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Losing hope: mental health and religious service non- attendance in Australia

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Abstract

Religious beliefs and practices are related to mental health. Many individuals report a religious affiliation, but do not have specific religious beliefs or practices such as attending religious services. These non-attendees are often assumed to resemble the non-religious, but are poorly studied. This study explored the demographic characteristics and mental health outcomes associated with being a non-attendee using data from a nationally representative Australian sample. Non-attendees were more likely to be non-Christian than attendees at religious services. They had worse mental health than both non-religious individuals and attendees, especially compared to the non-religious. Whether non-attendance is a result of or cause of poor mental health outcomes is not clear, and deserves further investigation. Non-attendees clearly differed in our sample from both non-religious individuals and attendees. Our results do not support the hypothesis that individuals who report a religious affiliation, but are not actively religious, are similar to non-religious individuals.

Keywords: Mental health; church attendance; religious affiliation; religiosity.

Background

Mental health disorders are amongst the most prevalent of illnesses, with 29% of people globally experiencing a common mental disorder within their lifetime (Steel et al., 2014). A growing body of evidence suggests that religion may be related in complex ways to mental health outcomes (Idler et al., 2003; King et al., 2013; Maselko, Hayward, Hanlon, Buka, & Meador, 2012; Nelson, Rosenfeld, Breitbart, & Galietta, 2002; T. B. Smith, McCullough, & Poll, 2003; Wong, Rew, & Slaikeu, 2006). Typically, there are three aspects of religion that need to be considered in determining its role in people's lives: religious affiliation, religious practices (such as attendance at religious services) and

religious beliefs (Voas & Crockett, 2005; Voas, 2009). On average, studies report a beneficial effect of intrinsic religiosity (a spiritual outlook on life, combined with religious practices) on mental health outcomes (T. B. Smith et al., 2003; Wong et al., 2006), but a large segment of the population in many countries professes a religious affiliation but does not attend religious services or have strong religious beliefs (Voas & Crockett, 2005; Voas, 2009). Where positive effects of religiosity are found on mental health, they are often strongly associated with a suite of behaviours that are collectively characterised as positive religious coping mechanisms (Ano & Vasconcelles, 2004; Pargament, Smith, Koenig & Perez, 1998), including seeking support from clergy and community members (Ano & Vasconcelles, 2004; Pargament, Koenig & Perez, 2000). It can be hypothesised that religiously affiliated individuals who do not attend services may have less access to these positive coping strategies; unfortunately, though, little is known about the relationship between religious affiliation and mental health in people who report a religious affiliation in the absence of specific religious practices such as church attendance. We call these individuals “non-attendees”, differentiating them from both religiously affiliated individuals who attend services (attendees) and those reporting no religious affiliation (non-religious). In population level studies, non-attendees are often simply assumed to resemble the non-religious (Woodberry, Park, Kellstedt, Regnerus, & Steensland, 2012). The implication of this assumption is that in their mental health, physical health, and other variables affected by religiosity, non-attendees should resemble the non-religious. More nuanced conclusions can be found in studies of adolescent non-attendees. The reality seems to be more complex, although much of the research only holds for specific contexts. For example, non-attendee adolescents who do not believe in God may have different social attitudes to poverty, the environment and drug use to non-religious adolescents (Robbins & Francis, 2010). Many non-attendee adolescents regard religion as extremely important in their lives, distinguishing them from non-religious youth (Smith & Denton, 2005). Non-attendees may have negative emotions associated with their lack of religious practices that nonreligious people do not, especially if they previously attended religious services. For example, individuals who profess an affiliation but do not attend religious services have sometimes been referred to using terms with a long pejorative pedigree such as

“lapsed”, “apostate”, or “schismatic” (Beaudoin, 2013; Warraq, 2003). For those who cease attending religious services, negative interactions with unsympathetic believers can cause emotional distress (Boyd, 2013; Beaudoin, 2013; Warraq, 2003). There are therefore good reasons to suspect that non-attendees may display a different relationship between religiosity and mental health than those in other groups, and that this needs to be studied.

This paper examines the mental health and demographics of Australian non-attendees using data from a large scale, nationally representative survey. It shows that non-attendees have worse mental health outcomes than non-religious people, and their mental health is also worse than that of more active participants in religious communities. The religious affiliations of non-attendees also differ from those reported by more religious individuals. These two findings support our hypothesis that non-attendees are a distinctive group.

Methods

Data source

The Australian Study of Health and Relationships (ASHR) was a large-scale, national survey of sexual health and relationships amongst Australian adults aged 16-59 (Smith, Rissel, Richters, Grulich, & de Visser, 2003; Smith, Rissel, Richters, Grulich, & de Visser, 2005). The methods are described in detail in papers originally arising from the study and are only described briefly here (Smith et al., 2003). In 2001-2002 a modified random-digit dialing method was used to recruit a sample for the administration of computer assisted telephone interviews. 19,307 computer assisted telephone interviews were conducted (10,173 men and 9,134 women). Participants were asked a range of questions about their general and sexual health and relationships. Demographic information was also collected about the participants, including their religious affiliation and attendance at religious services. A subset of 7,653 participants (4,184 men and 3,469 women) were asked a set of additional questions about their health and relationships (de Visser, Smith, Richters, & Rissel, 2007), some of which concerned mental health. Participants who received this survey are described as having

undertaken the long-form survey. Ethical approval for the ASHR surveys was gained from all institutions participating in the original research project (A. Smith et al., 2003). Data from female and male participants in the long-form survey is now available in the Australian Data Archive for use by researchers (Smith et al., 2005), who sign an undertaking regarding the ethical use of the data. In this study, the long-form results for women and men but not the short-form results were utilised, since only the long-form data contains information about both the religion and mental health of participants.

Measures

Survey items QDEM25 and QDEM26 in the ASHR long-form survey are measures of religious affiliation and attendance at religious services. Item QDEM25 asked participants what religious denomination they belonged to (if any). For Christians, permitted responses included Catholic, Anglican and a number of mainline Protestant categories. Raw responses to this survey item were recoded to merge members of doctrinally and liturgically similar Protestant denominations into a single category as described in a previous analysis of these data (de Visser et al., 2007). Survey item QDEM26 asked participants who had a religious affiliation how often they attended religious services or meetings. Using responses to this survey item, a religion variable was defined with three categories – non-attender, attendee (ever) or non-religious. These categories were employed in order to compare the group of interest – religiously affiliated non-attenders – with individuals who attend services and non-religious individuals.

Survey items QHEA2 through to QHEA7 were regarded as measures of mental health, since more specific questions about mental health were not asked, and formed the outcome variables for our analyses. Items QHEA2 to QHEA7 asked participants to indicate how frequently they felt nervous, sad, restless, hopeless, or that life was an effort. Respondents were asked to indicate whether they felt these emotions all, most, some or a little of the time or not at all. Frequent feelings such as sadness, hopelessness, worthlessness and restlessness are established as indicators of Axis I

clinical syndromes in the Diagnostic Manual of Mental Disorders, Fourth Edition (American Psychiatric Association & American Psychiatric Association, 2000), which was in use at the time of data collection.

Statistical analysis

The ASHR survey data are weighted to adjust for the probability of household selection and the selection of individuals within households and on the basis of age, sex and area of residence to ensure that the long-form survey respondents reflected the Australian population as reflected in the 2001 Census (A. Smith et al., 2003). The “svydesign” routine in the “survey” package for R-3.10.0 (www.rproject.org) was used to specify these weights for analysis (Lumley, 2011). Poisson log-linear models were fitted to crosstabulations to analyse survey data and implemented using the “svyloglin” routine in the “survey” package (Lumley, 2011). Poisson log-linear analysis is mathematically related to multinomial logistic regression and permits the computation of odds ratios equivalent to those of logistic regression (Lang, 1996). The log-linear models were fitted to crosstabulations between sex, marital status and religion (as defined above) to understand how non-attendees differed demographically from other groups. To understand the association between being a non-attendee and the frequency of negative emotions such as sadness and hopelessness, log-linear models were fitted to crosstabulations of religion and survey items QHEA2 to QHEA7. For the numeric variable age, the “svytest” routine in the “survey” package was used to detect age differences between non-attendees and attendees, and non-attendees and non-religious. Associations between variables were assumed to be statistically significant at $p < 0.05$.

Results

Demographic characteristics

Non-attendees comprised the smallest group of participants in the long-form survey ($N=347$), with nonreligious being the largest ($N=3919$), followed by attendees ($N =$

3387). Of the attendee group, 66.28% ($N = 2245$) attended less than monthly, with most of these ($N = 1887$) attending only on special occasions. Non-attendees, attendees and the non-religious did not differ significantly by age, sex, marital status or number of children. The reported religious affiliations of non-attendees, however, differed substantially from those of attendees. Relevant demographic characteristics of the non-attendee group are summarised in Table 1, with the same characteristics for those who attend services and non-religious individuals presented for easy comparison.

Table 1. Comparison of reported religious affiliation amongst non-attendees and attendees. Odds ratios associated with being a non-attendee are given for significant terms.

	Non-attendees	Attendees	Odds ratio (95% CI)
	Number (%)	Number (%)	
Religious affiliation			
Baptist	2 (0.58)*	103 (3.04)*	0.37 (0.18 - 0.74)
Catholic	99 (28.53)*	1367 (40.36)*	0.73 (0.58 - 0.91)
Protestant	84 (26.21)	974 (28.76)	-
Orthodox Christian	9 (2.59)*	168 (4.96)*	0.51 (0.34 - 0.78)
Other Christian	57 (16.43)	506 (14.94)	-
Buddhist	26 (7.49)*	77 (2.27)*	2.07 (1.33 - 3.30)
Islam	12 (3.46)	53 (1.56)	-
Other non-Christian	56 (16.14)*	135 (3.99)*	1.77 (1.31 - 2.38)

*Significant association with non-attendance ($p < 0.05$)

Mental Health

Non-attendees were less likely than the non-religious to rate their general health as “fair” (OR 0.81, 95% CI 0.68-0.97, $p = 0.02$). Compared to non-religious people, non-

attendees were more likely to say that they felt nervous “all of the time” (OR 1.38, 95% CI 1.02-1.86, $p=0.03$), and less likely to say that they felt nervous “a little” (OR 2.10, 95% CI 0.67-0.96, $p=0.02$). Non-attendees were more likely than both nonreligious individuals and attendees to say that they felt like nothing could cheer them up “most of the time” (Table 2). They were less likely than the non-religious (OR 0.83, 95% CI 0.71-0.98, $p=0.04$) and attendees (OR 0.83, 95% CI 0.69-0.99, $p=0.04$) to say that they felt restless “a little”. Non-attendees were less likely than the non-religious (OR 0.78, 95% CI 0.63 – 0.98, $p=0.03$), but not attendees, to say they felt “a little” that everything was an effort. Compared to both the non-religious and attendees, non-attendees were less likely to report feeling hopeless “a little” (Table 2). On the other hand, they were more likely than attendees, but not non-religious people, to report feeling hopeless and worthless “all the time” (Table 2). Where non-attendees differed in similar ways from attendees and non-religious, the degree of difference from non-religious people was always more extreme than that from attendees, as shown in Table 2.

Table 2. Selected significant differences in responses to health related survey questions according to attendance at religious services and religious affiliation.

		Non-attendees vs attendees		Non-attendees vs nonreligious	
Health related item	Question ID	Odds ratio (95% CI)	<i>P</i> value	Odds ratio (95% CI)	<i>P</i> value
In the last month, felt nothing could cheer me up most of the time	QHEA3	1.36 (1.04 – 1.79)	0.03	1.38 (1.05 – 1.81)	0.03
In the last month, felt hopeless all the time	QHEA5	1.66 (1.08 – 2.56)	0.02	Not sig.	-

In the last month, felt hopeless a little	QHEA5	0.75 (0.60 – 0.93)	0.01	0.79 (0.63 – 0.97)	0.03
In the last month, felt worthless all the time	QHEA7	1.88 (1.24 – 2.84)	0.003	2.10 (1.39-3.16)	0.0004

176

177 **Discussion**

178 On every mental health indicator (questions QHEA2-QHEA7 in the long form ASHR),
179 non-attendees responded more negatively than non-religious people, religious service
180 attendees or both. Where they responded more negatively relative to both religious
181 service attendees and the non-religious, the magnitude of the difference was greater
182 compared to the non-religious than to attendees. These results call into question the
183 assumption that religiously affiliated, but non-practising, individuals are generally similar
184 to non-religious people (Woodberry et al., 2012). Non-attendees' perceptions of their
185 general health also reflected a tendency towards negative outcomes compared towards
186 non-religious people. Non-attendees did not differ from religious individuals
187 (individuals), but were less likely to say that their health was "fair" than the non-religious
188 (the other options being "excellent", "good", "poor"). This suggests a general tendency
189 towards a less positive view of one's health amongst non-attendees compared to non-
190 religious individuals.

191 Non-attendees also differed from more religiously active individuals, with worse mental
192 health than the attendee group as measured by a number of indicators. Non-attendees
193 also reported a different mix of religious affiliations than attendees, further distinguishing
194 them from more religiously active individuals. Particularly notably, Buddhists and other
195 non-Christians (excluding Islam) were more likely to be non-attendees (Table 1). The
196 relatively high proportion of non-Christians amongst the non-attendee group
197 complicates the process of examining the possible reasons for poorer mental health
198 amongst non-attendees, as non-Christians comprise individuals with a wide variety of

affiliations that have differing access to and inclinations towards attending public worship. The association between negative mental health outcomes and non-attendance therefore needs to be interpreted quite differently for non-Christians in general, and individual non-Christian in particular, compared to Christians. It has been demonstrated that some religious groups (primarily associated with non-English speaking cultural backgrounds) have been obstructed from constructing venues for public worship in Australia, meaning that whilst non-Christians in these groups may wish to attend religious worship services, their ability to do so is curtailed (Villaroman, 2012). We therefore propose that access is a primary cause of the association between non-attendance and poor mental health for those non-Christians who have primary ties to non-English speaking communities, noting that non-Christian migrant communities in Australia are most likely to practice south Asian religions (Connor, 2012). The lack of accessibility of places of worship render it impossible for these individuals to employ some of the positive religious coping strategies described by Pargament et al. (1998). There is some support for this hypothesis, as Connor (2012) found that Australian migrants who were able to practice their religion in a communal setting has better mental health outcomes; this needs, however, to be the topic of future research. Access to places of worship is unlikely to explain poor mental health and non-attendance in some other non-Christian groups, however. For example, some non-Christians do not emphasise attending public worship as part of their religious identity (for example, Wiccans) (Berger & Ezzy, 2007). Attendance is also not regarded as particularly important by large numbers of Jews (Pew Research Center, 2013), who are subsumed within the non-Christian group in our data. It is also worth noting that adherents of new religious movements or Jews are likely to comprise very small numbers of the non-Christian (other) group in our data source – numbers of respondents of this type detailed in Smith and Denton (2005) are typical - and may therefore not contribute to the overall association between poor mental health and non-attendance that we discovered. The cause or existence of any association between non-attendance and poor mental health in these individuals therefore remains un-addressed by our study, and requires substantially more research, though we would expect different results for non-Christians followers of south Asian faiths.

We also expect the explanation for the association between poor mental health and non-attendance for Christians to differ from followers of eastern religions. In our sample, individuals reporting a Christian affiliation were generally more likely to attend religious services, reflecting the ubiquity of Christian places of worship in Australia and suggesting that while many non-Christians might want to attend services but not be able to, a different relationship linked poor mental health and non-attendance amongst Christians. The most compelling hypothesis to explain the association amongst Christians is self-selection out of religious practice due to risk behaviour (Brenda & Corwyn, 1997; Uecker, Regnerus & Vaaler, 2007), conflict with religious leaders (Smith, Longest, Hill, & Christoffersen, 2014), or episodes of mental illness (Dudley, 1999; Maselko et al., 2012; Regnerus & Smith, 2005). Whilst this study does not offer evidence in support of this hypothesis, it does reinforce that whether due to self-selection or another cause, a decline in religious practice (perhaps particularly amongst Christians) can be associated with negative mental health outcomes.

Aside from the primary finding that mental health was poorer amongst Christian non-attendees than Christian attendees, our results were also interesting because they differed in some important ways from some previously published findings relating to denominational trends in Church attendance. In our study, self-identifying Protestants (primarily mainline Protestants and Anglican/ Episcopalians), and “other” Christians (including evangelicals) were the only groups of Christians who were not significantly more likely to be attendees than non-attendees (see Table 1). These results are intriguingly different than those reported in the United States, in particular regarding Catholics, who are generally less likely to attend than Protestants (Smith & Denton, 2005; Smith, Christoffersen, & Davidson, 2011; Smith et al., 2014). It is unclear why this should be the case, however Connor (2012) provides one possible indication when he notes that Australian migrants are most likely to be Catholic or adherents of South Asian religions. Perhaps the same desire to attend, which we argue goes unsatisfied in the latter group and is linked to poor mental health, is amply satisfied amongst Catholic migrants due to the prevalence of Catholic Churches. Statistics on service attendees from one of Australia’s largest Australian Catholic dioceses offers some support for this

hypothesis, noting that a quarter were born in a non-English speaking country (Catholic Diocese of Parramatta, 2014). This finding offers intriguing avenues of research for those interested in religious coping amongst migrant communities, supporting our hypothesis that the availability of places of worship may be a key factor in the mental health of these populations.

The main limitation of our study is the heterogeneity of the non-Christian (other) group, which complicates the interpretation of results considerably. This limitation can only be addressed by studies that target the sub-groups within this category explicitly. The fact that we do not distinguish between levels of attendance in our attendee group could also be criticised as a limitation. Based on previous research, it might be suspected that more frequent attendees would be different from non-attendees, but perhaps not less frequent attendees, in mental health outcomes (Maselko et al., 2012; Smith, McCullough & Poll, 2003; Wong, Rew & Slaikeu, 2006). If this were the case, any difference in mental health outcomes between attendees and non-attendees would be explained by the better health outcomes of more frequent attendees alone. This is not true for our study, since the majority of our attendee group reported participating in religious services only on special occasions. Therefore, we believe that our results strongly suggest some fundamental difference between attendees and non-attendees, predisposing non-attendees to poorer mental health outcomes, which is not explained simply by the level of religious service attendance. This is a unique finding and suggests the need for a much greater research focus on individuals who report a religious affiliation, but do not attend religious services. This is especially the case because our study does not allow us to determine whether poor mental health precedes or post-dates non-attendance, which may be significant for better understanding the association (Maselko et al., 2012).

Conclusion

It is undoubtedly true that non-attendees performed worse on most mental health indicators than, and differed from, religiously affiliated individuals. However, they

performed even worse on mental health indicators when compared to the non-religious. The results in this study suggest that non-attendees (that is, individuals who describe themselves as religiously affiliated, but never attend religious services) differ both from religiously affiliated individuals who are more active in their faith communities and from non-religious people. They are a distinct group, and should not be assumed to resemble either non-religious or more religious individuals. They have unique experiences and stressors that distinguish them from these other groups (Boyd, 2013; Beaudoin, 2013; Warraq, 2003). They should be given more explicit consideration in studies of the effect of religiosity on mental health. Whether non-attendance is a result of or cause of poor mental health outcomes or whether access and availability of a religious community to attend influences mental health outcomes deserves further investigation.

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