

2015

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

Edward Kyle Waters

University of Notre Dame Australia, edward.waters@nd.edu.au

Helena Mary Millard

Zelda Doyle

Follow this and additional works at: [https://researchonline.nd.edu.au/health\\_article](https://researchonline.nd.edu.au/health_article)



Part of the [Life Sciences Commons](#), [Medicine and Health Sciences Commons](#), and the [Religion Commons](#)

This article was originally published as:

Waters, E. K., Millard, H. M., & Doyle, Z. (2015). Losing hope: Mental health and religious service non-attendance in Australia. *Mental Health, Religion and Culture, Early View (Online First)*.

<http://doi.org/10.1080/13674676.2014.1003290>

This article is posted on ResearchOnline@ND at  
[https://researchonline.nd.edu.au/health\\_article/129](https://researchonline.nd.edu.au/health_article/129). For more  
information, please contact [researchonline@nd.edu.au](mailto:researchonline@nd.edu.au).



**This is an Accepted manuscript of an article published in *Mental Health, Religion and Culture* on 30 January 2015, available online:  
<http://tandfonline.com/10.1080/13674676.2014.1003290>**

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

2 **Waters, E.K., Millard, H.M., Doyle, Z.**

3 **Abstract**

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

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

18

19 **Background**

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

28 religious beliefs (Voas & Crockett, 2005; Voas, 2009). On average, studies report a  
29 beneficial effect of intrinsic religiosity (a spiritual outlook on life, combined with religious  
30 practices) on mental health outcomes (T. B. Smith et al., 2003; Wong et al., 2006), but a  
31 large segment of the population in many countries professes a religious affiliation but  
32 does not attend religious services or have strong religious beliefs (Voas & Crockett,  
33 2005; Voas, 2009). Where positive effects of religiosity are found on mental health, they  
34 are often strongly associated with a suite of behaviours that are collectively  
35 characterised as positive religious coping mechanisms (Ano & Vasconcelles, 2004;  
36 Pargament, Smith, Koenig & Perez, 1998), including seeking support from clergy and  
37 community members (Ano & Vasconcelles, 2004; Pargament, Koenig & Perez, 2000). It  
38 can be hypothesised that religiously affiliated individuals who do not attend services  
39 may have less access to these positive coping strategies; unfortunately, though, little is  
40 known about the relationship between religious affiliation and mental health in people  
41 who report a religious affiliation in the absence of specific religious practices such as  
42 church attendance. We call these individuals “non-attendees”, differentiating them from  
43 both religiously affiliated individuals who attend services (attendees) and those reporting  
44 no religious affiliation (non-religious). In population level studies, non-attendees are  
45 often simply assumed to resemble the non-religious (Woodberry, Park, Kellstedt,  
46 Regnerus, & Steensland, 2012). The implication of this assumption is that in their  
47 mental health, physical health, and other variables affected by religiosity, non-attendees  
48 should resemble the non-religious. More nuanced conclusions can be found in studies  
49 of adolescent non-attendees. The reality seems to be more complex, although much of  
50 the research only holds for specific contexts. For example, non-attendeer adolescents  
51 who do not believe in God may have different social attitudes to poverty, the  
52 environment and drug use to non-religious adolescents (Robbins & Francis, 2010).  
53 Many non-attendeer adolescents regard religion as extremely important in their lives,  
54 distinguishing them from non-religious youth (Smith & Denton, 2005). Non-attendees  
55 may have negative emotions associated with their lack of religious practices that  
56 nonreligious people do not, especially if they previously attended religious services. For  
57 example, individuals who profess an affiliation but do not attend religious services have  
58 sometimes been referred to using terms with a long pejorative pedigree such as

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

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

## 72 **Methods**

### 73 ***Data source***

74 The Australian Study of Health and Relationships (ASHR) was a large-scale, national  
75 survey of sexual health and relationships amongst Australian adults aged 16-59 (Smith,  
76 Rissel, Richters, Grulich, & de Visser, 2003; Smith, Rissel, Richters, Grulich, & de  
77 Visser, 2005). The methods are described in detail in papers originally arising from the  
78 study and are only described briefly here (Smith et al., 2003). In 2001-2002 a modified  
79 random-digit dialing method was used to recruit a sample for the administration of  
80 computer assisted telephone interviews. 19,307 computer assisted telephone interviews  
81 were conducted (10,173 men and 9,134 women). Participants were asked a range of  
82 questions about their general and sexual health and relationships. Demographic  
83 information was also collected about the participants, including their religious affiliation  
84 and attendance at religious services. A subset of 7,653 participants (4,184 men and  
85 3,469 women) were asked a set of additional questions about their health and  
86 relationships (de Visser, Smith, Richters, & Rissel, 2007), some of which concerned  
87 mental health. Participants who received this survey are described as having

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

95

## 96 ***Measures***

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

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

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

## 120 ***Statistical analysis***

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

140

## 141 **Results**

### 142 ***Demographic characteristics***

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

145 3387). Of the attendee group, 66.28% ( $N = 2245$ ) attended less than monthly, with most  
 146 of these ( $N = 1887$ ) attending only on special occasions. Non-attendees, attendees and  
 147 the non-religious did not differ significantly by age, sex, marital status or number of  
 148 children. The reported religious affiliations of non-attendees, however, differed  
 149 substantially from those of attendees. Relevant demographic characteristics of the non-  
 150 attendee group are summarised in Table 1, with the same characteristics for those who  
 151 attend services and non-religious individuals presented for easy comparison.

152 Table 1. Comparison of reported religious affiliation amongst non-attendees and  
 153 attendees. Odds ratios associated with being a non-attendee are given for significant  
 154 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)

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

### 156 **Mental Health**

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

159 attendees were more likely to say that they felt nervous “all of the time” (OR 1.38, 95%  
 160 CI 1.02-1.86,  $p=0.03$ ), and less likely to say that they felt nervous “a little” (OR 2.10,  
 161 95% CI 0.67-0.96,  $p=0.02$ ). Non-attendees were more likely than both nonreligious  
 162 individuals and attendees to say that they felt like nothing could cheer them up “most of  
 163 the time” (Table 2). They were less likely than the non-religious (OR 0.83, 95% CI 0.71-  
 164 0.98,  $p=0.04$ ) and attendees (OR 0.83, 95% CI 0.69-0.99,  $p=0.04$ ) to say that they felt  
 165 restless “a little”. Non-attendees were less likely than the non-religious (OR 0.78, 95%  
 166 CI 0.63 – 0.98,  $p=0.03$ ), but not attendees, to say they felt “a little” that everything was  
 167 an effort. Compared to both the non-religious and attendees, non-attendees were less  
 168 likely to report feeling hopeless “a little” (Table 2). On the other hand, they were more  
 169 likely than attendees, but not non-religious people, to report feeling hopeless and  
 170 worthless “all the time” (Table 2). Where non-attendees differed in similar ways from  
 171 attendees and non-religious, the degree of difference from non-religious people was  
 172 always more extreme than that from attendees, as shown in Table 2.

173  
 174 Table 2. Selected significant differences in responses to health related survey questions  
 175 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

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

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

244  
245 Aside from the primary finding that mental health was poorer amongst Christian non-  
246 attendees than Christian attendees, our results were also interesting because they  
247 differed in some important ways from some previously published findings relating to  
248 denominational trends in Church attendance. In our study, self-identifying Protestants  
249 (primarily mainline Protestants and Anglican/ Episcopalians), and “other” Christians  
250 (including evangelicals) were the only groups of Christians who were not significantly  
251 more likely to be attendees than non-attendees (see Table 1). These results are  
252 intriguingly different than those reported in the United States, in particular regarding  
253 Catholics, who are generally less likely to attend than Protestants (Smith & Denton,  
254 2005; Smith, Christoffersen, & Davidson, 2011; Smith et al., 2014). It is unclear why this  
255 should be the case, however Connor (2012) provides one possible indication when he  
256 notes that Australian migrants are most likely to be Catholic or adherents of South Asian  
257 religions. Perhaps the same desire to attend, which we argue goes unsatisfied in the  
258 latter group and is linked to poor mental health, is amply satisfied amongst Catholic  
259 migrants due to the prevalence of Catholic Churches. Statistics on service attendees  
260 from one of Australia’s largest Australian Catholic dioceses offers some support for this

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

266

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

## 287 **Conclusion**

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

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

301

## 302 **References**

- 303 American Psychiatric Association (2000) *Diagnostic and Statistical Manual-Text*  
304 *Revision (DSM-IV-TRim, 2000)*. Arlington, VA: American Psychiatric Association.
- 305 Ano, G.G. & Vasconcelles, E.B. (2004) Religious coping and psychological adjustment  
306 to stress: a meta-analysis. *Journal of Clinical Psychology*, 61(4): 461-480.  
307 doi:10.1002/jclp.20049
- 308 Beaudoin, T. (2013) Deconversion and disaffiliation in contemporary US Roman  
309 Catholicism. *Horizons*, 40(02), 262-274. doi:10.1017/hor.2013.75
- 310 Berger, H., & Ezzy, D. (2007). *Teenage witches: Magical youth and the search for the*  
311 *self*. New York, NY: Rutgers University Press.
- 312 Boyd, T. A. (2013) *Leaving Zion: The experience of disaffiliation from the LDS Church*  
313 (Unpublished doctoral thesis). Pacific University, Oregon.
- 314 Catholic Diocese of Parramatta (2014) Faith in our future: Pastoral plan for the Catholic  
315 Diocese of Parramatta 2014-2018. North Parramatta, NSW, Australia: Catholic

316 Diocese of Parramatta. Retrieved from:  
317 [http://faithinourfuture.files.wordpress.com/2014/02/faith-in-our-future-diocese-of-](http://faithinourfuture.files.wordpress.com/2014/02/faith-in-our-future-diocese-of-parramatta-e28093-full-version-7mb1.pdf)  
318 [parramatta-e28093-full-version-7mb1.pdf](http://faithinourfuture.files.wordpress.com/2014/02/faith-in-our-future-diocese-of-parramatta-e28093-full-version-7mb1.pdf)

319 Connor, P. (2012) Balm for the soul: Immigrant religion and emotional well-being.  
320 *International Migration*, 50(2): 130-157. doi: 10.1111/j.1468-2435.2010.00623.x

321 De Visser, R. O., Smith, A. M., Richters, J. & Rissel, C. E. (2007) Associations between  
322 religiosity and sexuality in a representative sample of Australian adults. *Archives of*  
323 *Sexual Behavior*, 36(1), 33-46. doi 10.1007/s10508-006-9056-0.

324 Idler, E. L., Musick, M. A., Ellison, C. G., George, L. K., Krause, N., Ory, M. G. &  
325 Williams, D. R. (2003) Measuring multiple dimensions of religion and spirituality for  
326 health research: Conceptual background and findings from the 1998 general social  
327 survey. *Research on Aging*, 25(4), 327-365. doi:10.1177/0164027503025004001.

328 King, M., Marston, L., McManus, S., Brugha, T., Meltzer, H. & Bebbington, P. (2013)  
329 Religion, spirituality and mental health: Results from a national study of English  
330 households. *The British Journal of Psychiatry: The Journal of Mental Science*, 202(1),  
331 68-73. doi:10.1192/bjp.bp.112.112003.

332 Lang, J. B. (1996) On the comparison of multinomial and Poisson log-linear models.  
333 *Journal of the Royal Statistical Society. Series B (Methodological)*, 58(1), 253-266.  
334 Retrieved from <http://www.jstor.org/stable/2346177>

335 Lumley, T. (2011). *Complex surveys: A guide to analysis using R*. Hoboken, New  
336 Jersey: John Wiley & Sons.

337 Maselko, J., Hayward, R. D., Hanlon, A., Buka, S. & Meador, K. (2012) Religious  
338 service attendance and major depression: A case of reverse causality? *American*  
339 *Journal of Epidemiology*, 175(6), 576-583. doi:10.1093/aje/kwr349.

- 340 Nelson, C. J., Rosenfeld, B., Breitbart, W. & Galietta, M. (2002) Spirituality, religion, and  
341 depression in the terminally ill. *Psychosomatics*, 43(3), 213-220.  
342 doi:10.1176/appi.psy.43.3.213
- 343 Pargament, K.I., Koenig, H.G. & Perez, L. (2000) The many methods of religious  
344 coping: development and initial validation of the RCOPE. *Journal of Clinical*  
345 *Psychology*, 56(4), 519-543.
- 346 Pargament, K.I., Smith, B.W., Koenig, H.G. & Perez, L. (1998) Patterns of positive and  
347 negative religious coping with major life stressors. *Journal for the Scientific Study of*  
348 *Religion*, 37(4), 710-724.
- 349 Pew Research Center (2013) *A portrait of Jewish Americans: Findings from a Pew*  
350 *Research Center survey of U.S. Jews*. Washington, D.C.: Pew Research Center's  
351 Religion & Public Life Project. Retrieved from  
352 <http://www.pewforum.org/files/2013/10/jewish-american-full-report-for-web.pdf>
- 353 Robbins, M. & Francis, L. J. (2010) The teenage religion and values survey in england  
354 and wales: An overview. *British Journal of Religious Education*, 32(3), 307 - 320.  
355 doi:10.1080/01416200.2010.498623.
- 356 Smith, A. M. A., Rissel, C. E., Richters, J., Grulich, A. E. & de Visser, R. O. (2005)  
357 *Australian studies of health and relationships, 2001-2002, [computer file]*. Canberra:  
358 Australian Social Sciences Data Archive, The Australian National University.  
359 Retrieved March 10, 2014, from [http://www.ada.edu.au/social-](http://www.ada.edu.au/social-science/browse/health/australian-studies-of-health-and-relationships)  
360 [science/browse/health/australian-studies-of-health-and-relationships](http://www.ada.edu.au/social-science/browse/health/australian-studies-of-health-and-relationships)
- 361 Smith, A., Rissel, C. E., Richters, J., Grulich, A. E. & Visser, R. O. (2003) Sex in  
362 Australia: The rationale and methods of the Australian study of health and  
363 relationships. *Australian and New Zealand Journal of Public Health*, 27(2), 106-117.  
364 doi: 10.1111/j.1467-842X.2003.tb00797

- 365 Smith, C., Christoffersen, K., & Davidson, H. (2011) *Lost in transition: The dark side of*  
366 *emerging adulthood*. New York, NY: Oxford University Press.
- 367 Smith, C., & Denton, M. L. (2005) *Soul searching: The religious and spiritual lives of*  
368 *American teenagers*. New York, NY: Oxford University Press.
- 369 Smith, C., Longest, K., Hill, J. & Christoffersen, K. (2014) *Young Catholic America:*  
370 *Emerging adults in, out of, and gone from the Church*. New York, NY: Oxford  
371 University Press.
- 372 Smith, T. B., McCullough, M. E. & Poll, J. (2003) Religiousness and depression:  
373 Evidence for a main effect and the moderating influence of stressful life events.  
374 *Psychological Bulletin*, 129(4), 614. doi:10.1037/0033-2909.129.4.614.
- 375 Steel, Z., Marnane, C., Iranpour, C., Chey, T., Jackson, J. W., Patel, V. & Silove, D.  
376 (2014) The global prevalence of common mental disorders: A systematic review and  
377 meta-analysis 1980–2013, *International Journal of Epidemiology*, 43(2), 476-493.  
378 doi:10.1093/ije/dyu038.
- 379 Villaroman, N. G. (2012) 'Not in my backyard': The local planning process in Australia  
380 and its impact on minority places of worship, *Religion and Human Rights*, 7(3), 215-  
381 239. doi: 10.1163/18710328-12341237
- 382 Voas, D. (2009) The rise and fall of fuzzy fidelity in Europe. *European Sociological*  
383 *Review*, 25(2), 155-168. doi:10.1093/esr/jcn044.
- 384 Voas, D. & Crockett, A. (2005) Religion in Britain: Neither believing nor belonging.  
385 *Sociology*, 39(1), 11-28. doi:10.1177/0038038505048998.
- 386 Warraq, I. (2003) *Leaving Islam: Apostates speak out*. Amherst, NY: Prometheus  
387 Books.

388 Wong, Y. J., Rew, L., & Slaikeu, K. D. (2006) A systematic review of recent research on  
389 adolescent religiosity/spirituality and mental health. *Issues in Mental Health Nursing*,  
390 27(2), 161-183. doi:10.1080/01612840500436941.

391 Woodberry, R. D., Park, J. Z., Kellstedt, L. A., Regnerus, M. D., & Steensland, B. (2012)  
392 The measure of American religious traditions: Theoretical and measurement  
393 considerations. *Social Forces*, 91(1), 65-73. doi: 10.1093/sf/sos121