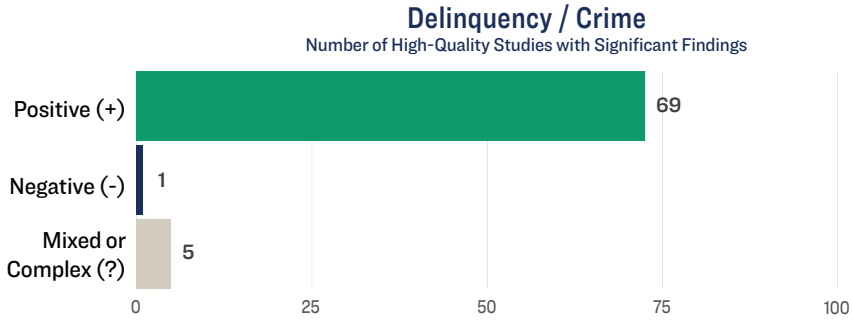
This report is the final installment in a three-part series titled Religion and Human Flourishing. Report 1 examined religion and mental health and found that although harmful forms of religion exist, the highest-quality evidence overwhelmingly links religious belief, practice, and participation with better mental health outcomes, including significantly greater positive emotion and significantly lower rates of depression and suicide. Report 2 focused on religion and physical health and similarly found that active religious involvement is significantly associated with improved physical health, including lower mortality risk and reduced substance use, with positive associations far outnumbering negative ones across all studied domains.

This third report shifts the focus to social health, examining relationships within marriages, families, communities, and broader society. As we move into the second quarter of the 21st century, the central question addressed here is: What does the best available social and medical science reveal about the connections between religion and the quality and functioning of human relationships?

Religion and Social Health

The *Handbook of Religion and Health* examines religion's relationship with four central domains of social health:[20] (1) delinquency and crime,[21] (2) social support,[22] (3) marital and family stability,[23] and (4) substance abuse and addiction.[24] Each of these domains will be examined in greater depth. We then turn to an additional, critically important area of social health that did not receive focal treatment in the *Handbook*—fertility and birthrates.

TOPIC 1: **Religion's Connection with Delinquency and Crime**



The first social health domain examined in the *Handbook* is delinquency and crime, and we follow that order here.[25] In doing so, we draw on the perspective of the late Rodney Stark,[26] widely regarded as one of the most influential sociologists of religion of the past half century and the author of more than 40 books. Reflecting on the state of criminological scholarship, Stark argued that "criminology is only half a field of study," because it devotes itself almost entirely to explaining why some people engage in crime while failing to ask why other people do not. He emphasized that a "large body of solid research"[27] demonstrates that both antisocial and prosocial behaviors are strongly shaped by religion. Yet Stark also observed a striking disciplinary blind spot: out of 16 widely-used criminology textbooks he reviewed, 14 did not include the word *religion* anywhere in their index, a silence he attributed not to a lack of evidence but to persistent antireligious bias within academic culture.[28]

The empirical literature reviewed in the *Handbook of Religion and Health* strongly supports Stark's key findings. Among the most rigorous studies examining religion in relation to delinquency and crime, 75 reported statistically significant findings. Of these, 69 found that higher religiosity was associated with lower rates of delinquent and criminal behavior.[29] Only one study reported a negative association,[30] yielding a positive-to-negative ratio of 69:1.[31] Together, these findings suggest that religion is among the most consistently protective factors identified in the social science literature on crime, despite its longstanding marginalization within criminological theory.

Important Considerations: Religion's Connection with Delinquency and Crime

Varying estimates of the "yearly economic cost of youth incarceration" in the U.S. for 2011 "ranged from $8 billion to $21 billion."[32] However, these estimates are now dated and include juveniles only. Varying estimates for the overall costs of crime in the United States across local, state, and federal levels range from $690 billion to a staggering $3.4 trillion.[33] Potential crime deterrents deserve serious consideration for myriad reasons, including: protection from harm for victims and communities, prevention of the tragedy of misdirected human potential, and reduction of financial costs.

Religion has significant impacts on decreasing delinquency and crime through multiple channels, including (but not limited to): (1) developmental and early-life pathways; (2) familial, cultural, and social channels; and (3) resources. We briefly address each of these channels of influence here.

Developmental and Early-Life Pathways

Research on antisocial and criminal behavior indicates that individual differences arise from a combination of inherited predispositions and formative environments.[34] Some studies suggest that a substantial share of variation in antisocial behavior reflects factors present early in life, while other research emphasizes the role of social, family, and environmental conditions.

Contemporary scholarship increasingly highlights interaction rather than determinism, with early predispositions shaped, amplified, or mitigated by relational and social contexts.

In this light, the nurturant parental bonding often encouraged within religious communities[35] may influence developmental pathways in ways that reduce later delinquency and criminal behavior.[36] In addition, parental religiosity—particularly maternal religiosity—has been associated with lower exposure to harmful substances during pregnancy, a factor that may affect early neurological development related to self-regulation and emotional control.[37]

These findings collectively suggest that religion may shape antisocial and prosocial behavior through multiple, overlapping early-life mechanisms, including prenatal conditions, family practices, and the interaction between inherited traits and social environments. These associations are probabilistic rather than deterministic and operate alongside a wide range of other influences.

Familial, Cultural, and Social Channels

Religious involvement within marriage, particularly when shared by both spouses, has consistently been associated with greater marital stability, higher relationship quality and satisfaction, and increased parental warmth.[38] Conversely, parental divorce, domestic violence, and lack of parental warmth and supervision have each been associated with juvenile delinquency and adult crime.[39]

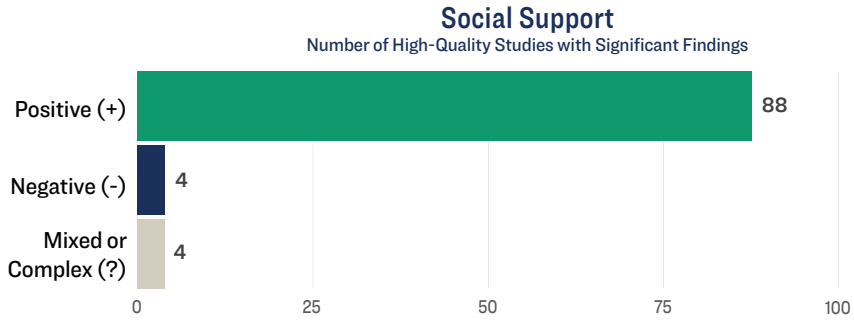
While parental and familial factors are important, peer influence is also a significant predictor of juvenile delinquency and later adult criminality.[40] In the peer domain, faith community attendance and youth group involvement can play dual roles in connecting youth with prosocial peer groups while serving a preventative function by helping youth avoid affiliation with antisocial peer networks[41]—thereby reducing antisocial behaviors, crime, and delinquency. Studies have also connected religious teachings, practices, and doctrines with positive emotion, lower depression and anxiety levels, lower substance abuse and addiction levels, and better overall mental health.[42]

Resources

Faith community involvement may also influence crime and delinquency through the provision of social and material resources.[43] Because mental illness and addiction are associated with elevated risks of antisocial behavior, supportive community contexts can function both preventively and as sources of intervention. Faith communities often provide layered forms of support, including social connection, pastoral counseling, and emergency financial assistance. These resources are especially salient in contexts marked by poverty or social marginalization.[44] Prior research suggests these forms of support are particularly consequential for racial and ethnic minority communities, who disproportionately experience economic and other resource-related disadvantages.[45]

These mechanisms do not fully explain religion's positive influences mitigating crime and delinquency, but they help illuminate the pattern observed in the empirical literature, including the 69:1 positive-to-negative ratio identified by the authors of the 2024 *Handbook* in studies examining religion and criminal behavior. To restate Stark's observation, criminology has largely focused on explaining why individuals engage in wrongdoing while giving far less attention to the factors that encourage prosocial behavior.[46] As the following section demonstrates, a substantial body of research indicates that religion plays a meaningful role in shaping healthy, prosocial behaviors.

TOPIC 2: **Religion's Connection with Social Support**



Turning from criminality to prosocial support and behavior, the empirical evidence remains potently positive. Among the 96 high-quality studies examining the relationship between religion and social support, 88 (approximately 92%) found that religiosity was associated with higher levels of social support and increased prosocial activity, including altruism, generosity, volunteering, and charitable giving.[47] Only four studies (approximately 4%) reported negative associations,[48] yielding a positive-to-negative ratio of approximately 22:1.[49]

Consistent with these findings, earlier reviews reached similar conclusions. Koenig and colleagues (2012) reported that, among 74 pre-2010 studies on religiosity and social support, 61 identified positive associations, while none of the rigorous studies reviewed reported a significant negative relationship.

Important Considerations: Religion's Connection with Social Support

A large and growing body of evidence demonstrates that social connection and integration are among the strongest predictors of health and longevity.[50] Two major meta-analyses by Holt-Lunstad and colleagues underscore the magnitude of these effects. A 2010 meta-analysis synthesizing 148 studies with a combined sample of 308,849 found that individuals with adequate social relationships were about 50% more likely to survive over follow-up periods than those with poor or insufficient relationships.[51] A subsequent 2015 meta-analysis integrating 70 studies and 48,673 participants similarly concluded that social isolation, loneliness, and living alone were associated with significantly elevated mortality risk.[52] These findings align with evidence highlighted in Report 2, which examined religion and physical health.[53] Notably, Hummer et al. (1999) found that weekly worship service attendance was associated with a 7.6-year longevity advantage, increasing to a gap of 13.7 years among African Americans, an effect likely attributable in part to the social integration fostered by weekly religious participation. Taken together, these findings underscore the central role of social connection in shaping health outcomes and provide an important bridge to the discussion of religion as a generator of social support and social capital.[54]

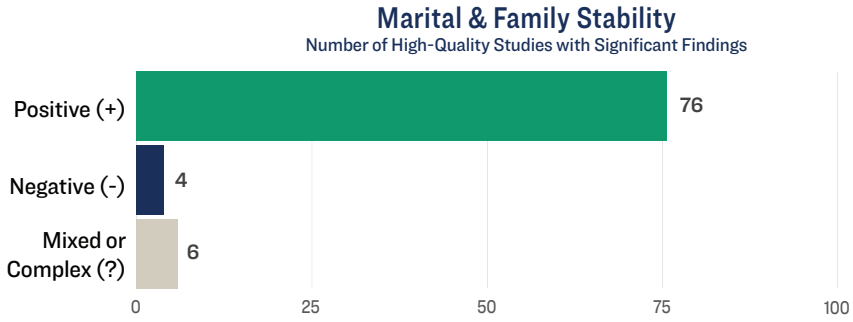
Just as individuals depend on social support, communities benefit from what scholars describe as social capital: networks of trust, reciprocity, and cooperation reflected in civic participation, volunteerism, and membership in prosocial organizations.[55] Few, if any, institutions generate these forms of durable social capital as consistently as religious communities.

Conversely, religious affiliation can, in some contexts, contribute to social division, a concern addressed in Reports 1 and 2. Yet the weight of the best available evidence indicates that religion more often promotes altruism, reciprocity, and service to others. Indeed, all major world faith traditions emphasize concern for those beyond one's immediate group, including care for strangers and outsiders.[56]

Empirical research further suggests that the benefits of religiosity extend well beyond congregational boundaries. As Rodney Stark observed, religious Americans contribute disproportionately to charitable giving, supporting not only religious causes but also secular ones.[57] Gallup World Poll data similarly indicate that religious attenders are nearly twice as likely as nonattenders to volunteer their time in a given month (57% versus 31%).[58] Thus, religious participation is associated not only with greater social support and longevity for religious individuals themselves, but also with increased contributions of time and resources that benefit broader society, including both religious and nonreligious communities.[59]

With this broader social context in view, our analysis now turns to marriage and family life, widely regarded by scholars and policymakers as foundational units of social health.

TOPIC 3: **Religion's Connection with Marital and Family Stability**



The 2024 *Handbook*'s review of the most methodologically rigorous studies examining religion and marital and family stability identified 86 studies reporting statistically significant findings. Of these, 76 studies (88%) found that higher levels of religiosity were associated with greater marital and family stability and/or higher relationship satisfaction.[60] Four studies (less than 5%) reported negative findings,[61] a 19:1 positive-to-negative ratio.[62] While the authors of the *Handbook* primarily emphasize studies from the past 15 years—a focus shared by this report—we also briefly note the cumulative findings from earlier editions. Across the first two editions of the *Handbook* (2001, 2012), the authors systematically reviewed 79 studies examining religion and marital stability. Of these, 68 studies (86%) found that higher religiosity was associated with lower divorce rates, greater marital satisfaction, reduced spousal abuse, and a higher likelihood of intact families with two biological parents in the home. Notably, none of the studies reviewed reported significantly lower marital stability among more religious individuals.[63] Viewed across multiple decades of research, the association between religiosity and relational health, including marital stability, appears even more pronounced than is evident in analyses limited to the most recent studies.[64]

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Important Considerations: Religion's Connection with Marital & Family Stability

What factors help explain the consistently higher levels of marital stability observed in more religious marriages? From a resource-based perspective, many faith communities provide structured forms of support, including marital education, counseling, and peer support groups. In addition, faith-based welfare and assistance programs often function as informal safety nets, offering material, emotional, and social support during periods of heightened stress, such as job loss, serious illness, injury, family bereavement, or natural disasters.[65] Multifaceted marital support during challenges can help protect against divorce.

Another pathway through which religion may contribute to marital stability involves shaping premarital behaviors that are themselves associated with long-term marital outcomes. Decisions such as cohabitation and the number of premarital sexual partners have been repeatedly linked to higher divorce risk later in life,[66] and religious teachings and norms typically discourage nonmarital sexual activity. The influence of religion on relationship stability may also persist after marriage. As the authors of the *Handbook* note, religious prohibitions against infidelity and pornography use may foster greater relational trust and more secure attachment, thereby strengthening sexual intimacy within marriage—a concept supported by recent research.[67]

Another influential religious mechanism identified by leading psychologists of religion Kenneth Pargament and Annette Mahoney is marital sanctification—the process by which individuals frame, perceive, and treat their marriage as sacred.[68] Empirical support for sanctification is substantial. In a large, nationally representative study, Ellison et al. (2011) found that "sanctification strongly predicts desirable marital outcomes" and that sanctification "appears to buffer the deleterious effects of financial and general stress on marital quality."[69] Similarly, a leading family studies scholar, Wes Burr, observed that "experiencing parts of family life as sacred gives them a unique, unusually powerful and salient influence in families."[70] Collectively, this research suggests that viewing marriage as sacred may elevate how spouses honor one another and, by extension, how parents honor the children who are raised within a union both parents view as "sacred."

From the perspective of potential harm, religion that is invoked in harsh or authoritarian ways can do significant damage to both marital and parental relationships.[71] Burr and his colleagues have accordingly observed that it is "what people *do* as a result of their ideals and beliefs around the sacred" that ultimately determines whether the sacred operates as a source of help or harm within families.[72]

Another complexity in the religion–marriage connection is that the marital instability or "divorce rate in inter-faith marriages is higher than same-faith marriages for each of the major faiths that have been examined in demographic studies."[73] Shared religious involvement tends to be a marital stabilizer and benefit while unshared faith can introduce additional challenges for marital cohesion and stability.[74]

Returning to the health-related pathways discussed earlier, Report 1 documented that higher levels of religious involvement are generally associated with better mental health, while Report 2 found similar associations with better physical health. Because mental and physical health challenges often place significant strain on marital and family relationships, these patterns suggest that individuals with higher levels of religiosity may experience indirect marital advantages through improved overall well-being.[75] Moreover, when mental or physical health challenges do arise, religious marriages and families often have access to faith-based social support and community resources that can help mitigate stress and promote relational resilience.

Even so, large-scale empirical research indicates that religious service attendance alone does not fully capture the ways in which religious involvement can benefit marriage and family life.[76] A leading psychologist of religion, Annette Mahoney, has urged scholars to attend not only to distal religious influences, such as formal participation in faith communities, but also to proximal influences that operate within the home.[77] Family studies scholars have similarly cautioned researchers, "Don't forget home," emphasizing the significance of sacred, home-centered practices and rituals.[78]

Supporting this perspective, a recent 11-nation study involving 16,474 participants found meaningful differences in relational outcomes between those who engaged in *both* faith community participation *and* home-based religious practices, contrasted with those who were secular, nominally religious, or consistent in attending services without engaging in home worship. The study reported that higher levels of sexual satisfaction and emotional closeness were associated with shared, home-centered religious practices, but not with shared church attendance alone.[79] Indeed, the authors found "a strong correlation between home-centered religious worship patterns and positive relationship outcomes," noting that women in relationships where both partners worshiped at home were twice as likely to report emotional closeness with their partner, alongside higher reported sexual satisfaction, better joint decision-making, fewer money-related conflicts, and more positive perceptions of partner virtues.[80]

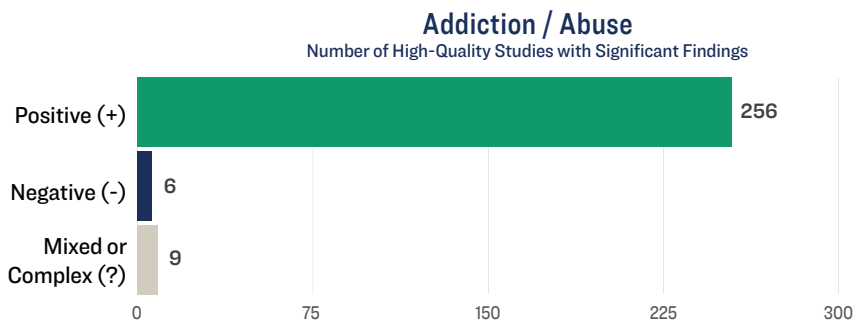
As a whole, this research suggests that religion may support marital and family well-being through multiple, reinforcing channels, including family-promoting beliefs, sacred home-based rituals, shared meaning-making practices, and the broader relational support of faith communities.[81]

Across the three reports in the Religion and Human Flourishing series, weekly attendance in a faith community is consistently shown to be associated with better outcomes. However, the 11-nation study highlights that home-centered religious practices are linked to even greater and often overlooked relational benefits.[82]

While the present report focuses primarily on elevated health and human flourishing, we must also confront patterns of dysfunction and harm. Accordingly, we conclude this section on marital and family stability by addressing the painful reality of domestic violence. A Pennsylvania Health and Human Services site reports that "an estimated 3 of every 4 incidents of spousal abuse involves alcohol,"[83] with another estimate approximating that as much as 80% of physical abuse of women is related to alcohol and drug abuse.[84] Put in concrete terms, if 20 women need medical attention due to severe domestic beatings in a particular hospital this coming weekend, 15-16 of those 20 cases are projected to involve alcohol or drug abuse as a contributing factor.[85] As emphasized in earlier reports in this series, high religious involvement is among the strongest protective factors identified in relation to substance abuse and addiction; by extension, healthy religious involvement also functions as a significant protective factor against domestic violence.

This relationship is documented in a national study of 6,800 respondents by sociologist Chris Ellison and colleagues who found that "religious involvement is correlated with reduced levels of domestic violence" and that "religious involvement, specifically church attendance, protects against domestic violence, and this protective effect is [even] stronger for African American men and women and for Hispanic men, groups that, for a variety of reasons, experience elevated risk for this type of violence."[86] More specifically, women who attended religious services frequently were significantly less likely to experience abuse, while men who attended religious services more than weekly were "72% less likely to abuse their female partners than men from comparable backgrounds who do not attend services."[87] Having noted the potent tie between domestic violence and substance abuse, we now turn to the topics of substance abuse and its long-term partner in crime, addiction.

TOPIC 4: **Religion's Protective Role Against Substance Abuse and Addiction**



If one were to ignore the composite findings from 1,543 rigorous studies demonstrating significant positive correlations between religiosity and six significant mental health outcomes, 14 important physical health outcomes, and three major social health outcomes,[88] the empirically established relationship between religiosity and significantly lower substance abuse alone would warrant serious attention from those concerned with public health. Substance abuse and addiction are therefore addressed extensively in all three reports in this Religion and Human Flourishing series, reflecting their direct and substantial effects on mental health, physical health, family stability, and societal well-being. The breadth and severity of these harms have generated extensive scholarly attention, including an Oxford handbook that identifies adolescent substance abuse as perhaps *the* leading public health problem in the United States.[89]

Given the extensive and far-reaching harms caused by substance abuse and addiction, a substantial body of research has focused on identifying effective strategies for prevention and rehabilitation.[90] A significant point of consideration is that religion has been repeatedly identified as both a leading *preventative force* for many, as well as a *rehabilitative help* for some.[91]

Relatively low rates of alcohol and drug abuse among the more religious also contribute to lower rates of mental illness (see Report 1) as well as several physical health concerns and phenomena, including cigarette smoking, heart disease, and cancer, among many others (see Report 2).

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.[92] Only six studies (2.2%) found religion to be correlated with higher rates[93] of substance abuse—a 43:1 positive-to-negative ratio.[94]

When it comes to substance abuse, the evidence is striking: the authors of the 2024 *Handbook* summarily state, "In almost no other area of mental health (except perhaps suicide) is there more evidence that religion makes a difference."[95]

Important Considerations: Religion's Connection with Substance Abuse and Addiction

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.[96] In families, religious involvement is associated with stronger two-parent households and healthier parental monitoring.[97] Conversely, well-established risk factors for substance abuse include childhood maltreatment, low parental monitoring, neglectful parenting, parental drug use, poor parental adjustment, parental divorce, early onset of drinking, and substance-using peers. This list of risk factors is important to consider here because "every one of these risk factors [has] been shown to be inversely related to religious involvement."[98]

While religion–family connections can be powerful in preventing substance abuse and addiction, no level of religious involvement or family stability provides absolute protection. Prevention and addiction are related but distinct issues. With respect to rehabilitation and recovery, the *Handbook* authors argue 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."[99]

At present, 256 rigorous studies document significant associations between religiosity and lower rates of substance abuse. Collectively, this evidence suggests that for many individuals, religious involvement provides a meaningful pathway away from substance abuse and addiction. The pattern is clear: "Religious involvement affects virtually every factor that influences the development and persistence" of substance abuse and addiction.[100]

Fertility: A Vital Addition to the Religion and Social Health Framework

In this final report of the three-part Religion and Human Flourishing series, we review the best available scientific research[101] on religion and four major social and relational phenomena: (1) delinquency and crime, (2) social support, (3) marital and family stability, and (4) substance abuse and addiction. While book-length studies and specialized handbooks exist for readers seeking deeper engagement with these topics—or with the two dozen phenomena addressed across the full series—we pause to note that the *Handbook* systematically examines each of these domains. We concur with Harvard professor Howard Koh's description of the volume as "stunningly ambitious."[102] Even so, no single handbook can cover every critical issue. One vital topic that did not receive extended treatment—and that has grown into an urgent concern for most developed nations in recent decades—is fertility.

The Pew Research Center recently reported that "the total fertility rate in the U.S. stands at 1.6 live births per woman in 2025, according to UN estimates."[103] This represents the lowest fertility rate in recorded U.S. history, with no improvement projected. Sustained below-replacement fertility weakens the base of the population pyramid; when fertility rates fall to 1.0, a nation's population will eventually be halved and, if the trend continues, halved again. As economist Catherine Pakaluk explains in her 2024 book-length study, "the political and economic consequences of these trends cannot be overstated. Below-replacement fertility in the United States imperils every New Deal–era entitlement program, every state pension program, and the future of economic prosperity as workers become scarce."[104]

The implications extend well beyond the United States. One recent report warns that "the decline in childbearing and, consequently, in the working age population will have catastrophic effects for economies around the world."[105] This raises a critical question: What does fertility decline have to do with religion? In response, Cranney and colleagues observe that "countries that reach [the] crucial replacement rate are, almost as a rule, religious. . . . Secular societies are simply not replacing themselves. Apparently, humanity's survival requires at least some religiosity."[106]

To date, social policy has shown little ability to meaningfully increase fertility rates. One of the few areas of sustained promise is religion: Religiously involved women are more likely to marry, remain married, and become married mothers.[107] In a global study of 30,000 adults across 24 countries, Stier and Kaplan (2020) found that higher religious attendance was associated with more positive views of children, including the belief that children enhance both happiness and social status.[108] Similarly, one recent report concluded that "research consistently shows that religious people have more children and express a desire for larger families," and that "differences in birth rates between countries [are] in large part due to differences in faith."[109] Extending this line of analysis, Pakaluk argues that strong religious commitment may function as "the only effective family policy" for some families, because many people of faith "will lay down their comforts, dreams, and selves for God, [but] not for subsidies," leading her to conclude that "religion is the cardinal family policy."[110]

Across the three reports in this series, we examined 26 total phenomena and found that for 24 of them, higher levels of religiosity are associated with improved health and quality of life.[111] As the world moves deeper into the latter three-quarters of the 21st century, however, the evidence suggests that religious commitment may also serve a more fundamental role: a literally vital factor in the continuation of human life itself.

Conclusion

Religion and Social Health: The Strongest Evidence Across All Domains

In summary, when we examined the 528 most rigorous studies on religion and social health identified by the authors of the 2024 *Handbook*, the results were striking. A total of 489 studies (approximately 93%) reported positive links between religion and social health, while only 15 studies (3%) reported negative associations.

For comparison, *The Religion and Physical Health Connection* (Report 2) found an overall positive-to-negative ratio of approximately 7:1, and *The Religion and Mental Health Connection* (Report 1) found a ratio of approximately 10:1. Notably, the findings for religion and social health are even more positive: 489 positive studies compared with 15 negative studies, yielding a ratio of approximately 33:1.

Higher levels of religious involvement are strongly associated with better mental health—including more robust coping with stress, lower rates of depression and anxiety, fewer personality disorders, and far lower levels of suicide and suicidal ideation. Higher religious involvement is also linked to better physical health, including significantly lower rates of cigarette smoking and cancer; reduced obesity, heart disease, hypertension, cerebrovascular disease, Alzheimer's disease, and chronic pain; healthier patterns of exercise, physical activity, diet, and immune function; and ultimately longer life. Yet as substantial as the mental and physical health benefits are, the social and relational advantages of religious involvement are even greater. This is not only because of the exceptionally strong 33:1 ratio of healthy to unhealthy outcomes reported in the highest-quality studies, but because these social benefits extend *beyond* the individual—shaping families, communities, and society as a whole.

In the social domain, the imbalance between positive and negative findings in the most rigorous studies is especially striking. For delinquency and crime, the imbalance is 69 to 1; for marital and family stability, it is 76 to 4 studies (a 19:1 ratio); for social support, 88 positive studies to 4 negative (a 22:1 ratio); and for substance abuse and addiction, 256 positive studies to 6 negative (a 43:1 ratio). Together, these patterns help explain why a leading sociologist of religion of the past half-century subtitled one of his final books *How Religion Benefits Everyone, Including Atheists*.[121]

Research also consistently points to a threshold effect: the benefits of religion are strongest among those with sustained, high levels of engagement. Active participation is linked to better physical health, including lower rates of cancer and longer life;[122] more robust mental health; and stronger marriages and families.[123] Across ages and faith traditions, the greatest benefits are typically seen among the faithful who attend religious services weekly or more.[124]

From a health-promotion perspective, this growing body of evidence offers potent, science-based support for active religious involvement, with wide-ranging mental, physical, and social benefits that extend beyond individuals to families, communities, and society at large.

Religion & Human Flourishing Series:

A Final Analysis

In our first report, *The Religion and Mental Health Connection*, we reviewed the highest-quality studies on religion and mental health. The overall pattern was clear: studies showed a correlation between religious involvement and good mental health, with a positive-to-negative ratio of nearly 10:1 (961 vs. 101).

This pattern was especially strong in several critical areas. Research consistently shows that religious involvement is associated with lower suicide risk (68 positive studies vs. 6 negative), better coping with stress (87 vs. 7), lower rates of substance abuse and addiction (256 vs. 6), and higher levels of positive emotions such as hope, meaning, and life satisfaction (233 vs. 9).

Taken together, these findings suggest that the evidence is not mixed or evenly divided. Across the best available science, religious involvement is overwhelmingly associated with better mental health and emotional well-being.

In our second report, *The Religion and Physical Health Connection*, we again focused only on the strongest and most carefully designed studies. Across all 15 areas of physical health we examined, the results pointed in the same direction: religious participation is consistently linked to better physical health.

Across all 15 areas of physical health we examined, the results pointed in the same direction: religious participation is consistently linked to better physical health.

The clearest benefits appeared in some of the most serious health outcomes. Studies showed strong positive links with lower risk of cerebrovascular disease (10:1), longer life and reduced mortality (approximately 15:1),[112] much lower rates of substance abuse and addiction (approximately 43:1), and dramatically lower rates of cigarette smoking (90:1).

Looking across all fifteen health domains together, 876 high-quality studies found beneficial associations between religious involvement and physical health, compared with 124 that found negative associations—an overall positive-to-negative ratio of about 7:1.

In plain terms, when religion is studied carefully and rigorously, the evidence consistently shows meaningful, measurable benefits for physical health.

Finally, in this our third and final report of the series—*Religion and Social Health: What Does the Best Science Reveal?*—the best available research points to clear and consistent findings across the social outcomes we examined.

The evidence linking religion to lower crime is especially strong. Across the highest-quality studies, there is a 69:1 ratio of positive to negative findings showing that higher levels of religiosity are associated with lower rates of delinquency and crime. This matters greatly, given that estimates of the total cost of crime in the United States range from $690 billion to as much as $3.4 trillion per year.[113]

The research also shows a strong link between religiosity and social support. Across high-quality studies, there is a 22:1 ratio of positive to negative findings indicating that higher levels of religiosity are associated with greater social support and higher rates of prosocial behavior—including altruism, generosity, volunteering, and charitable giving.[114] People who attend religious services frequently also give substantially more time and money to both faith-based and secular causes, contributing in ways that benefit society as a whole, including both religious and nonreligious individuals.[115]

Key Highlights

1. **Higher levels of religiosity are associated with lower rates of delinquency and crime**
2. **Higher levels of religiosity are associated with greater social support and higher rates of prosocial behavior**
3. **Higher levels of religiosity are linked to stronger marriages and families**
4. **Higher levels of religiosity are associated with lower rates of substance abuse and addiction**
5. **Higher levels of religiosity are associated with more positive views of children**

Research also shows a strong connection between religiosity and family stability. Across high-quality studies, there is a 19:1 ratio of positive to negative findings linking higher levels of religiosity to stronger marriages and families—including lower divorce rates, greater marital satisfaction, less spousal abuse and domestic violence, and a higher likelihood of intact families. In addition, a recent study spanning 11 nations found that families who consistently practiced religion both publicly (e.g., church attendance) and privately at home (e.g., family prayer and scripture study) reported higher levels of life happiness, relationship quality, sexual satisfaction, shared decision-making, partner virtues, and other important benefits.[116]

The evidence is especially strong when it comes to substance abuse and addiction. Across high-quality studies, there is a 43:1 ratio of positive to negative findings showing that higher levels of religiosity are associated with lower rates of substance abuse and addiction.[117] This matters for several vital reasons. Adolescent substance abuse remains one of the most serious public health challenges in the United States. Alcohol abuse is also a major factor in most cases of domestic violence. In both prevention and recovery, religion has repeatedly been shown to serve as a powerful protective factor for many individuals and a meaningful source of support for those seeking rehabilitation.[118]

A final aspect of social health—fertility—is not listed in the 2024 *Handbook* index, but it is addressed through a large global study of 30,000 adults across 24 countries. That study found that higher levels of religious attendance were associated with more positive views of children.[119] Other research similarly shows that "women who are involved in a faith community are . . . significantly more likely to have children."[120] Simply stated, high levels of religious commitment may play a vital role in sustaining family life and the continuation of society itself.

Accordingly, we offer several closing considerations:

1. **Governments as well as public and private agencies should consider partnering with religious organizations to address social issues of concern.** Many of the concerns over health and well-being that communities face can only be addressed by partnering with multiple agencies. The research cited suggests that religious organizations are vital partners in addressing issues of concerns such as crime, substance use, and more. As such, religious organizations should be invited to be a part of coalitions, working groups, and other teams aimed at improving some of society's most perplexing challenges.

2. **Support individuals, families, and communities in the practice of religion.** The research summarized here is not confined to any particular religious tradition. Rather, the evidence suggests that individuals, families, and communities tend to benefit when people are supported in living out their sincerely held religious commitments. Accordingly, organizations both public and private should consider whether their policies and practices reasonably accommodate and support religious expression among employees, clients, and community members.

3. **Ensure that policies support the practice of religion.** Policies, whether government policies (capital "P" policies) or the policies of agencies (small "p" policies), can influence the degree to which people feel able to practice religion. At times, policies might intentionally or unintentionally impact religious organizations and the practice of religion. Given the importance of religion to health in all its manifestations, it is vital that policies support and protect the practice of religion. Accordingly, similar to the use of health impact assessments and family impact analyses, when considering new policies, governments and agencies should conduct religious impact analyses on any new policies and on existing policies. Such assessments can help to determine whether a policy will help, hinder, or have a neutral effect on religions and religious practice. Attempts should be made for all policies to be supportive of religious practice regardless of whether the policy has a religious focus or not.

4. **Base policy judgments about religion and health on research, not assumptions.** Claims about the effects of religion on health, flourishing, and well-being should be evaluated using scientific research rather than popular narratives. Religion has at times been portrayed as largely harmful to health or social outcomes, yet the weight of medical and social-scientific evidence points in the opposite direction. As this review shows, religious involvement is consistently associated with positive outcomes for individuals, families, and communities. Policymakers, practitioners, and organizational leaders should therefore avoid repeating negative assumptions about religion that are not supported by the weight of evidence. They should instead engage seriously with the full body of scientific findings.

5. **Consider the implications of religion for health and well-being.** When examining the causes of physical, mental, or social health outcomes, policymakers and practitioners should consider what the scientific literature reveals about the religion and health connection. Although religion is sometimes avoided in health discussions out of concern that it may fall outside the bounds of scientific inquiry, the research on religion and health is rigorous and methodologically comparable to studies of other health-related behaviors and practices. Engaging this body of evidence can therefore strengthen—not weaken—efforts to understand and improve health outcomes.

6. **Make family formation, marital stability, and fertility explicit goals of health and social policy.** Because the evidence reviewed here links religious involvement with stronger marriages, lower divorce, less domestic violence, more positive views of children, and higher fertility, policymakers and health professionals should treat stable family life as a core dimension of human flourishing. Public agencies, health systems, employers, schools, responsible media, and community organizations should consider how their policies affect marriage, parenting, fertility, and family stability. Voluntary, pluralistic efforts could include marriage and relationship education, parenting and fatherhood programs, family-friendly workplace policies, and opt-in partnerships with faith communities that already support couples and parents. Strengthening marriages and families is not only a private matter, but central to happiness, health, social connection, and long-term societal well-being.

Appendix A:
Notable Findings on Religion and Social Health

Religion, Delinquency, and Crime

In a U.S. study with Add Health data (N = 9,401 adolescents), Regnerus (2003a) found that attendance at religious services was correlated with lower levels of delinquency and theft.[125]

In another U.S. study with Add Health data (N = 11,046 adolescents), Regnerus (2003b) found that both youth *and* parent attendance at religious services were correlated with lower levels of delinquency. Parental religiosity was most protective for girls.[126]

In a third U.S. study with Add Health data (N = 10,444 adolescents), Pearce and Haynie (2004) found that the lowest levels of delinquency were found when youth and their mother both reported high levels of religiosity.[127]

In a fourth U.S. study with Add Health data (N = 15,197 adolescents), Glanville et al. (2008) found that youth religious attendance was related to outcomes including lower school dropout rates, higher friends' GPA, and higher extracurricular activity participation. Each of these factors is related to lower delinquency and crime.[128]

In a fifth U.S. study with Add Health data (N = 13,796 adolescents), Miller and Vuolo (2018)[129] found that religious importance and religious attendance both predicted lower rates of delinquency over a 12-year period.

In a seven-year U.S. study of 1,354 adolescents, Guo (2021) found that among offenders, the "more religious adolescent offenders had a lower likelihood of engaging in future crime . . . for all dimensions of religiosity assessed."[130]

With criminal behavior, as with many other phenomena discussed across all three reports in this series, religiosity seems to wield both a preventative and a rehabilitative benefit.

Religion, Social Support, and Prosocial Activity

In a U.S. study (N = 92,008 adults), Chen et al. (2020a) found that attendance at church weekly or more often predicted greater "social integration" and significantly less loneliness over time across all three cohorts that were studied.[131]

In a Poland-based study (N = 6,403, ages 16+), Pawlikowski et al. (2019) found that persons who attended worship services weekly were 42% less likely to be lonely than nonattenders.[132]

In an Israel-based study (N = 1,191 adults ages 75–94), Cohen-Mansfield et al. (2016) found that those who reported becoming more religious over a two-decade span were more likely to report lower levels of loneliness.[133]

In an 8–14-year longitudinal study (N = 5681–7458 participants), Chen and VanderWeele (2018) found that greater religious attendance, prayer, and meditation predicted more forgiveness of others.[134] (For book-length treatment on the importance of forgiveness in physical, mental, relational, and spiritual health, see Worthington, 2006.)[135]

In a U.S. study (N = 12,258 adolescent participants) over seven years, Glanville et al. (2008) found that religious attendance was related to closer parent-child relationships, higher friend grades, lower friend truancy, and greater sport- and activity- participation. These variables also relate to high levels of social capital and prosocial connection.[136]

In a study of 1,154 U.S. adults over the age of 50, Krause (2015b) found that higher religious attendance was correlated with greater volunteering over time.[137]

Religion and Marital and Family Stability

Several book-length reviews or studies have emerged in recent years that offer in-depth treatment of connections between: (a) religion and marriage (Mahoney, 2010; Marks & Dollahite, 2017, 2026; Wilcox & Wolfinger, 2016) and (b) religion and parenting/youth development (Bengtson et al., 2013; Mahoney, 2010, 2021; Marks & Dollahite, 2017, 2026; Smith & Denton, 2005; Smith & Snell, 2009). We refer the interested reader to those works. In this report, we focus on only a limited number of high-quality, article-length studies.

In a U.S. study (N = 2,676 participants), Strawbridge et al. (2001)[138] found that individuals who attended religious services weekly were 57% more likely to be in a stable marriage.

In a U.S. study based on longitudinal Add Health data (N = 2,079 married participants), Uecker (2008) found that those who were more religious were significantly less likely to cohabitate and engage in premarital sex.[139] These findings are noteworthy in connection with marital stability because both cohabitation and premarital sex correlate with higher divorce rates and lower marital quality reported later on (Busby et al., 2010).

In a (relatively rare) exploration of religion in stepfamily contexts, King et al. (2019) studied 2,085 adolescents living with biological mothers and stepfathers and found that parents who were actively religious in wave 1 were significantly less likely to experience marital separation across time.[140]

In a religion and parenting study with 695 mother–child dyads (N = 1,390 participants), Goeke-Morey et al. (2013) found that maternal religiosity was positively related to healthy outcomes including attachment security, family cohesion, and child disclosure. Maternal religiosity was also related to lower levels of family conflict and psychological distress.[141]

In a U.S. study of 9,002 adults with parents, King et al. (2013) found that higher child religiosity was related to greater care for parents and higher quality of parent–child relationship. However, a change in religion for the child tended to weaken this relationship.[142]

In a study of 9,002 adolescents, Watts (2017) found that higher religiosity among women predicted fewer reports of child physical and sexual abuse and neglect.[143]

Religion, Substance Abuse, and Addiction

We briefly overview a few of the studies that have been identified by the authors of the 2024 *Handbook* in a developmental manner, moving from younger to older samples. Notable findings regarding religion and substance abuse/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 or 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.

The authors of the 2024 *Handbook* 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" (p. 170). Even within the U.S., however, economically depressed areas can provide fruitful ground for studying the connection between religion and health. Green and colleagues' (2010) finding in a 10-year prospective study of 725 African American young adults (ages 32–43 years) in a low-income area of Chicago found that infrequent religious attenders were more than eight times as 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 (Patel & Preedy, 2022).

Nordfjærn and colleagues (2018) found in a 5-year prospective study with 2,671 Norwegian adults (ages 40 and older) that religiosity—measured by church membership and the self-reported importance of religion—predicted greater abstention and less consumption of alcohol. The researchers concluded that religiosity was an important predictor of how much alcohol is consumed—or whether it is avoided—during the second half of life (i.e., 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 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 (Koenig et al., 2024).

In another recovery and rehabilitation study, Kelly and colleagues (2020, p. 2) 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." Further, religiously based Alcoholics Anonymous and Twelve-Step programs were found to be more cost effective. Koenig et al. (2024, p. 185) 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."

References

Atkins, R. G., Jr., & Hawdon, J. E. (2007). Religiosity and participation in mutual-aid support groups for addiction. *Journal of Substance Abuse Treatment*, 33(3), 321–331.

Baylor Institute for Studies of Religion. (2022, August 15). *Celebrating Rodney Stark, Distinguished Professor of the Social Sciences*. Baylor University. https://www.baylorisr.org/celebrating-rodney-stark-distinguished-professor-of-the-social-sciences/

Bengtson, V. L., Putney, N. M., & Harris, J. (2013). *Families of faith: How religion is passed down across generations*. Oxford University Press.

Benjet, C., Borges, G., Medina-Mora, M. E., Blanco, J., Zambrano, J., Orozco, R., Fleiz, C., & Rojas, E. (2007a). Drug use opportunities and the transition to drug use among adolescents from the Mexico City Metropolitan Area. *Drug and Alcohol Dependence*, 90(2–3), 128–134.

Benjet, C., Borges, G., Medina-Mora, M. E., Fleiz, C., Blanco, J., Zambrano, J., Rojas, E., & Ramirez, M. (2007b). Prevalence and socio-demographic correlates of drug use among adolescents: Results from the Mexican Adolescent Mental Health Survey. *Addiction*, 102(8), 1261–1268.

Bert, S. C. (2011). The influence of religiosity and spirituality on adolescent mothers and their teenage children. *Journal of Youth and Adolescence*, 40(1), 72–84.

Blay, S. L., Batista, A. D., Andreoli, S. B., & Gastal, F. L. (2008). The relationship between religiosity and tobacco, alcohol use, and depression in an elderly community population. *The American Journal of Geriatric Psychiatry*, 16(11), 934–943.

Branco, K. J., & Braam, A. W. (2006). The effects of church attendance, strength of faith, and cognitive impairment on socially inappropriate and abusive behavior among nursing home residents. *Journal of Religion, Spirituality & Aging*, 19(1), 17–36.

Brand, D., Zaidman-Zait, A., & Most, T. (2018). Parent couples' coping resources and involvement in their children's intervention program. *The Journal of Deaf Studies and Deaf Education*, 23(3), 189–199.

Burke, A., Lam, C. N., Stussman, B., & Yang, H. (2017). Prevalence and patterns of use of mantra, mindfulness and spiritual meditation among adults in the United States. *BMC Complementary and Alternative Medicine*, 17(1), 316.

Burr, W. R., Marks, L. D., & Day, R. (2012). *Sacred matters: Religion and spirituality in families*. Routledge.

Busby, D. M., Carroll, J. S., & Willoughby, B. J. (2010). Compatibility or restraint? The effects of sexual timing on marriage relationships. *Journal of Family Psychology*, 24(6), 766–774.

Carrico, A. W., Storholm, E. D., Flentje, A., Arnold, E. A., Pollack, L. M., Neilands, T. B., Rebchook, G. M., Peterson, J. L., Eke, A., Johnson, W., & Kegeles, S. M. (2017). Spirituality/religiosity, substance use, and HIV testing among young black men who have sex with men. *Drug and Alcohol Dependence*, 174, 106–112.

Carroll, J. S., James, S., & Boyd, H. (2020). *Religion in the home*. Wheatley Institute.

Charles, W. P., Curry, E. W., & Chalfant, H. P. (1985). Religiosity and delinquency over time: Deviance deterrence and deviance amplification. *Social Science Quarterly*, 66(1), 120–131.

Chen, Y., & VanderWeele, T. J. (2018). Associations of religious upbringing with subsequent health and well-being from adolescence to young adulthood: An outcome-wide analysis. *American Journal of Epidemiology*, 187(11), 2355–2364.

Chen, Y., Kim, E. S., & VanderWeele, T. J. (2020). Religious-service attendance and subsequent health and well-being throughout adulthood: Evidence from three prospective cohorts. *International Journal of Epidemiology*, 49(6), 2030–2040.

Cherry, K. E. (Ed.). (2009). *Lifespan perspectives on natural disasters*. Springer.

Cherry, K. E. (Ed.). (2015). *Traumatic stress and long-term recovery*: *Coping with disasters and other negative life events*. Springer.

Cherry, K. E. (2020). *The other side of suffering: Finding a path to peace after tragedy*. Oxford University Press.

Cohen-Mansfield, J., Shmotkin, D., & Hazan, H. (2016). Changes in religiosity in old age: An exploratory study. *The International Journal of Aging and Human Development*, 83(3), 256–273.

Cranney, S., Dyer, J., Hardy, S., Lambert, P., & Marks, L. (2024). *The tides of religion: Leaving, staying, and returning to faith*. Wheatley Institute.

Cummings, E. M., Merrilees, C. E., Taylor, L. K., Shirlow, P., Goeke-Morey, M. C., & Cairns, E. (2013). Longitudinal relations between sectarian and nonsectarian community violence and child adjustment in Northern Ireland. *Development and Psychopathology*, 25(3), 615–627.

Damian, E. (2019). Formal volunteering in Europe: Evidence across nations and time. *Cross-Cultural Research*, 53(4), 385–409.

Daoud, N., Sergienko, R., & Shoham-Vardi, I. (2020). Intimate partner violence prevalence, recurrence, types, and risk factors among Arab and Jewish immigrant and nonimmigrant women of childbearing age in Israel. *Journal of Interpersonal Violence*, 35(15–16), 2869–2896.

DeRose, L. F. (2021). Gender equity, religion, and fertility in Europe and North America. *Population and Development Review*, 47(1), 41–55.

Dollahite, D. C., Marks, L. D., & Dalton, H. (2018). Why religion helps and harms families: A conceptual model of a system of dualities at the nexus of faith and family life. *Journal of Family Theory & Review*, 10(1), 219–241.

Douthat, R. (2025). *Believe*. Zondervan.

Eitle, D. (2011). Religion and gambling among young adults in the United States: Moral communities and the deterrence hypothesis. *Journal for the Scientific Study of Religion*, 50(1), 61–81.

Ellis, A. (1980). *A case against religion: A psychotherapist's view and the case against religiosity*. American Atheist Press.

Ellison, C. G., Bartkowski, J. P., & Anderson, K. L. (1999). Are there religious variations in domestic violence? *Journal of Family Issues*, 20(1), 87–113.

Ellison, C. G., Henderson, A. K., Glenn, N. D., & Harkrider, K. E. (2011). Sanctification, stress, and marital quality. *Family Relations*, 60(4), 404–420.

Ellison, C. G., Trinitapoli, J. A., Anderson, K. L., & Johnson, B. R. (2007). Race/ethnicity, religious involvement, and domestic violence. *Violence Against Women*, 13(11), 1094–1112.

Fox, B. (2017). It's nature and nurture: Integrating biology and genetics into the social learning theory of criminal behavior. *Journal of Criminal Justice*, 49, 22–31.

Freud, S. (1927). *The future of an illusion*. Doubleday.

Gallup International. (2015, May 6). *Losing our religion? Two-thirds of people still claim to be religious*. https://www.gallup-international.bg/en/33531/losing-our-religion-two-thirds-of-people-still-claim-to-be-religious/ [broken link]

Glanville, J. L., Sikkink, D., & Hernandez, E. I. (2008). Religious involvement and educational outcomes: The role of social capital and extracurricular participation. *The Sociological Quarterly*, 49(1), 105–137.

Goeke-Morey, M. C., Cairns, E., Merrilees, C. E., Schermerhorn, A. C., Shirlow, P., & Cummings, E. M. (2013). Maternal religiosity, family resources and stressors, and parent–child attachment security in Northern Ireland. *Social Development*, 22(1), 19–37.

Goodkind, N. (2024, June 25). The fertility crisis is here and it will permanently alter the economy. *CNN*. https://www.cnn.com/2024/06/25/investing/premarket-stocks-trading/index.html

Green, K. M., Doherty, E. E., Reisinger, H. S., Chilcoat, H. D., & Ensminger, M. (2010). Social integration in young adulthood and the subsequent onset of substance use and disorders among a community population of urban African Americans. *Addiction*, 105(3), 484–493.

Guo, S. (2021). Developmental patterns of religiosity in relation to criminal trajectories among serious offenders moving from adolescence to young adult. *Crime & Delinquency*, 67(10), 1614–1644.

Harris, S. (2004). *The end of faith: Religion, terror, and the future of reason*. Norton.

Herman-Stahl, M. A., Krebs, C. P., Kroutil, L. A., & Heller, D. C. (2007). Risk and protective factors for methamphetamine use and nonmedical use of prescription stimulants among young adults aged 18 to 25. *Addictive Behaviors*, 32(5), 1003–1015.

Hernandez Ramones, S., Thomas, S., & Corichi, M. (2025, August 15). *5 facts about global fertility trends*. Pew Research Center. https://www.pewresearch.org/short-reads/2025/08/15/5-facts-about-global-fertility-trends/

Hodge, D. R., Marsiglia, F. F., & Nieri, T. (2011). Religion and substance use among youths of Mexican heritage: A social capital perspective. *Social Work Research*, 35(3), 137–146.

Hoffman, J. (Ed.). (2012). *Understanding religious rituals*. Routledge.

Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine*, 7(7), e1000316.

Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A meta-analytic review. *Perspectives on Psychological Science*, 10(2), 227–237.

House, J. S., Landis, K. R., & Umberson, D. (1988). Social relationships and health. *Science*, 241(4865), 540–545.

Hummer, R. A., Rogers, R. G., Nam, C. B., & Ellison, C. G. (1999). Religious involvement and US adult mortality. *Demography*, 36(2), 273–285.

Hwang, W., Cakirsoy-Aslan, A. D., Brown, M. T., & Silverstein, M. (2021). Husband–wife religious denomination homogamy and marital satisfaction over time: The moderating role of religious intensity. *Family Relations*, 70(5), 1498–1513.

Jang, S. J. (2019). Religiosity, crime, and drug use among juvenile offenders: A latent growth modeling approach. *Journal of Quantitative Criminology*, 35, 27–60.

Johnson, B. R. (2004). Religious programs and recidivism among former inmates in Prison Fellowship programs: A long-term follow-up study. *Justice Quarterly*, 21(2), 329–354.

Johnson, B. R., Larson, D. B., & Pitts, T. C. (1997). Religious programs, institutional adjustment, and recidivism among former inmates in Prison Fellowship programs. *Justice Quarterly*, 14(1), 145–166.

Justice Policy Institute. (2014). *Sticker shock: Calculating the full price tag for youth incarceration*. https://www.justicepolicy.org/uploads/justicepolicy/documents/sticker_shock_final_v2.pdf

Katerndahl, D., Burge, S., Ferrer, R., Becho, J., & Wood, R. (2015). Effects of religious and spiritual variables on outcomes in violent relationships. *The International Journal of Psychiatry in Medicine*, 49(4), 249–263.

Kelly, J. F., Abry, A., Ferri, M., & Humphreys, K. (2020). Alcoholics Anonymous and 12-step facilitation treatments for alcohol use disorder: A distillation of a 2020 Cochrane review for clinicians and policy makers. *Alcohol and Alcoholism*, 55(6), 641–651.

King, V., Ledwell, M., & Pearce-Morris, J. (2013). Religion and ties between adult children and their parents. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 68(5), 825–836.

King, V., Lindstrom, R., & Washington, C. (2019). Patterns of shared religious attendance and positive stepfamily functioning. *Journal of Research on Adolescence*, 29(2), 357–368.

Koenig, H. G., Larson, D. B., & McCullough, M. E. (2001). *Handbook of religion and health* (1st ed.). Oxford University Press.

Koenig, H. G., King, D., & Carson, V. B. (2012). *Handbook of religion and health* (2nd ed.). Oxford University Press.

Koenig, H. G., VanderWeele, T. J., & Peteet, J. R. (2024). *Handbook of religion and health* (3rd ed.). Oxford University Press.

Koh, H. (2024). Foreword. In H. G. Koenig, T. J. VanderWeele, & J. R. Peteet (Eds.), *Handbook of religion and health* (3rd ed.). Oxford University Press.

Krause, N. (2010a). Church-based emotional support and self-forgiveness in late life. *Review of Religious Research*, 52(1), 72–89.

Krause, N. (2015). Assessing the religious roots of volunteer work in middle and late life. *Research on Aging*, 37(5), 439–463.

Kroll, B., & Taylor, A. (2003). *Parental substance misuse and child welfare*. Jessica Kingsley Publishers.

Kvande, M. N., Reidunsdatter, R. J., Løhre, A., Nielsen, M. E., & Espnes, G. A. (2015). Religiousness and social support: A study in secular Norway. *Review of Religious Research*, 57(1), 87–109.

Laurenceau, J. P., Stanley, S. M., Olmos-Gallo, A., Baucom, B., & Markman, H. J. (2004). Community-based prevention of marital dysfunction: Multilevel modeling of a randomized effectiveness study. *Journal of Consulting and Clinical Psychology*, 72(6), 933–943.

Leavitt, C. E., Hendricks, J. J., Clarke, R. W., Marks, L. D., Dollahite, D. C., & Rose, A. H. (2024). Integrity and fidelity in highly religious marriages. *Family Relations*, 73(3), 2134–2151.

Lee, G. P., Ghandour, L. A., Takache, A. H., & Martins, S. S. (2014). Investigating the association between strategic and pathological gambling behaviors and substance use in youth: Could religious faith play a differential role? *The American Journal on Addictions*, 23(3), 280–287.

Lehrer, E. L. (2009). *Religion, economics, and demography: The effects of religion on education, work, and the family*. Routledge.

Mahoney, A. (2010). Religion in the home 1999 to 2009: A relational spirituality perspective. *Journal of Marriage and Family*, 72(4), 805–827.

Mahoney, A., Pargament, K. I., Tarakeshwar, N., & Swank, A. B. (2001). Religion in the home in the 1980s and 1990s: A meta-analytic review and conceptual analyses of links between religion, marriage, and parenting. *Journal of Family Psychology*, 15(4), 559–596.

Malinakova, K., Kopcakova, J., Madarasova Geckova, A., Van Dijk, J. P., Furstova, J., Kalman, M., Tavel, P., & Reijneveld, S. A. (2019). "I am spiritual, but not religious": Does one without the other protect against adolescent health-risk behaviour? *International Journal of Public Health*, 64(1), 115–124.

Marks, L. D., Baughman, S. B., Koenig, H. G., Dyer, W. J., Hardy, S. A., Lambert, P. W., & Schraedel, N. (2026a). *The religion and mental health connection: What does the best science reveal?* (Religion and human flourishing series, Report 1 of 3). Wheatley Institute.

Marks, L. D., Baughman, S. B., Koenig, H. G., Robbins, J. R., Lambert, P., & Navares, E. (2026b). *The religion and physical health connection: What does the best science reveal?* (Religion and human flourishing series, Report 2 of 3). Wheatley Institute.

Marks, L. D., & Dollahite, D. C. (2012). "Don't forget home": The importance of sacred ritual in families. In J. Hoffman (Ed.), *Understanding religious rituals* (pp. 186–203). Routledge.

Marks, L. D., & Dollahite, D. C. (2017). *Religion and families*. Routledge.

Marks, L. D., & Dollahite, D. C. (2026). *The psychology of religion and families*. Routledge.

Marks, L., Dollahite, D. C., & Baumgartner, J. (2010). "In God we trust": Perspectives on finances, family relationships, and faith. *Family Relations*, 59(4), 439–452.

Marks, L. D., Dollahite, D. C., & Dew, J. (2009). Enhancing cultural competence in financial counseling and planning: Understanding why families make religious contributions. *Financial Counseling and Planning*, 20(2), 14–26.

Marks, L. D., Dollahite, D. C., & Freeman, J. J. (2011). Faith and prayer in family life. In A. J. Hawkins, D. C. Dollahite, & T. W. Draper (Eds.), *Successful marriages and family life* (pp. 185–195). BYU Studies.

Marks, L. D., Nesteruk, O., Swanson, M., Garrison, M. E. B., & Davis, T. (2005). Religion and health among African Americans. *Research on Aging*, 27, 447–474.

McCartney, M. (2024, June 11). Japan and South Korea have a serious population problem. *Newsweek*. https://www.newsweek.com/japan-south-korea-face-population-decline-1910371

McClintock, C. H., Lau, E., & Miller, L. (2016). Phenotypic dimensions of spirituality: Implications for mental health in China, India, and the United States. *Frontiers in Psychology*, 7, 1600.

McFarland, M. J., Uecker, J. E., & Regnerus, M. D. (2011). The role of religion in shaping sexual frequency and satisfaction: Evidence from married and unmarried older adults. *Journal of Sex Research*, 48(2–3), 297–308.

Miller, T., & Vuolo, M. (2018). Examining the antiascetic hypothesis through social control theory: Delinquency, religion, and reciprocation across the early life course. *Crime & Delinquency*, 64(11), 1458–1488.

Neugebauer, R., Wickramaratne, P., Svob, C., McClintock, C. H., Gameroff, M. J., Miller, L., & Conway, A. (2020). Contribution of religion/spirituality and major depressive disorder to altruism. *Journal of Affective Disorders*, 262, 16–22.

Nordfjærn, T. (2018). Religiosity and alcohol use: Is religiosity important for abstention and consumption levels in the second half of life? *Substance Use & Misuse*, 53(14), 2271–2280.

Pargament, K. I., & Mahoney, A. (2005). Theory: Sacred matters: Sanctification as a vital topic for the psychology of religion. *The International Journal for the Psychology of Religion*, 15(3), 179–198.

Pawlikowski, J., Białowolski, P., Węziak-Białowolska, D., & VanderWeele, T. J. (2019). Religious service attendance, health behaviors and well-being—An outcome-wide longitudinal analysis. *European Journal of Public Health*, 29(6), 1177–1183.

Pearce, L. D., & Haynie, D. L. (2004). Intergenerational religious dynamics and adolescent delinquency. *Social Forces*, 82(4), 1553–1572.

Pecoraro, A., Pacciolla, A., O'Cleirigh, C., Mimiaga, M., Kwiatek, P., Blokhina, E., Verbitskaya, E., Krupitsky, E., & Woody, G. E. (2016). Proactive coping and spirituality among patients who left or remained in antiretroviral treatment in St. Petersburg, Russian Federation. *AIDS Care*, 28(3), 334–338.

Paine, T. (1827). *The age of reason: In two parts.* G. N. Devries.

Pakaluk, C. R. (2024). *Hannah's children: The women quietly defying the birth dearth*. Regnery Gateway.

Patel, V. B., & Preedy, V. R. (2022). *Handbook of substance misuse and addictions: From biology to public health.* Springer.

Prothero, S. (2010). *God is not one*. HarperOne.

Putnam, R. D. (2001). *Bowling alone: The collapse and revival of American community*. Touchstone.

Regnerus, M. D. (2003a). Moral communities and adolescent delinquency: Religious contexts and community social control. *The Sociological Quarterly*, 44(4), 523–554.

Regnerus, M. D. (2003b). Linked lives, faith, and behavior: Intergenerational religious influence on adolescent delinquency. *Journal for the Scientific Study of Religion*, 42(2), 189–203.

Reeve, C. L., & Basalik, D. (2011). A state level investigation of the associations among intellectual capital, religiosity and reproductive health. *Intelligence*, 39(1), 64–73.

Renzetti, C. M., DeWall, C. N., Messer, A., & Pond, R. (2017). By the grace of God: Religiosity, religious self-regulation, and perpetration of intimate partner violence. *Journal of Family Issues*, 38(14), 1974–1997.

Rose, A. H., Anderson, S., Miller, R. B., Marks, L. D., Hatch, T. G., & Card, N. A. (2018). Longitudinal test of forgiveness and perceived forgiveness as mediators between religiosity and marital satisfaction in long-term marital relationships. *The American Journal of Family Therapy*, 46(4), 356–374.

Rosenfeld, M. J., & Roesler, K. (2019, August). Stability and change in predictors of marital dissolution in the US, 1950–2015: The rise of family inequality. Paper presented at the annual meeting of the American Sociological Association, New York, NY.

Rye, M. S., Pargament, K. I., Pan, W., Yingling, D. W., Shogren, K. A., & Ito, M. (2005). Can group interventions facilitate forgiveness of an ex-spouse? A randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 73(5), 880–892.

Sacks, J. (2017). *Not in God's name: Confronting religious violence*. Schocken.

Sahin, I., & Unlu, A. (2021). The effect of Muslim religiosity on youth delinquency. *Criminal Justice Review*, 46(3), 361–381.

Schuster, I., & Krahé, B. (2019). Predictors of sexual aggression perpetration among male and female college students: Cross-cultural evidence from Chile and Turkey. *Sexual Abuse*, 31(3), 318–343.

Shafer, K., Petts, R. J., & Renick, A. J. (2019). Religious variability in the relationship between masculinity and father involvement. *Journal for the Scientific Study of Religion*, 58(2), 378–397.

Sharma, A. (2006). Forward. In W. Tyndale (Ed.), *Visions of development: Faith-based initiatives* (pp. xiii–xiv). Ashgate Publishing.

Smith, C., & Davidson, H. (2014). *The paradox of generosity: Giving we receive, grasping we lose*. Oxford University Press.

Smith, C., & Denton, M. L. (2005). *Soul searching: The religious and spiritual lives of American teenagers.* Oxford University Press.

Smith, C., & Snell, P. (2009). *Souls in transitions: The religious and spiritual lives of emerging adults*. Oxford University Press.

SPHS Behavioral Health. (n.d.). Drug and alcohol abuse and children. Westmoreland County. https://www.westmorelandcountypa.gov/1351/Drug-Alcohol-Abuse-Children

Stanford, W. D., Hendricks, J. J., Futris, T. G., Marks, L. D., & Dollahite, D. C. (2025). Sources of influence in marriage and parenting for interfaith couples. *Marriage & Family Review*, 61(4), 373–408.

Stark, R. (2012). *America's blessings*. Templeton Press.

Stark, R., & Bainbridge, W. S. (1996). *A theory of religion*. Rutgers University Press.

Stark, R., & Finke, R. (2000). *Acts of faith: Explaining the human side of religion*. University of California Press.

Stier, H., & Kaplan, A. (2020). Are children a joy or a burden? Individual- and macro-level characteristics and the perception of children. *European Journal of Population*, 36(2), 387–413.

Strawbridge, W. J., Shema, S. J., Cohen, R. D., & Kaplan, G. A. (2001). Religious attendance increases survival by improving and maintaining good health behaviors, mental health, and social relationships. *Annals of Behavioral Medicine*, 23(1), 68–74.

Taylor, R. J., Chatters, L. M., & Levin, J. (2004). R*eligion in the lives of African Americans: Social, psychological, and health perspectives*. Sage Publications.

Terry-McElrath, Y. M., O'Malley, P. M., Johnston, L. D., Bray, B. C., Patrick, M. E., & Schulenberg, J. E. (2017). Longitudinal patterns of marijuana use across ages 18–50 in a US national sample: A descriptive examination of predictors and health correlates of repeated measures latent class membership. *Drug and Alcohol Dependence*, 171, 70–83.

Thomas, J., O'Hara, L., Tahboub-Schulte, S., Grey, I., & Chowdhury, N. (2018). Holy anorexia: Eating disorders symptomatology and religiosity among Muslim women in the United Arab Emirates. *Psychiatry Research*, 260, 495–499.

Toussaint, L. L., & Williams, D. R. (2008). National survey results for Protestant, Catholic, and nonreligious experiences of seeking forgiveness and of forgiveness of self, of others, and by God. *Journal of Psychology & Christianity*, 27(2), 120–130.

Uecker, J. E. (2008). Religion, pledging, and the premarital sexual behavior of married young adults. *Journal of Marriage and Family*, 70(3), 728–744.

VanderWeele, T. J. (2017) Religious communities and human flourishing. *Current Directions in Psychological Science*, 26(5), 476–481.

Watts, S. J. (2017). The link between child abuse and neglect and delinquency: Examining the mediating role of social bonds. *Victims & Offenders*, 12(5), 700–717.

Wilcox, W. B., & Wolfinger, N. H. (2016). *Soul mates: Religion, sex, love, and marriage among African Americans and Latinos*. Oxford University Press.

Wormley, A. S., Vornlocher, C., Baldwin, C. R., & Rodriguez, M. (2025). Beliefs about God buffer against the health risks of loneliness and social isolation in five major religions and 22 countries. *Scientific Reports*, 15, 37187.

Worthington, E. L., Jr. (2006). *Forgiveness and reconciliation*. Routledge.

Yaden, D. B., Batz-Barbarich, C. L., Ng, V., Vaziri, H., Gladstone, J. N., Pawelski, J. O., & Tay, L. (2022). A meta-analysis of religion/spirituality and life satisfaction. *Journal of Happiness Studies*, 23, 4147–4163.

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. Peteet, *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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7 Jason S. Carroll, PhD, Family Initiative Director, Wheatley Institute
8 Wormley et al., 2025, p. 1.
9 Wormley et al., 2025.
10 Sharma, 2006.
11 Paine, 1827, conclusion.
12 Harris, 2004, p. 27.
13 We are indebted to *New York Times* columnist Ross Douthat (2025, p. 162) for these insights.
14 Sacks, 2015, p. 39.
15 Dollahite et al., 2018.
16 See Report 2 for specific decade-by-decade increases in the number of peer-reviewed studies.
17 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).
18 Koenig et al., 2024, p. ix.
19 We express thanks to Michael Beattie for preparing the figures for Reports 1, 2, and 3 in this series.
20 The four-chapter coverage in Koenig et al. (2024) on social health topics is excellent and rich but substantially less voluminous than the coverage of mental health or physical health, which receive about ten chapters each. This is likely due to the relatively lower number of high-quality studies on religion and social health compared with studies on religion and mental or physical health.
21 Koenig et al., 2024, ch. 13.
22 Koenig et al., 2024, ch. 15.
23 Koenig et al., 2024, ch. 14.
24 Koenig et al., 2024, ch. 10. Koenig et al. (2024) addresses the topics of substance use and substance use disorders solely in the section on mental health; however, given the direct and profound implications of addiction on various aspects of health, we address substance use disorders in all three reports in this series: mental health in Report 1, physical health in Report 2, and social health in Report 3.
25 Koenig et al., 2024, ch. 13.
26 For Rodney Stark's preeminence in the sociology of religion, see Baylor Institute for Studies of Religion, 2022.
27 Stark (2012, p. 37) mentions "247 studies [from 1944 to 2010] that reported a positive effect of religion on reducing crime, deviance, and delinquency—often a very strong effect."
28 Stark, 2012, pp. 37–38.
29 See Koenig et al. (2024, pp. 760–764) for all 69 studies with positive findings.
30 The single study that reported negative findings was Reeve & Basalik, 2011.
31 No studies reported complex findings, but five studies reported mixed findings (Branco & Braam, 2006; Miller & Vuolo, 2018; Peek et al., 1985; Sahin & Unlu, 2021; Schuster & Krahé, 2019). See Appendix A for brief reviews of a small number of notable studies.
32 Justice Policy Institute, 2014; see Koenig et al., 2024, p. 238.
33 Koenig et al., 2024, p. 239.
34 Fox, 2017. According to Koenig et al. (2024, p. 239), "60% of anti-social and criminal behavior is heritable," and "50% connects to environmental factors."

35 Marks & Dollahite, 2017, 2026.
36 Koenig et al., 2024, p. 243.
37 Koenig et al., 2024, p. 243.
38 Marks & Dollahite, 2026.
39 Koenig et al., 2024, p. 243.
40 Koenig et al., 2024, p. 244–248.
41 Smith & Denton, 2005; Smith & Snell, 2009.
42 See Report 1 in this series, *The Religion and Mental Health Connection: What Does the Best Science Reveal?* (Marks et al., 2026).
43 Koenig et al., 2024; Marks & Dollahite, 2026.
44 Marks et al., 2009, 2010.
45 Marks & Dollahite, 2026; Taylor et al., 2004; Wilcox & Wolfinger, 2016.
46 Stark, 2012, p. 37, emphasis added.
47 See Koenig et al. (2024, pp. 770–776) for 88 studies with positive findings.
48 Four studies with negative findings were: Ju et al., 2018; Okun et al. 2015; Rao et al., 2016; Shilo & Savaya, 2012.
49 One study reported complex findings (Tsang et al., 2020), and three reported mixed findings (Damian, 2019; Kvande et al., 2015b; Toussaint & Williams, 2008).
50 See Appendix A for brief reviews of a small number of notable studies.
51 Holt-Lunstad et al., 2010; Koenig et al., 2024, p. 284.
52 House et al., 1988; Tew et al., 2012.
53 See Report 2 in this series: *The Religion and Physical Health Connection: What Does the Best Science Reveal?* (Marks et al., 2026).
54 Marks & Dollahite, 2026. In the 21st century when, in the words of sociologist Thomas Putnam, many of us are "bowling alone" and increasingly isolated, faith communities serve as one of the last strongholds of deep, meaningful, and enduring relationships across time and generations. See Putnam, 2001.
55 Koenig et al., 2024, p. 286; Putnam, 2001.
56 Koenig et al., 2024, p. 289.
57 Stark, 2012, p.117. Leading sociologist of religion Rodney Stark (2012, p. 117) reported that:

> the average American household has contributed about 5 percent of its income to charitable causes. About two-thirds . . . goes to churches and church-related charities; the other third to secular charities. . . . Despite the substantial amounts they give to religious causes, . . . religious Americans are the major source of funding for the secular charities as well.

58 Stark, 2012, p.119. For a book-length treatment of this issue, see Smith & Davidson, 2014.
59 Smith & Davidson, 2014; Stark, 2012.
60 See Koenig et al. (2024, pp. 765–770) for all 76 studies with positive findings.
61 The four studies with negative findings included Brand et al., 2018; Daoud et al., 2020; Renzetti et al., 2017; Shafer et al., 2019.
62 One study reported complex findings (Hwang et al., 2021) and five reported mixed findings (Ellison et al., 1999; Katerndahl et al., 2015; Malinakova et al., 2019b; McFarland et al., 2011; Rose et al., 2018). See Appendix A for brief reviews of a small number of notable studies.
63 Koenig et al., 2024, p. 267.
64 We have noted that of the 528 most rigorous studies on religion and social health, 489 (93%) reported significant positive correlations. Further, the work of Rodney Stark (2012) and others documents that this remarkably positive body of empirical work was compiled by researchers working in disciplines with strong and long-held biases against religion.
65 Cherry, 2009, 2015, 2020; Marks et al., 2009, 2010.
66 Busby et al., 2010.
67 Koenig et al., 2024, p. 266; see also Leavitt et al., 2024.
68 Pargament & Mahoney, 2005; see also Burr et al., 2012.
69 Ellison et al., 2011, p. 404.
70 Burr et al., 2012, p. 16.
71 Marks & Dollahite, 2026.
72 Burr et al., 2012, p. 17, emphasis in original.
73 Lehrer, 2009; Marks & Dollahite, 2017, p. 60.
74 Stanford et al., 2025.
75 Koenig et al., 2001, 2012, 2024.
76 Carroll et al., 2020.

77 Mahoney et al., 2001; Mahoney, 2010
78 Mahoney et al., 2001; Mahoney, 2010; Marks & Dollahite, 2012, p. 186.
79 See Carroll et al., 2020, executive summary.
80 See Carroll et al., 2020, executive summary.
81 See Carroll et al., 2020, executive summary.
82 Carroll et al., 2020; Hoffman, 2012.
83 SPHS Behavioral Health, n.d.
84 Kroll & Taylor, 2003.
85 Marks & Dollahite, 2017.
86 Ellison et al., 2007, p. 1094.
87 Ellison et al., 2007, p. 1105.
88 This figure discounts the 256 positive studies on substance abuse and addiction but includes the other phenomena identified and systematically catalogued by Koenig et al. (2024).
89 Zucker & Brown, 2019.
90 Patel & Preedy, 2022.
91 Koenig, 2001, 2012, 2024. For more detailed reports on notable findings on religion and substance abuse and addiction, see Appendix A.
92 See Koenig et al. (2024, pp. 719–736) for 256 studies with positive findings.
93 Studies with negative findings included: 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 et al. (2016) is listed three times with separate subsamples in the appendix of Koenig et al. (2024) but is one study.
94 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).
95 Koenig et al., 2024, p. 164.
96 Koenig et al., 2024, p. 175.
97 Koenig et al., 2024, p. 175.
98 Koenig et al., 2024, p. 175.
99 Koenig et al., 2024, p. 175.
100 Koenig et al., 2024, p. 175.
101 As selected by Koenig, VanderWeele, & Peteet, 2024.
102 Quoted in Koenig et al., 2024, p. ix.
103 Hernandez Ramones, 2025.
104 Pakaluk, 2024, p. 30.
105 Cranney et al., 2024, p. 13; Goodkind, 2024.
106 Cranney et al., 2024, p. 14.
107 Marks et al., 2011.
108 Stier & Kaplan, 2020. This study is cited by Koenig et al. (2024) but its potential implications on fertility are not discussed in detail.
109 Cranney et al., 2024, pp. 13–14; DeRose, 2021.
110 Pakaluk, 2024, p. 337.
111 We covered 26 total phenomena, but for two of them (schizophrenia and bipolar disorder) the religion and health connection was mixed instead of significantly positive.
112 The symbol ≈ means roughly equal.
113 Koenig et al., 2024, p. 239.
114 See Koenig et al. (2024, pp. 770–776) for 88 studies with positive findings.
115 Smith & Davidson, 2014; Stark, 2012.
116 Carroll et al., 2020, executive summary.
117 Zucker & Brown, 2019.
118 Koenig et al., 2001, 2012, 2024.
119 Stier, H., & Kaplan, A. (2020). Are children a joy or a burden? Individual-and macro-level characteristics and the perception of children. *European Journal of Population*, 36(2), 387–413. (This study is cited by Koenig et al. (2024) but its potential implications on fertility are not discussed in detail.)
120 Marks et al., 2011, p. 187; see also Cranney et al., 2024.
121 Stark, 2012.

122 Koenig et al., 2001, 2012, 2024.
123 Bengtson et al., 2013; Burr et al, 2012; Marks & Dollahite, 2026; Wilcox & Wolfinger, 2018.
124 Marks & Dollahite, 2026; Smith & Denton, 2005; Smith & Snell, 2009; Wormley et al., 2025.
125 Regnerus, 2003a.
126 Regnerus, 2003b).
127 Pearce & Haynie, 2004.
128 Glanville et al., 2008.
129 Miller & Vuolo, 2018.
130 Guo, 2021. Quotation from Koenig et al., 2024, p. 249.
131 Chen et al., 2020.
132 Pawlikowski et al., 2019.
133 Cohen-Mansfield, 2016.
134 Chen & VanderWeele, 2018.
135 Worthington, 2006; see also Burr et al., 2012.
136 Glanville et al., 2008.
137 Krause, 2015.
138 Strawbridge et al., 2001.
139 Uecker, 2008.
140 King et al., 2019.
141 Cummings et al., 2013.
142 King et al., 2013.
143 Watts, 2017.